

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0004630 Facility Name: The Christian Village Address: 1507 7th Street Lincoln 62656 County: Logan Telephone Number: (217) 732-2189 Fax #: (217) 732-1904 HFS ID Number: Date of Initial License for Current Owners: 9/1/1965 Type of Ownership: ☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501(c)(3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Susan McGhee Telephone Number: (314) 587-7903

Email Address:

Facility Name & ID Number The Christian Village # 0004630 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

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	243,008	33,118		276,126		276,126		276,126			1
2	Food Purchase		263,767		263,767		263,767	(3,242)	260,525			2
3	Housekeeping	130,675	31,791		162,466		162,466		162,466			3
4	Laundry	68,454	4,707		73,161		73,161	658	73,819			4
5	Heat and Other Utilities			187,610	187,610		187,610	(14,476)	173,134			5
6	Maintenance	116,674	9,987	72,672	199,333		199,333	15,856	215,189			6
7	Other (specify):*											7
8	TOTAL General Services	558,811	343,370	260,282	1,162,463		1,162,463	(1,204)	1,161,259			8
	B. Health Care and Programs											
9	Medical Director	3,200			3,200		3,200		3,200			9
10	Nursing and Medical Records	2,571,633	225,962	22,662	2,820,257		2,820,257		2,820,257			10
10a	Therapy		4,177	674,278	678,455		678,455		678,455			10a
11	Activities	95,663	4,055		99,718		99,718		99,718			11
12	Social Services	114,717		6,541	121,258		121,258		121,258			12
13	CNA Training			22,698	22,698		22,698		22,698			13
14	Program Transportation			8,509	8,509		8,509	(4,450)	4,059			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,785,213	234,194	734,688	3,754,095		3,754,095	(4,450)	3,749,645			16
	C. General Administration											
17	Administrative	128,995	4,366	423,708	557,069		557,069	(362,012)	195,057			17
18	Directors Fees											18
19	Professional Services			30,092	30,092		30,092	22,345	52,437			19
20	Dues, Fees, Subscriptions & Promotions			17,092	17,092		17,092	5,207	22,299			20
21	Clerical & General Office Expenses	87,884	10,737	64,117	162,738		162,738	140,051	302,789			21
22	Employee Benefits & Payroll Taxes			713,214	713,214		713,214	32,445	745,659			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,040	11,040		11,040	10,398	21,438			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,904	61,904		61,904	889	62,793			26
27	Other (specify):* Marketing	49,806	1,380	18,049	69,235		69,235	(69,235)				27
28	TOTAL General Administration	266,685	16,483	1,339,216	1,622,384		1,622,384	(219,912)	1,402,472			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,610,709	594,047	2,334,186	6,538,942		6,538,942	(225,566)	6,313,376			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			249,801	249,801		249,801	18,730	268,531			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,601	86,601		86,601	(76,885)	9,716			32
33	Real Estate Taxes			1,264	1,264		1,264	(1,264)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,571	11,571		11,571	4,214	15,785			35
36	Other (specify):* Financing Fee			1,620	1,620		1,620		1,620			36
37	TOTAL Ownership			350,857	350,857		350,857	(55,205)	295,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			173,205	173,205		173,205	(18,820)	154,385			39
40	Barber and Beauty Shops			30,594	30,594		30,594		30,594			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* Apt/Congregate			505,711	505,711		505,711	(505,711)				43
44	TOTAL Special Cost Centers			770,830	770,830		770,830	(524,531)	246,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,610,709	594,047	3,455,873	7,660,629		7,660,629	(805,302)	6,855,327			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,992)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,310)	5		5
6	Rented Facility Space	(1,030)	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	(76,885)	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	(5,618)	21		24
25	Fund Raising, Advertising and Promotional	(69,235)	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 Apartment/Congregate	(514,558)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (684,628)		\$	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 Amount	2 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)	(120,674)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (120,674)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (805,302)		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 Yes	2 No	3 Amount	4 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

The Christian Village

ID# 0004630

Report Period Beginning: July 1, 2010

Ending: June 30, 2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending	\$ (1,250)	2	1
2	Transporation	(4,450)	14	2
3	Apt / Congregate	(505,711)	43	3
4	RE Tax on Vacant Lots	(1,264)	33	4
5	Misc Revenue	(1,787)	21	5
6	Late Fees	(96)	21	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	(514,558)		49

Summary A

June 30, 2011

[illegible]

Summary B

June 30, 2011

[illegible]

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This worksheet is not applicable.								\$		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

Ending: ne 30, 2011

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 not applicable.			\$	\$		\$	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

