

Facility Name & ID Number Christian Nursing Home

0004630 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 _____

	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	124	Skilled (SNF)	124	45,260	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	124	TOTALS	124	45,260	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,210	15,899	6,204	38,313	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,210	15,899	6,204	38,313	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.65%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 9/1/1995

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 124 and days of care provided 4,056

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/17 Fiscal Year: 6/30/17

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

Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning:

7/1/16

Ending:

6/30/17

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	248,293	29,441	2,650	280,384		280,384		280,384		1
2	Food Purchase		235,909		235,909		235,909	(1,875)	234,034		2
3	Housekeeping	109,649	24,734		134,383		134,383		134,383		3
4	Laundry	52,868	1,686		54,554		54,554		54,554		4
5	Heat and Other Utilities			161,710	161,710		161,710	807	162,517		5
6	Maintenance	58,889	5,820	109,282	173,991		173,991	3,246	177,237		6
7	Other (specify):* Trash			3,725	3,725		3,725		3,725		7
8	TOTAL General Services	469,699	297,590	277,367	1,044,656		1,044,656	2,178	1,046,834		8
	B. Health Care and Programs										
9	Medical Director			28,800	28,800		28,800		28,800		9
10	Nursing and Medical Records	2,782,830	134,882	151,346	3,069,058		3,069,058	(3,122)	3,065,936		10
10a	Therapy			777,873	777,873		777,873		777,873		10a
11	Activities	78,492	4,718	869	84,079		84,079		84,079		11
12	Social Services	153,875	3,125	14,815	171,815		171,815		171,815		12
13	CNA Training										13
14	Program Transportation			12,550	12,550		12,550	(4,138)	8,412		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,015,197	142,725	986,253	4,144,175		4,144,175	(7,260)	4,136,915		16
	C. General Administration										
17	Administrative	95,690		478,573	574,263		574,263	(355,132)	219,131		17
18	Directors Fees										18
19	Professional Services			7,218	7,218		7,218	67,875	75,093		19
20	Dues, Fees, Subscriptions & Promotions			42,317	42,317		42,317	(1,452)	40,865		20
21	Clerical & General Office Expenses	118,227	18,588	239,811	376,626		376,626	197,286	573,912		21
22	Employee Benefits & Payroll Taxes			846,037	846,037		846,037	64,164	910,201		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,056	16,056		16,056	37,837	53,893		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,901	140,901		140,901	38,811	179,712		26
27	Other (specify):* Marketing	63,243	11,151	42,562	116,956		116,956	(116,956)			27
28	TOTAL General Administration	277,160	29,739	1,813,475	2,120,374		2,120,374	(67,567)	2,052,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,762,056	470,054	3,077,095	7,309,205		7,309,205	(72,649)	7,236,556		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.

Facility Name & ID Number

Christian Nursing Home

#0004630

Report Period Beginning:

7/1/16

Ending:

6/30/17

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			693,191	693,191		693,191	33,449	726,640			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,486	149,486		149,486	(72,413)	77,073			32
33	Real Estate Taxes			407	407		407	(407)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,703	19,703		19,703		19,703			35
36	Other (specify):* Deferred Financing Costs			1,371	1,371		1,371		1,371			36
37	TOTAL Ownership			864,158	864,158		864,158	(39,371)	824,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			323,885	323,885		323,885	(14,350)	309,535			39
40	Barber and Beauty Shops			27,042	27,042		27,042		27,042			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			274,935	274,935		274,935		274,935			42
43	Other (specify):*	389,099		993,107	1,382,206		1,382,206	(1,382,206)				43
44	TOTAL Special Cost Centers	389,099		1,618,969	2,008,068		2,008,068	(1,396,556)	611,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,151,155	470,054	5,560,222	10,181,431		10,181,431	(1,508,576)	8,672,855			45

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

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	(1,875)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,018)	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	(72,413)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,122)	10		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	(86,681)	21		24
25	Fund Raising, Advertising and Promotional	(116,956)	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	(1,526,661)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,808,726)		\$	30

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)	300,150	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 300,150		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,508,576)		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

BHF USE ONLY							
48		49		50		51	52

Christian Nursing Home

ID# 0004630

Report Period Beginning: 7/1/16

Ending: 6/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation	\$ (4,138)	14	1
2	Garden Villa/Apt/Congregate	(1,479,763)	43	2
3	Real Estate Tax	(407)	33	3
4	Late fees, Fines and Penalties	(32,353)	21	4
5	Miscellaneous Revenue	(8,548)	21	5
6	Lobbying Expense	(1,452)	20	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				25
26				26
27				27
28				28
29				29
30				30
31				31
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	(1,526,661)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home# 0004630

