

		FOR BHF USE					

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**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0004630</u></p> <p>Facility Name: <u>Christian Nursing Home</u></p> <p>Address: <u>1507 7th Street</u> <u>Lincoln</u> <u>62656</u> <small>Number City Zip Code</small></p> <p>County: <u>Logan</u></p> <p>Telephone Number: <u>217-732-2189</u> Fax # <u>217-732-1904</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/1/1965</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kenna Hudson</u> Telephone Number: <u>314-587-7924</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/14</u> to <u>6/30/15</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Dr. Timothy Phillippe</u> (Title) <u>CEO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Amanda Tinney, CPA</u> <u>Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4389</u> Fax # <u>314-925-4350</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Dr. Timothy Phillippe</u> (Title) <u>CEO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Amanda Tinney, CPA</u> <u>Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4389</u> Fax # <u>314-925-4350</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Dr. Timothy Phillippe</u> (Title) <u>CEO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Amanda Tinney, CPA</u> <u>Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4389</u> Fax # <u>314-925-4350</u>							

Facility Name & ID Number Christian Nursing Home

0004630 Report Period Beginning: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,119	14,859	4,652	36,630	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,119	14,859	4,652	36,630	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.60%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals, Lawn & Maint. Care, Housekeeping & Laundry Services for IL Residents

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 09/01/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 112 and days of care provided 3,313

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	271,696	25,928		297,624		297,624		297,624		1
2	Food Purchase		244,345		244,345		244,345	(819)	243,526		2
3	Housekeeping	101,378	28,221		129,599		129,599		129,599		3
4	Laundry	49,671	6,446		56,117		56,117		56,117		4
5	Heat and Other Utilities			157,397	157,397		157,397	543	157,940		5
6	Maintenance	81,882	17,806	114,296	213,984		213,984	4,562	218,546		6
7	Other (specify):* Trash			2,724	2,724		2,724		2,724		7
8	TOTAL General Services	504,627	322,746	274,417	1,101,790		1,101,790	4,286	1,106,076		8
	B. Health Care and Programs										
9	Medical Director			28,800	28,800		28,800		28,800		9
10	Nursing and Medical Records	2,153,549	89,637	223,793	2,466,979		2,466,979		2,466,979		10
10a	Therapy		2,931	699,613	702,544		702,544		702,544		10a
11	Activities	68,148	5,136		73,284		73,284		73,284		11
12	Social Services	164,692	2,588	13,501	180,781		180,781		180,781		12
13	CNA Training										13
14	Program Transportation	24,395		4,728	29,123		29,123	(5,700)	23,423		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,410,784	100,292	970,435	3,481,511		3,481,511	(5,700)	3,475,811		16
	C. General Administration										
17	Administrative	94,100	1,173	465,000	560,273		560,273	(332,454)	227,819		17
18	Directors Fees										18
19	Professional Services			35,926	35,926		35,926	39,705	75,631		19
20	Dues, Fees, Subscriptions & Promotions			35,700	35,700		35,700		35,700		20
21	Clerical & General Office Expenses	91,010	8,827	214,938	314,775		314,775	126,249	441,024		21
22	Employee Benefits & Payroll Taxes			780,160	780,160		780,160	44,653	824,813		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,212	10,212		10,212	23,645	33,857		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			111,365	111,365		111,365	(10,484)	100,881		26
27	Other (specify):* Marketing	38,757	2,360	35,668	76,785		76,785	(76,785)			27
28	TOTAL General Administration	223,867	12,360	1,688,969	1,925,196		1,925,196	(185,471)	1,739,725		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,139,278	435,398	2,933,821	6,508,497		6,508,497	(186,885)	6,321,612		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			619,263	619,263	619,263	37,241	656,504				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,748	201,748	201,748	(91,108)	110,640				32
33	Real Estate Taxes			2,822	2,822	2,822	(2,822)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,255	17,255	17,255		17,255				35
36	Other (specify):*											36
37	TOTAL Ownership			841,088	841,088	841,088	(56,689)	784,399				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			253,972	253,972	253,972	(5,940)	248,032				39
40	Barber and Beauty Shops			32,035	32,035	32,035		32,035				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,555	263,555	263,555		263,555				42
43	Other (specify):* Apt/Congregate	171,596		369,346	540,942	540,942	(540,942)					43
44	TOTAL Special Cost Centers	171,596		918,908	1,090,504	1,090,504	(546,882)	543,622				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,310,874	435,398	4,693,817	8,440,089	8,440,089	(790,456)	7,649,633				45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/14