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		X	Renovation Projects		6/30/07	\$ 469,125	\$ 456,820	6/30/2031	0.0057	\$ 25,229	1
2	Bond Fund	X		Debt Restructure	\$3,495.00	Various*	1,025,000	707,637	6/30/2032	Various*	41,941	2
3	*this is an allocation of the total GO bond debt which includes several different series with several different rates of interest											3
4	Illinois Finance Authority		X	Renovation Projects		6/30/10	2,000,000	2,000,000	5/15/2027	0.0613	19,430	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$3,495.00		\$ 3,494,125	\$ 3,164,457			\$ 86,601	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,494,125	\$ 3,164,457			\$ 86,601	15

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ None

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

1. Real Estate Tax accrual used on 2010 report.	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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:	2006 <table><tr><td>8</td></tr><tr><td>9</td></tr><tr><td>10</td></tr><tr><td>11</td></tr><tr><td>12</td></tr></table>	8	9	10	11	12	<table><tr><td></td><td>FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2010 \$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr></table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2010 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
8																							
9																							
10																							
11																							
12																							
	FOR BHF USE ONLY																						
13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

FACILITY NAME The Christian Village COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(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. 12-036-031-00	See Attached	\$ 963.34	\$
2. 12-623-005-00	See Attached	\$ 327.54	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,290.88	\$

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

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	Facility	42,000	Various	\$ 83,965	1
2	Home Office Allocation			5,715	2
3	TOTALS	42,000		\$ 89,680	3

Facility Name & ID Number The Christian Village

0004630

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	48		1965	1965	\$ 272,125	\$ 5,522	54	\$ 5,522	\$	\$ 271,475	4
5	26		1969	1969	282,500	6,152	50	6,152		283,729	5
6	26		1972	1972	318,878	7,351	47	7,351		321,589	6
7	12			2000	1,279,292	31,982	40	31,982		343,809	7
8	Home Office Allocation				59,090	3,813		3,813		135,711	8
	Improvement Type**										
9	Building Improvement			1965	48,022		20				9
10	Building Improvement			1969	49,853		20				10
11	Building Improvement			1972	56,049		20				11
12	Land Improvements			1975	103,638		20			103,638	12
13	Various			1979	11,989	266	Various	266		8,547	13
14	Various			1980	37,495	1,085	Various	1,085		34,511	14
15	Various			1981	6,258		Various			6,258	15
16	Various			1982	19,747		Various			19,747	16
17	Various			1983	43,814		Various			43,814	17
18	Various			1984	5,420		Various			5,420	18
19	Various			1985	82,598	223	Various	223		80,611	19
20	Various			1986	53,889	275	Various	275		53,889	20
21	Various			1987	29,494		Various			29,494	21
22	Various			1988	6,150		Various			6,150	22
23	Various			1989	58,128		Various			58,128	23
24	Various			1990	19,086	22	Various	22		18,803	24
25	Various			1991	32,617	20	Various	20		32,314	25
26	Various			1992	53,005	2,336	Various	2,336		51,112	26
27	Various			1993	18,422	655	Various	655		16,209	27
28	Various			1994	10,251		Various			10,251	28
29	Various			1995	32,888		Various			32,888	29
30	Various			1996	18,144		Various			18,144	30
31	Various			1997	36,170		Various			36,170	31
32	Various			1998	30,440		Various			30,440	32
33	Various			1999	53,955		Various			53,955	33
34	Various			2000	856,790	21,590	Various	21,590		285,777	34
35	Various			2001	65,793	3,888	Various	3,888		65,328	35
36	Various			2002	16,745	1,360	Various	1,360		12,129	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 The Christian Village