Report Period Beginning:

7/1/16

Ending:

6/30/17

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	(1,875)	0	0	0	0	0	0	0	0	0	0	(1,875)	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	(1,018)	1,825	0	0	0	0	0	0	0	0	0	807	5
6	Maintenance	0	3,246	0	0	0	0	0	0	0	0	0	3,246	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,893)	5,071	0	2,178	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	(3,122)	0	0	0	0	0	0	0	0	0	0	(3,122)	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	(4,138)	0	0	0	0	0	0	0	0	0	0	(4,138)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(7,260)	0	0	0	0	0	0	0	0	0	0	(7,260)	16
	C. General Administration													
17	Administrative	0	(355,132)	0	0	0	0	0	0	0	0	0	(355,132)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	67,875	0	0	0	0	0	0	0	0	0	67,875	19
20	Fees, Subscriptions & Promotions	(1,452)	0	0	0	0	0	0	0	0	0	0	(1,452)	20
21	Clerical & General Office Expenses	(127,582)	324,868	0	0	0	0	0	0	0	0	0	197,286	21
22	Employee Benefits & Payroll Taxes	0	64,164	0	0	0	0	0	0	0	0	0	64,164	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	37,837	0	0	0	0	0	0	0	0	0	37,837	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	38,811	0	0	0	0	0	0	0	0	0	38,811	26
27	Other (specify):*	(116,956)	0	0	0	0	0	0	0	0	0	0	(116,956)	27
28	TOTAL General Administration	(245,990)	178,423	0	(67,567)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(256,143)	183,494	0	(72,649)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	0	33,449	0	0	0	0	0	0	0	0	0	33,449	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72,413)	0	0	0	0	0	0	0	0	0	0	(72,413)	32
33	Real Estate Taxes	(407)	0	0	0	0	0	0	0	0	0	0	(407)	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	(72,820)	33,449	0	(39,371)	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	(14,350)	0	0	0	0	0	0	0	0	0	(14,350)	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):*	(1,479,763)	97,557	0	0	0	0	0	0	0	0	0	(1,382,206)	43
44	TOTAL Special Cost Centers	(1,479,763)	83,207	0	(1,396,556)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,808,726)	300,150	0	(1,508,576)	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Horizons	100.00%	\$ 1,825	\$ 1,825	1
2	V	6 Maintenance				3,246	3,246	2
3	V	17 Administrative	478,573			123,441	(355,132)	3
4	V	19 Professional Services				67,875	67,875	4
5	V	21 Clerical				286,376	286,376	5
6	V	22 Employee Benefits				64,164	64,164	6
7	V	21 Dues & Subscriptions				8,237	8,237	7
8	V	24 Travel and Seminars				37,837	37,837	8
9	V	26 Insurance				38,811	38,811	9
10	V	30 Depreciation				33,449	33,449	10
11	V	21 Other Administrative Expense				30,255	30,255	11
12	V	43 Independent Living				97,557	97,557	12
13	V	39 Pharmacy Services	270,467	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	256,117	(14,350)	13
14	Total		\$ 749,040			\$ 1,049,190	\$ * 300,150	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:

7/1/16

Ending:

6/30/17

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

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0004630

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7/1/16

Ending: 6/30/17

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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Report Period Beginning:

7/1/16

Ending:

6/30/17

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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		6/30/07	\$ 382,171	\$ 740,144	6/30/31	5.6700	\$ 19,151	1									
2	Illinois Finance Authority Series 2010	X	Refinance Debt		7/31/10	2,000,000	915,210	5/15/27	6.1300	25,225	2									
3	Bond Fund	X	Debt Relocation	Various	Various	843,874	446,332	6/30/32	Various	11,721	3									
4	Illinois Finance Authority Series 2016	X	Refinance Debt		3/1/16	2,780,395	6,344,984	5/15/40	5.0000	93,389	4									
5											5									
Working Capital																				
6	Interest Offset									(72,413)	6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 6,006,440	\$ 8,446,670			\$ 77,073	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 6,006,440	\$ 8,446,670			\$ 77,073	15									

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.)