Ending: 6/30/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(819)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,358)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(91,108)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,272)	21		24
25	Fund Raising, Advertising and Promotional	(76,785)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(552,394)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (847,736)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	57,280		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 57,280		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (790,456)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Christian Nursing Home

ID# 0004630

Report Period Beginning: 7/1/14

Ending: 6/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Transportation	\$ (5,700)	14	1
2	Apt / Congregate	(540,942)	43	2
3	Real Estate Tax	(2,822)	33	3
4	Late Fees, Fines and Penalties	(2,238)	21	4
5	Miscellaneous Revenue	(690)	21	5
6	Late Fees, Fines and Penalties	(2)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(552,394)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(819)	0	0	0	0	0	0	0	0	0	0	(819)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,358)	1,901	0	0	0	0	0	0	0	0	0	543	5
6	Maintenance	(2)	4,564	0	0	0	0	0	0	0	0	0	4,562	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,179)	6,465	0	4,286	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(5,700)	0	0	0	0	0	0	0	0	0	0	(5,700)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,700)	0	0	0	0	0	0	0	0	0	0	(5,700)	16
	C. General Administration													
17	Administrative	0	(332,454)	0	0	0	0	0	0	0	0	0	(332,454)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	39,705	0	0	0	0	0	0	0	0	0	39,705	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(128,200)	254,449	0	0	0	0	0	0	0	0	0	126,249	21
22	Employee Benefits & Payroll Taxes	0	44,653	0	0	0	0	0	0	0	0	0	44,653	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	23,645	0	0	0	0	0	0	0	0	0	23,645	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(10,484)	0	0	0	0	0	0	0	0	0	(10,484)	26
27	Other (specify):*	(76,785)	0	0	0	0	0	0	0	0	0	0	(76,785)	27
28	TOTAL General Administration	(204,985)	19,514	0	(185,471)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(212,864)	25,979	0	(186,885)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	37,241	0	0	0	0	0	0	0	0	0	37,241	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(91,108)	0	0	0	0	0	0	0	0	0	0	(91,108)	32
33	Real Estate Taxes	(2,822)	0	0	0	0	0	0	0	0	0	0	(2,822)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(93,930)	37,241	0	(56,689)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(5,940)	0	0	0	0	0	0	0	0	0	(5,940)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(540,942)	0	0	0	0	0	0	0	0	0	0	(540,942)	43
44	TOTAL Special Cost Centers	(540,942)	(5,940)	0	(546,882)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(847,736)	57,280	0	0	0	0	0	0	0	0	0	(790,456)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board of Directors Attachment						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 1,901	\$ 1,901	1
2	V	6 Maintenance				4,564	4,564	2
3	V	17 Administrative	465,000			132,546	(332,454)	3
4	V	19 Professional Services				39,705	39,705	4
5	V	21 Clerical				253,636	253,636	5
6	V	22 Employee Benefits				44,653	44,653	6
7	V	21 Dues & Subscriptions				178	178	7
8	V	24 Travel and Seminars				23,645	23,645	8
9	V	26 Insurance				(10,484)	(10,484)	9
10	V	30 Depreciation				37,241	37,241	10
11	V	21 Other Administrative Expense				635	635	11
12	V	39 Pharmacy Services	191,619	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	185,679	(5,940)	12
13	V							13
14	Total		\$ 656,619			\$ 713,899	\$ * 57,280	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	This workpaper is N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	This workpaper is N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning:

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Ending:

6/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Illinois Finance Authority Series 2007	X		Refinance Debt		6/30/2007	\$ 382,171	\$ 898,306	6/30/2031	5.6700	\$ 47,758						
2	Illinois Finance Authority Series 2010	X		Refinance Debt		7/31/2010	2,000,000	2,008,181	5/15/2027	6.1300	123,011						
3	Bond Fund	X		Debt Relocation	\$3,314.00	***	843,874	547,014	6/30/2032	***	30,979						
4											4						
5											5						
Working Capital																	
6											6						
7											7						
8											8						
9	TOTAL Facility Related				\$3,314.00		\$ 3,226,045	\$ 3,453,501			\$ 201,748						
B. Non-Facility Related*																	
10											10						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 3,226,045	\$ 3,453,501			\$ 201,748						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2014 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 314-587-7916

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-623-005-00</u>	<u>See Attached Tax Bills</u>	\$ <u>341.00</u>	\$ _____
2. <u>12-036-031-00</u>	<u>See Attached Tax Bills</u>	\$ <u>1,003.00</u>	\$ _____
3. <u>12-036-032-00</u>	<u>See Attached Tax Bills</u>	\$ <u>980.00</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>2,324.00</u></u>	\$ <u><u> </u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Christian Nursing Home

0004630 Report Period Beginning:

7/1/14 Ending:

6/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS

CONGREGATE BUILDING

DUPLEXS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>42,000</u>	<u>Various</u>	<u>\$ 82,465</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>6,890</u>	<u>2</u>
3	TOTALS	42,000		\$ 89,355	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

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6/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	48	1965	1965	\$ 272,125	\$	54	\$	\$	\$ 272,125	4
5	26	1969	1969	282,500		50			282,500	5
6	26	1972	1972	318,878		47			318,878	6
7	12		2000	1,279,292	31,982	40	31,982		471,739	7
8	Home Office Allocation			66,812	7,184		7,184		49,536	8
	Improvement Type**									
9	Various		1965	153,924	19,026	Various	19,026		79,404	9
10	Various		1975	22,324		Various			22,324	10
11	Various		1976	754		Various			754	11
12	Various		1979	11,989	266	Various	266		9,613	12
13	Various		1980	37,495		Various			38,309	13
14	Various		1981	2,005		Various			2,005	14
15	Various		1982	19,747		Various			19,747	15
16	Various		1983	88,870		Various			88,869	16
17	Various		1984	5,420		Various			5,420	17
18	Various		1985	77,584	223	Various	223		76,488	18
19	Various		1986	24,379		Various			24,379	19
20	Various		1987	21,639		Various			21,639	20
21	Various		1988	10,116		Various			10,116	21
22	Various		1989	58,128		Various			58,128	22
23	Various		1990	16,116	20	Various	20		15,915	23
24	Various		1991	12,572	20	Various	20		12,350	24
25	Various		1992	22,776		Various			22,776	25
26	Various		1993	18,422	394	Various	394		18,415	26
27	Various		1994	10,251		Various			10,251	27
28	Various		1995	46,568		Various			46,568	28
29	Various		1996	18,144		Various			18,144	29
30	Various		1997	34,079		Various			34,079	30
31	Various		1998	47,371		Various			47,371	31
32	Various		1999	40,547	247	Various	247		40,547	32
33	Various		2000	915,480	22,208	Various	22,208		370,797	33
34	Various		2001	59,289		Various			59,289	34
35	Various		2002	16,745	629	Various	629		15,277	35
36	Various		2003	72,782		Various			72,782	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2004	\$ 31,268	\$	Various	\$	\$	\$ 31,268	37
38	Various	2005	50,766	3,582	Various	3,582		50,373	38
39	Various	2006	47,183	2,342	Various	2,342		38,521	39
40	Various	2007	6,145	615	Various	615		4,799	40
41	Various	2008	131,902	13,190	Various	13,190		94,140	41
42	Various	2009	258,283	19,824	Various	19,824		123,816	42
43	Various	2010	42,717	4,272	Various	4,272		22,049	43
44	400 Hall - Skylight Roof	4/30/2011	6,250	110	10	110		475	44
45	300 Hall - Repaired recirculation line	3/31/2011	1,095	66	10	66		284	45
46	Central Dayroom - Carpet	3/31/2011	656	20	10	20		86	46
47	Chaplain Office - Carpet	6/30/2011	3,298	625	10	625		2,656	47
48	100 Hall Shower Room - Whirlpool Tub	6/30/2011	8,508	330	10	330		1,347	48
49	100 Wing A/C Replacement	9/14/2011	2,609	851	10	851		3,474	49
50	Therapy Gym - Wall Cabinets	4/14/2011	201	261	10	261		1,000	50
51	Hot Water Heater	3/14/2012	5,188	519	10	519		1,729	51
52	SNF Plumbing	7/1/2012	5,117	256	20	256		768	52
53	SNF Roofing	7/1/2012	19,300	1,930	10	1,930		5,790	53
54	Fire Alarm System	7/1/2012	122,597	12,260	10	12,260		36,779	54
55	Circuit Breakers	7/1/2012	7,250	483	15	483		1,450	55
56	40x40 Garage	7/1/2012	40,468	1,619	25	1,619		4,856	56
57	SNF Ceiling/Drywall	7/1/2012	1,423	142	10	142		427	57
58	SNF Doors and Locks	7/1/2012	5,611	561	10	561		1,683	58
59	HVAC	7/1/2012	31,853	2,124	15	2,124		6,371	59
60	Nurse Call System	7/1/2012	2,355	235	10	235		706	60
61	SNF Flooring	7/1/2012	7,267	1,453	5	1,453		4,360	61
62	Electric Rewiring and Panels	7/1/2012	27,428	1,371	20	1,371		4,114	62
63	SNF Ceiling Tracks/Walls	7/1/2012	307,874	30,787	10	30,787		92,362	63
64	SNF Painting	7/1/2012	161,416	16,142	10	16,142		48,425	64
65	SNF Flooring	7/1/2012	246,763	24,676	10	24,676		74,029	65
66	SNF HVAC	7/1/2012	146,459	9,764	15	9,764		29,292	66
67	SNF Plumbing/Electric	7/1/2012	384,150	19,208	20	19,208		57,623	67
68	SNF Lighting/Appliances	7/1/2012	24,367	2,437	10	2,437		7,310	68
69	SNF Doors	7/1/2012	22,643	2,264	10	2,264		6,793	69
70	TOTAL (lines 4 thru 69)		\$ 6,245,533	\$ 256,518		\$ 256,518	\$	\$ 3,395,689	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