0004630

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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	2003	\$ 73,567	\$ 7,279	Various	\$ 7,279	\$	\$ 57,450	37
38	Various	2004	44,448	2,161	Various	2,161		39,518	38
39	Various	2005	61,137	5,163	Various	5,163		41,671	39
40	Various	2006	44,552	4,609	Various	4,609		26,871	40
41	Various	2007	15,523	1,513	Various	1,513		6,421	41
42	Kitchen Flooring	3/21/2008	19,500	1,950	10	1,950		6,500	42
43	Add & Move Fire Alarms	3/31/2008	3,336	334	10	334		1,112	43
44	Paving, extended parking lots, 2 new exits	5/10/2008	15,137	1,514	10	1,514		4,794	44
45	Kitchen Project	5/23/2008	681	68	10	68		216	45
46	Handrails outside of building	5/30/2008	17,013	1,701	10	1,701		5,387	46
47	Kitchen Remodeling Project - Sink	5/31/2008	3,457	346	10	346		1,096	47
48	white vinyl fencing	6/19/2008	3,580	358	10	358		1,104	48
49	Install new 100 Wing exit door	6/20/2008	18,396	1,840	10	1,840		5,673	49
50	Kitchen Remodeling Project-	6/30/2008	4,821	482	10	482		1,486	50
51	Roofing - shingles and labor	7/22/2008	21,000	2,100	10	2,100		6,300	51
52	Landscaping - front entrance, main building	7/28/2008		206	10	206			52
53	Landscaping - flag pole and Alzheimer's area	7/28/2008	1,214	121	10	121		363	53
54	Glass sliding door - Dayroom	8/27/2008		250	10	250			54
55	Plank flooring	9/8/2008	7,268	727	10	727		2,059	55
56	Roof	9/20/2008	3,410	341	10	341		966	56
57	Hot water boiler & installation	2/27/2009	10,748	1,075	10	1,075		2,598	57
58	Accutech Resident Security System	4/28/2009	59,164	5,916	10	5,916		13,307	58
59	Sprinkler Project - Architect	6/1/2009	1,503	150	10	150		313	59
60	Rooftop A/C units	6/19/2009	5,500	550	10	550		1,146	60
61	A/C coil - 100 hallway	6/19/2009	3,542	708	5	708		1,475	61
62	2 A/C Rooftop units	6/23/2009	16,000	1,600	10	1,600		3,333	62
63	2 Ton Air Handler in Attic	7/6/2009	1,165	116	10	116		232	63
64	Grease Trap for Kitchen	7/6/2009	5,156	516	10	516		1,032	64
65	Roofing - Kitchen	8/4/2009	6,500	650	10	650		1,246	65
66	Roofing - 200 Wing	8/4/2009	8,000	800	10	800		1,533	66
67	Exterior Soffit Work	8/11/2009	14,844	1,484	10	1,484		2,845	67
68	Boiler Replacement	8/17/2009	113,000	5,650	20	5,650		10,829	68
69	Delay Egress Locks, Keypad	8/17/2009	4,854	485	10	485		930	69
70	TOTAL (lines 4 thru 69)		\$ 4,676,751	\$ 139,303		\$ 139,303	\$	\$ 2,719,846	70

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

Facility Name & ID Number The Christian Village

0004630

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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		\$ 4,676,751	\$ 139,303		\$ 139,303	\$	\$ 2,719,846	1
2	Horton 4100LE HD-Swing	9/21/2009	2,089	209	10	209		383	2
3	Environmental Study	10/15/2009	3,135	314	10	314		549	3
4	Additional Costs Related to Boiler Repl	3/13/2010	10,500	1,050	10	1,050		1,400	4
5	Courtyard Soffit Work	3/31/2010	13,440	1,344	10	1,344		1,792	5
6	Courtyard Patio & Sidewalk repair	4/5/2010	6,047	605	10	605		756	6
7	100 Hall - Install Fire Rated Door	7/31/2010	120	12	10	12		12	7
8	Landscaping for Sign	7/31/2010	446	45	10	45		45	8
9	Replacement Sewer Line	9/30/2010	9,939	828	10	828		828	9
10	Front Dayroom - Carpet	12/31/2010	2,225	130	10	130		130	10
11	300 Hall - Repaired Recirculation line	3/31/2011	1,095	37	10	37		37	11
12	Central Dayroom - Carpet	3/31/2011	656	22	10	22		22	12
13	Therapy Gym - Wall Cabinets	4/14/2011	201	5	10	5		5	13
14	400 Hall - Skylight Roof	4/30/2011	6,250	156	10	156		156	14
15	Chaplain Office - Carpet	6/30/2011	3,298	27	10	27		27	15
16	100 Hall Shower Room - Whirlpool Tub	6/30/2011	8,508	71	10	71		71	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	TOTAL (lines 1 thru 33)		\$ 4,744,699	\$ 144,158		\$ 144,158	\$	\$ 2,726,059	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	\$689,261	\$83,243	\$83,243	\$		\$375,085	71
72	Current Year Purchases	138,059	6,548	6,548			6,548	72
73	Fully Depreciated Assets	576,971	3,459	3,459			576,971	73
74	Home Office Allocation	280,152	18,079	18,079			31,085	74
75	TOTALS	\$1,684,443	\$111,329	\$111,329	\$		\$989,689	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		\$57,140	\$8,249	\$8,249	\$		\$17,553	76
77	Patient Transportation	2000 Chevy Van Lift	9/9/2003	8,432				3	8,432	77
78	Patient Transportation	1998 Buick LeSabre Custom Seda	3/1/2010	4,240	1,060	1,060		4	1,394	78
79	Home Office Allocation			34,580	2,232	2,232			14,481	79
80	TOTALS			\$104,392	\$11,541	\$11,541	\$		\$41,860	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)	\$6,623,214	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$267,028	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$267,028	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)	\$3,757,653	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	113	582	87
88	Land	230,405			88
89	Apartment/Congregate	2,315,768	77,491	1,481,373	89
90	Duplex	2,284,079	58,555	1,583,422	90
91	TOTALS	\$4,835,952	\$136,159	\$3,070,177	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$54,629	92
93			93
94			94
95		\$54,629	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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

**

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: \$18,815
- Description: See Attached Detail Schedule

(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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

The Christian Village does not train C N A's, they are hired already certified.