Facility Name & ID Number **Christian Nursing Home**

0004630

Report Period Beginning:

7/1/16

Ending:

6/30/17

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 2016 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 2017 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:	2012	_____	8
	2013	_____	9
	2014	_____	10
	2015	_____	11
	2016	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ _____	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 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 2016 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 2016.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>120-623-005-00</u>	<u>See attached tax bills</u>	\$ <u>334.78</u>	\$ _____
2.	<u>12-036-031-00</u>	<u>See attached tax bills</u>	\$ <u>1,114.64</u>	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>1,449.42</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

7/1/16 Ending:

6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,353 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

Duplexes

AL Villa

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>43,560</u>		<u>\$ 83,965</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>7,514</u>	<u>2</u>
3	TOTALS	43,560		\$ 91,479	3

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	74	1965	1965	\$ 554,625	\$	54	\$	\$	\$ 554,625	4
5	26	1972	1972	318,878		47			318,878	5
6	24	2000	2000	1,279,292	31,982	40	31,982		535,704	6
7		2016	2016	4,191,053	87,314	40	87,314		87,314	7
8	Home Office Allocation			74,549	2,838		2,838		59,845	8
Improvement Type**										
9	Various		1965	153,924	19,026	Various	19,026		117,456	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		10,146	12
13	Various		1980	36,891		Various			36,891	13
14	Various		1982	2,875		Various			2,875	14
15	Various		1983	51,143		Various			51,143	15
16	Various		1985	7,800	223	Various	223		7,150	16
17	Various		1986	341		Various			341	17
18	Various		1987	626		Various			626	18
19	Various		1988	3,966		Various			3,966	19
20	Various		1989	475		Various			475	20
21	Various		1990		19	Various	19			21
22	Various		1991	711	20	Various	20		530	22
23	Various		1992	16,457		Various			16,457	23
24	Various		1993	18,422		Various			18,422	24
25	Various		1994	9,278		Various			9,278	25
26	Various		1995	35,562		Various			35,562	26
27	Various		1996	3,400		Various			3,400	27
28	Various		1998	6,993		Various			6,993	28
29	Various		2000	898,348	22,015	Various	22,015		398,023	29
30	Various		2001	59,289		Various			59,289	30
31	Various		2002	14,534	629	Various	629		14,324	31
32	Various		2003	73,567		Various			73,567	32
33	Various		2004	2,564		Various			2,564	33
34	Various		2005	18,556		Various			18,556	34
35	Various		2006	47,183	1,277	Various	1,277		41,970	35
36	Various		2007	6,145	615	Various	615		6,028	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:

7/1/16

Ending:

6/30/17

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	2008	\$ 131,902	\$ 13,190	Various	\$ 13,190		\$ 120,520	37
38	Various	2009	258,283	19,824	Various	19,824		163,465	38
39	Various	2010	42,717	4,272	Various	4,272		30,592	39
40	Various	2011	12,157	1,216	Various	1,216		7,435	40
41	Hot Water Heater	3/14/2012	5,188	519	10	519		2,767	41
42	SNF Plumbing	7/1/2012	5,117	256	20	256		1,279	42
43	SNF Roofing	7/1/2012	19,300	1,930	10	1,930		9,650	43
44	Fire Alarm System	7/1/2012	98,624	9,862	10	9,862		49,310	44
45	Circuit Breakers	7/1/2012	7,250	483	15	483		2,417	45
46	40x40 Garage	7/1/2012	20,234	809	25	809		4,047	46
47	SNF Doors and Locks	7/1/2012	5,611	561	10	561		2,806	47
48	HVAC	7/1/2012	30,910	2,061	15	2,061		10,303	48
49	SNF Flooring	7/1/2012	7,267	1,334	5	1,334		7,148	49
50	Electric Rewiring and Panels	7/1/2012	27,428	1,371	20	1,371		6,857	50
51	SNF Ceiling Tracks/Walls	7/1/2012	307,874	30,787	10	30,787		153,937	51
52	SNF Painting	7/1/2012	161,416	16,142	10	16,142		80,708	52
53	SNF Flooring	7/1/2012	246,763	24,676	10	24,676		123,382	53
54	SNF HVAC	7/1/2012	146,459	9,764	15	9,764		48,820	54
55	SNF Plumbing/Electric	7/1/2012	384,150	19,208	20	19,208		96,038	55
56	SNF Lighting/Appliances	7/1/2012	24,367	2,437	10	2,437		12,183	56
57	SNF Doors	7/1/2012	22,643	2,264	10	2,264		11,321	57
58	SNF Cabinetry	7/1/2012	28,283	2,828	10	2,828		14,141	58
59	SNF Wardrobes/Cabinets	7/1/2012	148,943	14,894	10	14,894		74,471	59
60	SNF Doors/Hardware	7/1/2012	89,067	8,907	10	8,907		44,534	60
61	SNF Nurse Station	7/1/2012	87,912	5,861	15	5,861		29,304	61
62	SNF Ceiling Tracks/Studs	7/1/2012	289,088	28,909	10	28,909		144,544	62
63	SNF Flooring	7/1/2012	111,988	11,199	10	11,199		55,994	63
64	SNF Electrical Work/Lighting	7/1/2012	269,685	17,979	15	17,979		89,895	64
65	SNF Painting	7/1/2012	54,628	5,463	10	5,463		27,314	65
66	Fire Sprinkler	7/1/2012	434,888	17,396	25	17,396		86,978	66
67	IDPH Design and Plan for SNF	7/1/2012	11,736	1,174	10	1,174		5,868	67
68	Asbestos Survey	7/1/2012	10,465	1,047	10	1,047		5,233	68
69	Ceiling/Sky Lights	7/1/2012	2,685	269	10	269		1,343	69
70	TOTAL (lines 4 thru 69)		\$ 11,427,542	\$ 445,116		\$ 445,116		\$ 4,040,080	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:

7/1/16

Ending:

6/30/17**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		\$ 11,427,542	\$ 445,116		\$ 445,116	\$	\$ 4,040,080	1
2	Courtyard Design and Specifications	7/10/2012	5,488	549	10	549		2,744	2
3	Electricalwork- 300 hall	7/1/2012	3,143	314	10	314		1,572	3
4	10 Ton AC Unit- 300 Hall	7/1/2012	6,922	461	10	461		2,192	4
5	400 Hall Shower Room Tub	7/1/2012	11,211	1,121	10	1,121		5,138	5
6	Boiler Circulation Pump	2/12/2013	3,100	310	10	310		1,369	6
7	SNF 400 Hall/Alz Unit	6/30/2013	282,149	28,216	10	28,216		116,649	7
8	Sprinkler	6/30/2013	4,262	170	25	170		696	8
9	Nurse's Station Maglock Doors	6/30/2013	3,536	354	10	354		1,444	9
10	Vinyl for 400 Hall Lounge	6/14/2013	4,225	423	10	423		1,725	10
11	Carpet- 400 Wing	6/19/2013	24,847	4,969	5	4,969		20,292	11
12	Oxygen Room- Exhaust Fan & Roof Curb	12/9/2013	3,451	345	10	345		1,237	12
13	Sewer Discovery	2/13/2013	17,068	683	25	683		3,015	13
14	Excavate and Repair Sewer Lines/Manhol	6/13/2013	12,100	605	20	605		2,470	14
15	Directional Sign & Graphics	10/23/2013	3,730	373	10	373		1,399	15
16	Replace AC in the kitchen	6/19/2014	17,980	1,798	10	1,798		5,544	16
17	Whirlpool door	12/2/2014	2,805	280	10	280		725	17
18	Asphalt paving & concrete of parking l	6/25/2014	77,561	9,695	8	9,695		29,893	18
19	Sewer Project	3/17/2014	189,600	7,584	25	7,584		25,280	19
20	Hydraulic sink install @ beauty shop	3/20/2015	3,564	356	10	356		832	20
21	Install Emergency door	4/21/2015	9,993	999	10	999		2,248	21
22	Emergency Exit bar	4/21/2015	2,123	212	10	212		478	22
23	Replace resident garage door	5/7/2015	522	52	10	52		113	23
24	Sump Pump	7/1/2015	562	56	10	56		108	24
25	New Rubber roof 40x30 section	9/16/2015	5,900	590	10	590		1,033	25
26	New Service hall double doors	9/23/2015	4,287	429	10	429		751	26
27	Install new roof Building 7	10/21/2015	10,875	1,088	10	1,088		1,903	27
28	Replace Mixing valve @ Memory care	2/15/2016	2,624	262	10	262		372	28
29	Therapy Room West Door	2/24/2016	4,049	405	10	405		574	29
30	400 Wing Trane AC unit	5/28/2016	6,875	688	10	688		802	30
31	200 Wing Heil 3 ton AC condensing unit	5/28/2016	2,681	268	10	268		313	31
32	200 Wing Heil 4 ton 3 phase AC unit	5/28/2016	4,284	428	10	428		500	32
33	Privacy Fence project at TCV	7/1/2016	84,965	4,248	20	4,248		4,248	33
34	TOTAL (lines 1 thru 33)		\$ 12,244,024	\$ 513,447		\$ 513,447	\$	\$ 4,277,739	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:

7/1/16

Ending:

6/30/17

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		\$ 12,244,024	\$ 513,447		\$ 513,447	\$	\$ 4,277,739	1
2	Brick Memorial Walkway	7/1/2016	4,067	203	20	203		203	2
3	5 Ton HVAC unit	7/1/2016	2,340	234	10	234		234	3
4	STS SNF Landscaping	9/22/2016	12,104	504	20	504		504	4
5	500 Hall Egress exit doors delay	10/24/2016	3,402	255	10	255		255	5
6	North West Kitchen Door	3/17/2017	2,744	91	10	91		91	6
7	North East Kitchen Door	3/17/2017	2,744	91	10	91		91	7
8	Install Water filtration system	4/4/2017	1,695	42	10	42		42	8
9	Door Latching Bolts	4/5/2017	1,225	31	10	31		31	9
10	Otis Passenger Elevator	4/13/2017	107,676	1,346	20	1,346		1,346	10
11	Memory Care Unit 2' Wood Blinds	4/18/2017	1,918	48	10	48		48	11
12	GP Rhab Court Yard & Parking lot concret	4/22/2017	9,428	118	20	118		118	12
13	SNF Unit 205 Rubber Roof	5/8/2017	4,889	81	10	81		81	13
14	Gravel Parking lot near Maint. garage	5/9/2017	11,330	94	20	94		94	14
15	Memory Care Roof Build 200 & 400	5/18/2017	28,855	481	10	481		481	15
16	Memory Care Unit New Flooring	6/10/2017	45,234	377	10	377		377	16
17	Memory Care Nurse Sta. Counter	6/19/2017	2,194	18	10	18		18	17
18	Rounding to tie to FS		1	1		1		(15)	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,485,870	\$ 517,464		\$ 517,464	\$	\$ 4,281,738	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	\$ 1,148,644	\$ 149,293	\$ 149,293	\$		\$ 800,563	71
72	Current Year Purchases	164,043	24,234	24,234			24,234	72
73	Fully Depreciated Assets	659,674					659,674	73
74	Home Office Allocation	244,182	29,383	29,383			186,189	74
75	TOTALS	\$ 2,216,543	\$ 202,910	\$ 202,910	\$		\$ 1,670,660	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	\$ 5,038	\$ 5,038	\$		\$ 106,351	76
77										77
78										78
79	Home Office Allocation			10,795	1,228	1,228			9,188	79
80	TOTALS			\$ 117,723	\$ 6,266	\$ 6,266	\$		\$ 115,539	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	\$ 14,911,615	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 726,640	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 726,640	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)	\$ 6,067,937	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	238,843			88
89	Garden Villa	1,395,452	46,655	50,543	89
90	Apartment/Congregate/Duplex	5,029,936	176,568	3,450,795	90
91	TOTALS	\$ 6,669,931	\$ 223,223	\$ 3,507,038	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 37,805	92
93	Home Office Allocation	17,383	93
94			94
95		\$ 55,188	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: 7/1/16

Ending: 6/30/17

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 19,703 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.

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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	6,638	\$ 322,339	\$	6,638	\$ 322,339	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,012	102,942		2,012	102,942	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		8,386	352,592		8,386	352,592	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				265,607		265,607	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>						31,546		31,546	12
13	Other (specify): <u>Radiology</u>						12,382		12,382	13
14	TOTAL			\$	17,035	\$ 777,873	\$ 309,535	17,035	\$ 1,087,408	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: 7/1/16

Ending:

6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 8,280	\$	1
2	Cash-Patient Deposits	35,512		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>157,389</u>)	1,473,095		3
4	Supply Inventory (priced at)	16,611		4
5	Short-Term Investments	3,666,917		5
6	Prepaid Insurance	22,807		6
7	Other Prepaid Expenses	18,165		7
8	Accounts Receivable (owners or related parties)	4,178,191		8
9	Other(specify): <u>Acc Int Rec/Pledges Rec</u>	115,065		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,534,643	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	322,808		13
14	Buildings, at Historical Cost	17,968,136		14
15	Leasehold Improvements, at Historical Cost	828,372		15
16	Equipment, at Historical Cost	2,125,190		16
17	Accumulated Depreciation (book methods)	(9,319,753)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	227,953		21
22	Other Long-Term Assets (spe <u>CIP</u>)	37,805		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,190,511	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,725,154	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,512		28
29	Short-Term Notes Payable	41,986		29
30	Accrued Salaries Payable	333,852		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	50,756		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 462,106	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,446,670		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees</u>	294,130		43
44	<u>Other Liabilities</u>	435,489		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,176,289	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,638,395	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,086,759	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 21,725,154	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,926,631	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,926,631	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	160,132	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)		15
16	Other (describe) Rounding	(4)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 160,128	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)	\$ 12,086,759	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: 7/1/16Ending: 6/30/17**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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,680,472	1
2	Discounts and Allowances for all Levels	(5,387,055)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,293,417	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,867,346	6
7	Oxygen	1,231	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,868,577	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	26,112	13
14	Non-Patient Meals	1,875	14
15	Telephone, Television and Radio	3,562	15
16	Rental of Facility Space	1,018	16
17	Sale of Drugs	361,815	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,176	19
20	Radiology and X-Ray	23,956	20
21	Other Medical Services	125,378	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 606,892	23
D. Non-Operating Revenue			
24	Contributions	166,210	24
25	Interest and Other Investment Income***	72,413	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 238,623	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/Apt/Duplex</u>	1,209,257	28
28a	<u>Miscellaneous</u>	124,797	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,334,054	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,341,563	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,044,656	31
32	Health Care	4,144,175	32
33	General Administration	2,120,374	33
B. Capital Expense			
34	Ownership	864,158	34
C. Ancillary Expense			
35	Special Cost Centers	1,733,133	35
36	Provider Participation Fee	274,935	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,181,431	40
41	Income before Income Taxes (line 30 minus line 40)**	160,132	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 160,132	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,867,795	44
45	Private Pay - Net Inpatient Revenue	2,624,373	45
46	Medicare - Net Inpatient Revenue	(801,246)	46
47	Other-(specify) <u>HMO, Medicare Advantage</u>	(529,958)	47
48	Other-(specify) <u>Part B, Nursing</u>	(867,547)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,293,417	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:

7/1/16

Ending:

6/30/17

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	1,948	2,061	\$ 97,948	\$ 47.52	1
2	Assistant Director of Nursing	1,765	1,946	64,788	33.29	2
3	Registered Nurses	7,136	7,644	231,802	30.32	3
4	Licensed Practical Nurses	38,202	40,908	1,023,331	25.02	4
5	CNAs & Orderlies	89,874	96,516	1,333,512	13.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,814	1,954	29,021	14.85	9
10	Activity Assistants	4,032	4,387	49,471	11.28	10
11	Social Service Workers	7,246	8,052	153,875	19.11	11
12	Dietician	644	730	17,907	24.53	12
13	Food Service Supervisor	815	851	23,536	27.66	13
14	Head Cook	4,418	4,847	55,184	11.39	14
15	Cook Helpers/Assistants	14,616	15,482	151,666	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,223	3,372	58,889	17.46	17
18	Housekeepers	10,506	11,408	109,649	9.61	18
19	Laundry	4,819	5,073	52,868	10.42	19
20	Administrator	1,960	2,072	95,690	46.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,161	3,413	68,255	20.00	23
24	Clerical	3,107	3,274	49,972	15.26	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	1,711	1,991	31,449	15.80	31
32	Other Health C: <u>Marketing</u>	2,323	2,524	63,243	25.06	32
33	Other(specify) <u>AL/Apt/Duplex</u>	35,991	41,816	389,099	9.31	33
34	TOTAL (lines 1 - 33)	239,311	260,321	\$ 4,151,155 *	\$ 15.95	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	32	2,801	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	3,163	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	93	5,814	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	413	\$ 40,578		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	489	\$ 21,871	V10-3	50
51	Licensed Practical Nurses	982	36,055	V10-3	51
52	Certified Nurse Assistants/Aides	3,103	79,381	V10-3	52
53	TOTAL (lines 50 - 52)	4,574	\$ 137,307		53

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. LEADING AGE - \$9,073
- (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. \$ 32,730 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. \$ 274,935
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. \$ 1,875
- (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: PLANTE MORAN PLLC
- (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