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Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,245,533	\$ 256,518		\$ 256,518	\$	\$ 3,395,689	1
2	SNF Cabinetry	7/1/2012	28,283	2,828	10	2,828		8,485	2
3	SNF Wardrobes/Cabinets	7/1/2012	148,943	14,894	10	14,894		44,683	3
4	SNF Doors/Hardware	7/1/2012	89,067	8,907	10	8,907		26,720	4
5	SNF Nurse Station	7/1/2012	87,912	5,861	15	5,861		17,582	5
6	SNF Ceiling Tracks/Studs	7/1/2012	289,088	28,909	10	28,909		86,726	6
7	SNF Flooring	7/1/2012	111,988	11,199	10	11,199		33,596	7
8	SNF Electrical Work/Lighting	7/1/2012	269,685	17,979	15	17,979		53,937	8
9	SNF Painting	7/1/2012	54,628	5,463	10	5,463		16,389	9
10	Fire Sprinkler	7/1/2012	434,888	17,396	25	17,396		52,187	10
11	IDPH Design and Plan for SNF	7/1/2012	11,736	1,174	10	1,174		3,521	11
12	Asbestos Survey	7/1/2012	10,465	1,047	10	1,047		3,140	12
13	Ceiling/Sky Lights	7/1/2012	2,685	269	10	269		806	13
14	Sign for Main Entrance	7/24/2012	3,143	314	10	314		943	14
15	Courtyard Design and Specifications	7/10/2012	1,847	185	10	185		554	15
16	17 Holes- Excavation	10/4/2012	6,922	461	15	461		1,269	16
17	Electrical work- main dining room	7/13/2012	1,756	176	10	176		527	17
18	Dementia Wing- 2 doors	7/18/2012	1,938	194	10	194		581	18
19	Dining Room Windows/Awning	12/27/2012	11,211	1,121	10	1,121		2,896	19
20	Electricalwork- 300 hall	7/1/2012	2,248	314	10	314		943	20
21	10 Ton AC Unit- 300 Hall	7/1/2012	5,488	461	10	461		1,269	21
22	400 Hall Shower Room Tub	7/1/2012	2,168	1,121	10	1,121		2,896	22
23	Emergency Stop/Light for Generator	1/29/2013	940	47	20	47		118	23
24	Fire Alarm Module Installation	2/1/2013	1,072	107	10	107		259	24
25	Boiler Circulation Pump	2/12/2013	3,100	310	10	310		749	25
26	Sewer Mapping/Improvement	3/14/2013	277	28	10	28		65	26
27	SNF Casework- 400 Hall/Alz Unit	6/30/2013	38,377	3,838	10	3,838		7,995	27
28	SNF Doors/Hardware/Locks- 400 Hall/Alz	6/30/2013	25,215	2,522	10	2,522		5,253	28
29	SNF Crash Oak Rails- 400 Hall/Alz	6/30/2013	14,391	1,439	10	1,439		2,998	29
30	SNF Ceiling Work- Tracks and Tiles	6/30/2013	1,305	130	10	130		272	30
31	SNF Painting and Demo- 400 Hall/Alz	6/30/2013	187,377	18,738	10	18,738		39,037	31
32	SNF Flooring and Demo- 400 Hall/Alz	6/30/2013	182,647	18,265	10	18,265		38,051	32
33	SNF Lighting & Electric- 400 Hall/Alz	6/30/2013	5,315	532	10	532		1,107	33
34	TOTAL (lines 1 thru 33)		\$ 8,281,638	\$ 422,747		\$ 422,747	\$	\$ 3,851,243	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,281,638	\$ 422,747		\$ 422,747	\$	\$ 3,851,243	1
2	Sprinkler	6/30/2013	4,262	170	25	170		355	2
3	Nurse's Station Maglock Doors	6/30/2013	3,536	354	10	354		737	3
4	400 Hall Nurse's Station Electric	1/18/2013	1,751	175	10	175		438	4
5	Vinyl for 400 Hall Lounge	6/14/2013	4,225	423	10	423		880	5
6	Carpet- 400 Wing	6/19/2013	24,847	4,969	5	4,969		10,353	6
7	Doors & Locks- 200 Hall	6/25/2013	2,243	224	10	224		467	7
