

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0004630</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Christian Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/15</u> to <u>6/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1507 7th Street</u> <u>Lincoln</u> <u>62656</u>																																																	
Number City Zip Code																																																	
County: <u>Logan</u>																																																	
Telephone Number: <u>217-732-2189</u> Fax # <u>217-732-1904</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Susan McGhee</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Susan McGhee</u>	(Title) <u>CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																																			
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	(Telephone) <u>()</u> Fax # <u>()</u>																																																
Date of Initial License for Current Owners: <u>9/1/1965</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____	
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		☐	Trust	_____																																													
		☐	Other _____	_____																																													
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																															
Name: <u>Kenna Hudson</u>																																																	
Telephone Number: <u>314-587-7924</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number

Christian Nursing Home

#

0004630

Report Period Beginning:

7/1/15

Ending:

6/30/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,384	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	45,384	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,903	15,425	3,937	35,265	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,903	15,425	3,937	35,265	14

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

77.70%

D. How many bed-hold days during this year were paid by the Department?

None

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals, Lawn & Maint Care, Housekeeping & laundry Services for IL Residents

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

X

NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

X

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

X

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

124

and days of care provided

2,625

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

6/30/16

Fiscal Year:

6/30/16

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/15 Ending: 6/30/16
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	232,470	26,166	2,099	260,735		260,735		260,735			1
2	Food Purchase		211,315		211,315		211,315	(2,193)	209,122			2
3	Housekeeping	70,219	20,971		91,190		91,190		91,190			3
4	Laundry	35,560	338		35,898		35,898		35,898			4
5	Heat and Other Utilities			142,737	142,737		142,737	358	143,095			5
6	Maintenance	53,467	9,875	86,507	149,849		149,849	3,408	153,257			6
7	Other (specify):* Trash			3,654	3,654		3,654		3,654			7
8	TOTAL General Services	391,716	268,665	234,997	895,378		895,378	1,573	896,951			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800		28,800			9
10	Nursing and Medical Records	2,255,351	122,142	163,103	2,540,596		2,540,596	(6,169)	2,534,427			10
10a	Therapy			684,276	684,276		684,276		684,276			10a
11	Activities	75,772	4,656	869	81,297		81,297		81,297			11
12	Social Services	159,840	1,751	15,070	176,661		176,661		176,661			12
13	CNA Training											13
14	Program Transportation			5,389	5,389		5,389	(5,900)	(511)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,490,963	128,549	897,507	3,517,019		3,517,019	(12,069)	3,504,950			16
	C. General Administration											
17	Administrative	90,647		464,000	554,647		554,647	(348,768)	205,879			17
18	Directors Fees											18
19	Professional Services			27,201	27,201		27,201	93,927	121,128			19
20	Dues, Fees, Subscriptions & Promotions			38,522	38,522		38,522	(1,166)	37,356			20
21	Clerical & General Office Expenses	128,590	10,111	112,649	251,350		251,350	234,253	485,603			21
22	Employee Benefits & Payroll Taxes			768,320	768,320		768,320	47,329	815,649			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,775	9,775		9,775	38,568	48,343			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,100	93,100		93,100	25,382	118,482			26
27	Other (specify):* Marketing	47,546	36,365	749	84,660		84,660	(84,660)				27
28	TOTAL General Administration	266,783	46,476	1,514,316	1,827,575		1,827,575	4,865	1,832,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,149,462	443,690	2,646,820	6,239,972		6,239,972	(5,631)	6,234,341			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			597,426	597,426		597,426	33,460	630,886			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,880	79,880		79,880	(77,031)	2,849			32
33	Real Estate Taxes			3,446	3,446		3,446	(3,446)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,457	18,457		18,457		18,457			35
36	Other (specify):* Deferred Financing Costs			35,670	35,670		35,670		35,670			36
37	TOTAL Ownership			734,879	734,879		734,879	(47,017)	687,862			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			200,971	200,971		200,971	(7,119)	193,852			39