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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.)

	1	2	3	4	5	6	7	8		
	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	\$	6,648	\$ 257,277	\$	6,648	\$ 257,277	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,118	110,114		2,118	110,114	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		7,091	306,887		7,091	306,887	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	15,857	\$ 674,278	\$	15,857	\$ 674,278	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.

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	\$ 6,673,013	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,592)	436,072		3
4	Supply Inventory (priced at)	24,965		4
5	Short-Term Investments	530,145		5
6	Prepaid Insurance	200		6
7	Other Prepaid Expenses	12,636		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/Other A/R	11,190		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,688,221	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,370		13
14	Buildings, at Historical Cost	8,870,892		14
15	Leasehold Improvements, at Historical Cost	304,935		15
16	Equipment, at Historical Cost	1,744,169		16
17	Accumulated Depreciation (book methods)	(6,713,344)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,085,979		21
22	Other Long-Term Assets (specify): CIP	1,308,017		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,915,018	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,603,239	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 388,227	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,279		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	406,081		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	591		32
33	Accrued Interest Payable	28,343		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Liabilities	22,970		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 865,491	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,164,457		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Apartment Income	830,843		43
44	Apt & Cong Life Right & Sec	747,822		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,743,122	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,608,613	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,994,626	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,603,239	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,182,877	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,182,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	811,750	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)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 811,750	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)	\$ 9,994,626	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Christian Village# 0004630Report Period Beginning: July 1, 2010Ending: June 30, 2011

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,309,402	1
2	Discounts and Allowances for all Levels	(1,657,649)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,651,753	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,131,385	6
7	Oxygen	14,419	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,145,804	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	30,454	13
14	Non-Patient Meals	1,992	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,030	16
17	Sale of Drugs	212,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,730	19
20	Radiology and X-Ray	22,097	20
21	Other Medical Services	14,098	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 317,808	23
	D. Non-Operating Revenue		
24	Contributions	324,170	24
25	Interest and Other Investment Income***	76,885	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 401,055	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Residential/Congregate - See Groupings</u>	803,145	28
28a	<u>Unrealized Gain/Loss & Miscellaneous Income See Groupi</u>	152,814	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 955,959	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,472,379	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,162,463	31
32	Health Care	3,754,095	32
33	General Administration	1,622,384	33
	B. Capital Expense		
34	Ownership	350,857	34
	C. Ancillary Expense		
35	Special Cost Centers	770,830	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,660,629	40
41	Income before Income Taxes (line 30 minus line 40)**	811,750	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 811,750	43

* 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.

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	2,011	2,125	\$ 88,237	\$ 41.52	1
2	Assistant Director of Nursing	1,604	1,781	48,245	27.09	2
3	Registered Nurses	13,146	14,143	385,724	27.27	3
4	Licensed Practical Nurses	33,199	35,931	724,238	20.16	4
5	CNAs & Orderlies	87,796	97,385	1,165,718	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,822	2,008	24,198	12.05	9
10	Activity Assistants	7,319	7,709	71,465	9.27	10
11	Social Service Workers	7,247	7,950	114,717	14.43	11
12	Dietician	1,503	1,625	34,604	21.29	12
13	Food Service Supervisor	360	375	8,208	21.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,454	21,735	200,196	9.21	15
16	Dishwashers					16
17	Maintenance Workers	7,889	8,353	116,674	13.97	17
18	Housekeepers	10,763	11,980	130,675	10.91	18
19	Laundry	6,664	7,003	68,454	9.77	19
20	Administrator	1,917	2,000	85,733	42.87	20
21	Assistant Administrator	1,840	2,000	43,262	21.63	21
22	Other Administrative					22
23	Office Manager	1,806	2,027	32,773	16.17	23
24	Clerical	3,705	4,005	55,111	13.76	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	3,861	4,211	56,592	13.44	31
32	Other Health Care(specify)	3,487	4,045	106,079	26.22	32
33	Other(specify) <u>Marketing</u>	1,815	1,997	49,806	24.94	33
34	TOTAL (lines 1 - 33)	220,208	240,388	\$ 3,610,709 *	\$ 15.02	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	48	3,200	1-3	36
37	Medical Records Consultant	32	2,192	9-3	37
38	Nurse Consultant	48	6,106	10-3	38
39	Pharmacist Consultant	84	3,393	10-3	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	81	4,835	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	293	\$ 19,726		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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, AAHSA \$8,116.19

(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? _____

(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? _____

(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. \$ 30,963 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. _____

(9) Are you presently operating under a sublease agreement? _____ YES No NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO No 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. \$ 61,320
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. \$ 1,992

(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. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? None

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. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.