8	Flooring- Oxygen Room	9/17/2013	800	80	10	80		147	8
9	Oxygen Room- Ceiling Replacement	9/4/2013	706	71	10	71		129	9
10	Oxygen Room- Exhaust Fan & Roof Curb	12/9/2013	3,451	345	10	345		546	10
11	Sewer Discovery	2/13/2013	17,068	627	25	627		1,594	11
12	Excavate and Repair Sewer Lines/Manhol	6/13/2013	12,100	555	20	555		1,211	12
13	Directional Sign & Graphics	10/23/2013	3,730	342	10	342		622	13
14	Repalce AC in the kitchen	6/19/2014	17,980	1,798	10	1,798		1,948	14
15	Install power to POE injectors Wireles	1/14/2015	1,377	57	10	57		57	15
16	Whirlpool door	12/2/2014	2,805	140	10	140		140	16
17	Hydraulic sink install @ beauty shop	3/20/2015	3,564	90	10	90		90	17
18	Install Emergency door	4/21/2015	9,993	167	10	167		167	18
19	Emergency Exit bar	4/21/2015	2,123	36	10	36		36	19
20	Asphalt paving & concrete of parking l	6/25/2014	77,561	8,898	8	8,898		9,706	20
21	Sewer Project	3/17/2014	190,800	7,005	25	7,005		9,549	21
22	Install power to POE injectors Wireles	1/14/2015	1,377	69	10	69		69	22
23	Whirlpool door	12/2/2014	2,805	164	10	164		164	23
24	Hydraulic sink install @ beauty shop	3/20/2015	3,564	119	10	119		119	24
25	Install Emergency door	4/21/2015	9,993	250	10	250		250	25
26	Emergency Exit bar	4/21/2015	2,123	53	10	53		53	26
27	Replace resident garage door	5/7/2015	522	9	10	9		9	27
28									28
29									29
30									30
31									31
32	To Tie to FS		(7,788)	161		161		64	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,679,156	\$ 450,098		\$ 450,098	\$	\$ 3,891,143	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 875,060	\$ 137,144	\$ 137,144	\$		\$ 531,405	71
72	Current Year Purchases	82,428	8,421	8,421			8,421	72
73	Fully Depreciated Assets	800,543	13,361	13,361			800,543	73
74	Home Office Allocation	268,255	28,843	28,843			183,069	74
75	TOTALS	\$ 2,026,286	\$ 187,769	\$ 187,769	\$		\$ 1,523,438	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	See Detail Attachment	Various	\$ 106,928	\$ 17,423	\$ 17,423	\$	Various	\$ 93,743	76
77										77
78										78
79	Home Office Allocation			11,292	1,214	1,214			7,809	79
80	TOTALS			\$ 118,220	\$ 18,637	\$ 18,637	\$		\$ 101,552	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,913,017	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 656,504	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 656,504	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,516,133	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Ford Ranger Truck	\$ 4,800	\$	\$ 4,800	86
87	Tandem Axel Utility Trailer	900		900	87
88	Land	229,930			88
89	Apartment/Congregate	2,254,257	72,762	1,641,570	89
90	Duplex	2,280,494	64,464	1,684,216	90
91	TOTALS	\$ 4,770,381	\$ 137,226	\$ 3,331,486	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 273,979	92
93	Home Office Allocation	102	93
94			94
95		\$ 274,081	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/14

Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 26,788 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/14 Ending: 6/30/15
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>TCV only hires certified CNAs.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	V10A-3	hrs	\$	6,273	\$	249,639	\$	6,273	\$	249,639	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,844		102,501		1,844		102,501	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	V10A-3	hrs		7,897		347,473		7,897		347,473	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$	16,014	\$	699,613	\$	16,014	\$	699,613	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/14

Ending:

6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 4,924,263	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>89,488</u>)	865,411		3
4	Supply Inventory (priced at)	10,652		4
5	Short-Term Investments	703,185		5
6	Prepaid Insurance	13,093		6
7	Other Prepaid Expenses	16,673		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int. / Other A/R</u>	145,371		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,678,648	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	200,000		11
12	Long-Term Investments			12
13	Land	322,808		13
14	Buildings, at Historical Cost	12,335,798		14
15	Leasehold Improvements, at Historical Cost	560,582		15
16	Equipment, at Historical Cost	2,110,961		16
17	Accumulated Depreciation (book methods)	(8,607,205)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,736,120		21
22	Other Long-Term Assets (spec <u>CIP</u>)	273,979		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,933,043	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,611,691	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 67,629	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,393		28
29	Short-Term Notes Payable	255,226		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,162		32
33	Accrued Interest Payable	22,141		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Other Accrued Liabilities</u>	242,050		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 622,601	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,453,501		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees</u>	462,734		43
44	<u>Apt & Cong Life Right & Sec</u>	381,325		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,297,560	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,920,161	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,691,530	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,611,691	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,826,648	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,826,648	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	864,885	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 864,882	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,691,530	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,882,639	1
2	Discounts and Allowances for all Levels	(2,357,241)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,525,398	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,794,925	6
7	Oxygen	1,465	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,796,390	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	31,554	13
14	Non-Patient Meals	819	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,358	16
17	Sale of Drugs	198,353	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,194	19
20	Radiology and X-Ray	28,227	20
21	Other Medical Services	50,888	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 378,393	23
D. Non-Operating Revenue			
24	Contributions	630,526	24
25	Interest and Other Investment Income***	91,108	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 721,634	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	856,784	28
28a	<u>Miscellaneous</u>	26,375	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 883,159	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,304,974	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,101,790	31
32	Health Care	3,481,511	32
33	General Administration	1,925,196	33
B. Capital Expense			
34	Ownership	841,088	34
C. Ancillary Expense			
35	Special Cost Centers	826,949	35
36	Provider Participation Fee	263,555	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,440,089	40
41	Income before Income Taxes (line 30 minus line 40)**	864,885	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 864,885	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,452,186	44
45	Private Pay - Net Inpatient Revenue	2,555,988	45
46	Medicare - Net Inpatient Revenue	(475,019)	46
47	Other-(specify) <u>HMO/Medicare Advantage/Outpatient Part B</u>	(79,222)	47
48	Other-(specify) <u>Nursing</u>	71,465	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,525,398	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