40	Barber and Beauty Shops		22	28,275	28,297		28,297		28,297			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,771	259,771		259,771		259,771			42
43	Other (specify):* Apt/ Congregate	332,876		718,275	1,051,151		1,051,151	(1,051,151)				43
44	TOTAL Special Cost Centers	332,876	22	1,207,292	1,540,190		1,540,190	(1,058,270)	481,920			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,482,338	443,712	4,588,991	8,515,041		8,515,041	(1,110,918)	7,404,123			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	(2,193)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,161)	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	(77,031)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,169)	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	(16,652)	21		24
25	Fund Raising, Advertising and Promotional	(84,660)	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 PG 5A	(1,126,283)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,314,149)		\$	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)	203,231		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 203,231		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,110,918)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation	\$ (5,900)	14	1
2	Apt/Congregate	(1,111,977)	43	2
3	Real Estate Tax	(3,446)	33	3
4	Late Fees, Fines and Penalties	(1,444)	21	4
5	Miscellaneous Revenue	(2,350)	21	5
6	Lobbying Expense	(1,166)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,126,283)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	(2,193)	0	0	0	0	0	0	0	0	0	0	(2,193)	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	(1,161)	1,519	0	0	0	0	0	0	0	0	0	358	5
6	Maintenance	0	3,408	0	0	0	0	0	0	0	0	0	3,408	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,354)	4,927	0	0	0	0	0	0	0	0	0	1,573	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	(6,169)	0	0	0	0	0	0	0	0	0	0	(6,169)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(5,900)	0	0	0	0	0	0	0	0	0	0	(5,900)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(12,069)	0	0	0	0	0	0	0	0	0	0	(12,069)	16
	C. General Administration													
17	Administrative	0	(348,768)	0	0	0	0	0	0	0	0	0	(348,768)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	93,927	0	0	0	0	0	0	0	0	0	93,927	19
20	Fees, Subscriptions & Promotions	(1,166)	0	0	0	0	0	0	0	0	0	0	(1,166)	20
21	Clerical & General Office Expenses	(20,446)	254,699	0	0	0	0	0	0	0	0	0	234,253	21
22	Employee Benefits & Payroll Taxes	0	47,329	0	0	0	0	0	0	0	0	0	47,329	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	38,568	0	0	0	0	0	0	0	0	0	38,568	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	25,382	0	0	0	0	0	0	0	0	0	25,382	26
27	Other (specify):*	(84,660)	0	0	0	0	0	0	0	0	0	0	(84,660)	27
28	TOTAL General Administration	(106,272)	111,137	0	0	0	0	0	0	0	0	0	4,865	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(121,695)	116,064	0	0	0	0	0	0	0	0	0	(5,631)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	33,460	0	0	0	0	0	0	0	0	0	33,460	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(77,031)	0	0	0	0	0	0	0	0	0	0	(77,031)	32
33	Real Estate Taxes	(3,446)	0	0	0	0	0	0	0	0	0	0	(3,446)	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	(80,477)	33,460	0	0	0	0	0	0	0	0	0	(47,017)	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	(7,119)	0	0	0	0	0	0	0	0	0	(7,119)	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):*	(1,111,977)	60,826	0	0	0	0	0	0	0	0	0	(1,051,151)	43
44	TOTAL Special Cost Centers	(1,111,977)	53,707	0	0	0	0	0	0	0	0	0	(1,058,270)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,314,149)	203,231	0	0	0	0	0	0	0	0	0	(1,110,918)	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 1,519	\$ 1,519	1
2	V	6	Maintenance				3,408	3,408	2
3	V	17	Administrative	464,000			115,232	(348,768)	3
4	V	19	Professional Services				93,927	93,927	4
5	V	21	Clerical				210,261	210,261	5
6	V	22	Employee Benefits				47,329	47,329	6
7	V	21	Dues & Subscriptions				5,528	5,528	7
8	V	24	Travel and Seminars				38,568	38,568	8
9	V	26	Insurance				25,382	25,382	9
10	V	30	Depreciation				33,460	33,460	10
11	V	21	Other Administrative Expense				38,910	38,910	11
12	V	43	Independent Living				60,826	60,826	12
13	V	39	Pharmacy Services	188,844	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	181,725	(7,119)	13
14	Total			\$ 652,844			\$ 856,075	\$ * 203,231	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

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	\$ 20,521	1	
2	Illinois Finance Authority Series 2010	X		Refinance Debt		7/31/10	2,000,000	915,210	5/15/27	6.1300	44,392	2	
3	Bond Fund	X		Debt Relocation	\$3,314.00	Various	843,874	498,714	6/30/32	Various	11,016	3	
4	Illinois Finance Authority Series 2016	X		Refinance Debt		3/1/16	2,780,395	3,035,424	5/15/40	5.0000	3,951	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,314.00		\$ 6,006,440	\$ 5,189,492			\$ 79,880	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	\$ 5,189,492			\$ 79,880	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 120-623-005-00	See attached tax bills	\$ 332.96	\$
2. 12-036-031-00	See attached tax bills	\$ 1,107.34	\$
3. 12-036-032-00	See attached tax bills	\$ 293.96	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,734.26	\$