Ending:

6/30/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,240	1,458	\$ 52,602	\$ 36.08	1
2	Assistant Director of Nursing	1,768	1,987	60,573	30.48	2
3	Registered Nurses	7,819	8,294	215,106	25.94	3
4	Licensed Practical Nurses	28,235	30,964	636,462	20.55	4
5	CNAs & Orderlies	85,952	93,278	1,056,691	11.33	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	2,493	2,527	30,270	11.98	9
10	Activity Assistants	1,973	2,199	23,846	10.84	10
11	Social Service Workers	7,435	8,408	141,274	16.80	11
12	Dietician	1,888	2,120	53,871	25.41	12
13	Food Service Supervisor	-	-	-		13
14	Head Cook	6,865	7,381	71,969	9.75	14
15	Cook Helpers/Assistants	12,537	13,368	124,165	9.29	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	2,688	2,886	35,842	12.42	17
18	Housekeepers	10,574	11,666	101,995	8.74	18
19	Laundry	3,487	3,812	35,875	9.41	19
20	Administrator	1,730	2,110	94,708	44.89	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	3,647	4,194	67,287	16.04	23
24	Clerical	3,303	3,635	38,937	10.71	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	1,832	2,028	31,174	15.37	31
32	Other Health Care(specify)	8,186	8,800	205,233	23.32	32
33	Other(specify)	14,904	17,034	232,994	13.68	33
34	TOTAL (lines 1 - 33)	208,556	228,149	\$ 3,310,874 *	\$ 14.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	144	28,800	V09-3	36
37	Medical Records Consultant	45	2,393	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	3,033	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	68	4,426	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	401	\$ 38,652		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	932	\$ 71,345	V10-3	50
51	Licensed Practical Nurses	108	4,073	V10-3	51
52	Certified Nurse Assistants/Aides	5,526	130,963	V10-3	52
53	TOTAL (lines 50 - 52)	6,566	\$ 206,381		53

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/14

Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jo Hillard	Administrator	0	\$ 94,100	Workers' Compensation Insurance	\$ 141,035	IDPH License Fee	\$		
				Unemployment Compensation Insurance	15,361	Advertising: Employee Recruitment	2,546		
				FICA Taxes	239,422	Health Care Worker Background Check			
				Employee Health Insurance	330,990	(Indicate # of checks performed <u>17</u>)	493		
				Employee Meals		Patient Background Checks	108		
				Illinois Municipal Retirement Fund (IMRF)*			1,080		
				New Hire Expense	36,593	License	2,471		
				Employee Uniforms	606	Dues	20,426		
				Employee Expense	10,653	Subscriptions	8,683		
				457 Plan Expense	5,500				
						Less: Public Relations Expense	()		
				Home Office Allocation	44,653	Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 94,100	TOTAL (agree to Schedule V, line 22, col.8)	\$ 824,813	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,700		
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fee			\$ 465,000				Out-of-State Travel	\$ 3,391	
							In-State Travel	4,803	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 465,000				Seminar Expense	2,018	
(Attach a copy of any management service agreement)									
C. Professional Services				TOTAL			Home Office Allocation		23,645
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Pathway Health	Pathway Health		\$ (2,000)				(agree to Sch. V, line 24, col. 8)		
National Research	Employee Surveys		1,684				TOTAL	\$ 33,857	
Davis & Campbell	Legal		26,948						
Heyl, Royster, Voelker	Legal		155						
Polsinelli Shughart, PC	Legal		999						
Rick Hobler	Legal		1,375						
Thomas Van Hook	Legal		360						
Delaney, Delaney & Voorn	Legal		6,405						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 35,926						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/14

Ending: 6/30/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN/Leading Age - \$8,557.03
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,191 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 263,555
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 819
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTONLARSONALLEN LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.