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 40,200

B. General Construction Type: Exterior BrickFrame SteelNumber 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

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	Facility	43,560	Various	\$ 83,965	1
2	Home Office Allocation			6,610	2
3	TOTALS	43,560		\$ 90,575	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	\$	54	\$	\$	272,125	4
5	26		1969	1969	282,500		50			282,500	5
6	26		1972	1972	318,878		47			318,878	6
7	24			2000	1,279,292	31,982	40	31,982		503,721	7
8	Home Office Allocation				65,387	2,620		2,620		50,143	8
	Improvement Type**										
9	Various		1965		153,924	19,026	Various	19,026		98,430	9
10	Various		1975		22,324		Various			22,324	10
11	Various		1976		754		Various			754	11
12	Various		1979		11,989	266	Various	266		9,880	12
13	Various		1980		37,495		Various			37,495	13
14	Various		1981		2,005		Various			2,005	14
15	Various		1982		19,318		Various			19,318	15
16	Various		1983		88,870		Various			88,870	16
17	Various		1984		5,420		Various			5,420	17
18	Various		1985		77,584	223	Various	223		76,711	18
19	Various		1986		24,379		Various			24,379	19
20	Various		1987		21,639		Various			21,639	20
21	Various		1988		10,116		Various			10,116	21
22	Various		1989		58,128		Various			58,128	22
23	Various		1990		5,930	20	Various	20		5,749	23
24	Various		1991		12,572	20	Various	20		12,370	24
25	Various		1992		22,776		Various			22,776	25
26	Various		1993		18,422	7	Various	7		18,422	26
27	Various		1994		10,251		Various			10,251	27
28	Various		1995		35,562		Various			35,562	28
29	Various		1996		11,019		Various			11,019	29
30	Various		1997		34,079		Various			34,079	30
31	Various		1998		46,393		Various			46,393	31
32	Various		1999		40,547		Various			40,547	32
33	Various		2000		914,547	22,015	Various	22,015		392,206	33
34	Various		2001		59,289		Various			59,289	34
35	Various		2002		16,745	629	Various	629		15,906	35
36	Various		2003		73,567		Various			73,567	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:

7/1/15

Ending:

6/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2004	\$ 30,422	\$	Various	\$	\$	\$ 30,422	37
38 Various	2005	51,644	394	Various	394		51,644	38
39 Various	2006	47,183	2,173	Various	2,173		40,693	39
40 Various	2007	6,145	615	Various	615		5,414	40
41 Various	2008	131,902	13,190	Various	13,190		107,330	41
42 Various	2009	258,283	19,824	Various	19,824		143,640	42
43 Various	2010	42,717	4,272	Various	4,272		26,321	43
44 400 Hall - Skylight Roof	4/30/2011	6,250	625	10	625		3,281	44
45								45
46								46
47 Chaplain Office - Carpet	6/30/2011	3,298	330	10	330		1,676	47
48								48
49 100 Wing A/C Replacement	9/14/2011	2,609	261	10	261		1,261	49
50								50
51 Hot Water Heater	3/14/2012	5,188	519	10	519		2,248	51
52 SNF Plumbing	7/1/2012	5,117	256	20	256		1,023	52
53 SNF Roofing	7/1/2012	19,300	1,930	10	1,930		7,720	53
54 Fire Alarm System	7/1/2012	98,624	9,862	10	9,862		39,448	54
55 Circuit Breakers	7/1/2012	7,250	483	15	483		1,933	55
56 40x40 Garage	7/1/2012	20,234	809	25	809		3,238	56
57								57
58 SNF Doors and Locks	7/1/2012	5,611	561	10	561		2,245	58
59 HVAC	7/1/2012	30,910	2,061	15	2,061		8,242	59
60								60
61 SNF Flooring	7/1/2012	7,267	1,453	5	1,453		5,814	61
62 Electric Rewiring and Panels	7/1/2012	27,428	1,371	20	1,371		5,486	62
63 SNF Ceiling Tracks/Walls	7/1/2012	307,874	30,787	10	30,787		123,149	63
64 SNF Painting	7/1/2012	161,416	16,142	10	16,142		64,566	64
65 SNF Flooring	7/1/2012	246,763	24,676	10	24,676		98,705	65
66 SNF HVAC	7/1/2012	146,459	9,764	15	9,764		39,056	66
67 SNF Plumbing/Electric	7/1/2012	384,150	19,208	20	19,208		76,830	67
68 SNF Lighting/Appliances	7/1/2012	24,367	2,437	10	2,437		9,747	68
69 SNF Doors	7/1/2012	22,643	2,264	10	2,264		9,057	69
70 TOTAL (lines 4 thru 69)		\$ 6,154,880	\$ 243,075		\$ 243,075	\$	\$ 3,591,161	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:

7/1/15

Ending:

6/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 6,154,880	\$ 243,075		\$ 243,075	\$	\$ 3,591,161	1
2 SNF Cabinetry	7/1/2012	28,283	2,828	10	2,828		11,313	2
3 SNF Wardrobes/Cabinets	7/1/2012	148,943	14,894	10	14,894		59,577	3
4 SNF Doors/Hardware	7/1/2012	89,067	8,907	10	8,907		35,627	4
5 SNF Nurse Station	7/1/2012	87,912	5,861	15	5,861		23,443	5
6 SNF Ceiling Tracks/Studs	7/1/2012	289,088	28,909	10	28,909		115,635	6
7 SNF Flooring	7/1/2012	111,988	11,199	10	11,199		44,795	7
8 SNF Electrical Work/Lighting	7/1/2012	269,685	17,979	15	17,979		71,916	8
9 SNF Painting	7/1/2012	54,628	5,463	10	5,463		21,851	9
10 Fire Sprinkler	7/1/2012	434,888	17,396	25	17,396		69,582	10
11 IDPH Design and Plan for SNF	7/1/2012	11,736	1,174	10	1,174		4,694	11
12 Asbestos Survey	7/1/2012	10,465	1,047	10	1,047		4,186	12
13 Ceiling/Sky Lights	7/1/2012	2,685	269	10	269		1,074	13
14								14
15 Courtyard Design and Specifications	7/10/2012	5,488	549	10	549		2,195	15
16								16
17								17
18								18
19								19
20 Electricalwork- 300 hall	7/1/2012	3,143	314	10	314		1,257	20
21 10 Ton AC Unit- 300 Hall	7/1/2012	6,922	461	10	461		1,731	21
22 400 Hall Shower Room Tub	7/1/2012	11,211	1,121	10	1,121		4,017	22
23								23
24								24
25 Boiler Circulation Pump	2/12/2013	3,100	310	10	310		1,059	25
26								26
27 SNF 400 Hall/Alz Unit	6/30/2013	282,149	28,216	10	28,216		88,433	27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 8,006,261	\$ 389,972		\$ 389,972	\$	\$ 4,153,546	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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,006,261	\$ 389,972		\$ 389,972	\$	\$ 4,153,546	1
2	<u>Sprinkler</u>	6/30/2013	4,262	170	25	170		526	2
3	<u>Nurse's Station Maglock Doors</u>	6/30/2013	3,536	354	10	354		1,090	3
4									4
5	<u>Vinyl for 400 Hall Lounge</u>	6/14/2013	4,225	423	10	423		1,303	5
6	<u>Carpet- 400 Wing</u>	6/19/2013	24,847	4,969	5	4,969		15,322	6
7									7
8									8
9									9
10	<u>Oxygen Room- Exhaust Fan & Roof Curb</u>	12/9/2013	3,451	345	10	345		892	10
11	<u>Sewer Discovery</u>	2/13/2013	17,068	683	25	683		2,333	11
12	<u>Excavate and Repair Sewer Lines/Manhol</u>	6/13/2013	12,100	605	20	605		1,865	12
13	<u>Directional Sign & Graphics</u>	10/23/2013	3,730	373	10	373		1,026	13
14	<u>Replace AC in the kitchen</u>	6/19/2014	17,980	1,798	10	1,798		3,746	14
15									15
16	<u>Whirlpool door</u>	12/2/2014	2,805	280	10	280		444	16
17	<u>Hydraulic sink install @ beauty shop</u>	3/20/2015	3,564	356	10	356		475	17
18	<u>Install Emergency door</u>	4/21/2015	9,993	999	10	999		1,249	18
19	<u>Emergency Exit bar</u>	4/21/2015	2,123	212	10	212		265	19
20	<u>Asphalt paving & concrete of parking l</u>	6/25/2014	77,561	9,695	8	9,695		20,198	20
21	<u>Sewer Project</u>	3/17/2014	189,600	7,584	25	7,584		17,696	21
22	<u>Replace resident garage door</u>	5/7/2015	522	52	10	52		61	22
23	<u>Sump Pump</u>	7/1/2015	562	52	10	52		52	23
24	<u>New Rubber roof 40x30 section</u>	9/16/2015	5,900	443	10	443		443	24
25	<u>New Service hall double doors</u>	9/23/2015	4,287	322	10	322		322	25
26	<u>Install new roof Building 7</u>	10/21/2015	10,875	816	10	816		816	26
27	<u>Replace Mixing valve @ Memory care</u>	2/15/2016	2,624	109	10	109		109	27
28	<u>Therapy Room West Door</u>	2/24/2016	4,049	169	10	169		169	28
29	<u>400 Wing Trane AC unit</u>	5/28/2016	6,875	115	10	115		115	29
30	<u>200 Wing Heil 3 ton AC condensing unit</u>	5/28/2016	2,681	45	10	45		45	30
31	<u>200 Wing Heil 4 ton 3 phase AC unit</u>	5/28/2016	4,284	71	10	71		71	31
32	<u>Rounding to tie to FS</u>		1	1		1		3	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,425,766	\$ 421,013		\$ 421,013	\$	\$ 4,224,182	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	\$1,094,470	\$161,507	\$161,507	\$		\$644,490	71
72	Current Year Purchases	54,174	6,768	6,768			6,768	72
73	Fully Depreciated Assets	896,406	3,188	3,188			896,406	73
74	Home Office Allocation	240,610	28,770	28,770			177,618	74
75	TOTALS	\$2,285,660	\$200,233	\$200,233	\$		\$1,725,282	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	\$7,570	\$7,570	\$	Various	\$101,313	76
77										77
78										78
79	Home Office Allocation			9,495	2,069	2,069			7,002	79
80	TOTALS			\$116,423	\$9,639	\$9,639	\$		\$108,315	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)	\$10,918,424	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$630,885	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$630,885	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)	\$6,057,779	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	3,888	3,888	89
90	Apartment/Congregate/Duplex	4,565,615	134,473	3,416,608	90
91	TOTALS	\$6,205,610	\$138,361	\$3,426,196	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$4,646,669	92
93	Home Office Allocation	4,207	93
94			94
95		\$4,650,876	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: 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. YESNO

		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: YESNO
- Terms: *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$18,457Description: See attached 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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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

TCV only hires certified CNAs

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

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	\$	6,428	\$ 256,617	\$	6,428	\$ 256,617	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,791	100,240		1,791	100,240	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		7,407	327,419		7,407	327,419	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
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	15,626	\$ 684,276	\$	15,626	\$ 684,276	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	\$ 1,780,766	\$	1
2	Cash-Patient Deposits	32,110		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,583)	898,093		3
4	Supply Inventory (priced at)	9,992		4
5	Short-Term Investments	744,432		5
6	Prepaid Insurance	13,977		6
7	Other Prepaid Expenses	12,853		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc Int Rec/ Pledges Rec</u>	228,139		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,720,362	\$	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	13,706,539		14
15	Leasehold Improvements, at Historical Cost	570,216		15
16	Equipment, at Historical Cost	2,202,370		16
17	Accumulated Depreciation (book methods)	(9,249,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,023,450		21
22	Other Long-Term Assets (spe CIP	4,646,669		22
23	Other(specify): <u>Deferred Financing Costs</u>	70,063		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,292,903	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,013,265	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 538,869	\$	26
27	Officer's Accounts Payable	32,110		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	266,199		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,536		32
33	Accrued Interest Payable	43,910		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Liabilities</u>	138,959		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,021,583	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,189,492		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	875,559		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,065,051	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,086,634	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,926,631	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,013,265	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,691,530	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,691,530	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	592,122	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) Changes in Temp Restricted Net Assets	(357,014)	15
16	Other (describe) Rounding	(7)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 235,101	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,926,631	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning: 7/1/15

Ending:

6/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,027,726	1
2	Discounts and Allowances for all Levels	(3,914,514)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,113,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,090,448	6
7	Oxygen	1,562	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,092,010	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	28,487	13
14	Non-Patient Meals	2,193	14
15	Telephone, Television and Radio	1,431	15
16	Rental of Facility Space	1,161	16
17	Sale of Drugs	231,263	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,278	19
20	Radiology and X-Ray	25,486	20
21	Other Medical Services	32,993	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 354,292	23
	D. Non-Operating Revenue		
24	Contributions	594,939	24
25	Interest and Other Investment Income***	77,031	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 671,970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	849,964	28
28a	<u>Miscellaneous</u>	25,715	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 875,679	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,107,163	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	895,378	31
32	Health Care	3,517,019	32
33	General Administration	1,827,575	33
	B. Capital Expense		
34	Ownership	734,879	34
	C. Ancillary Expense		
35	Special Cost Centers	1,280,419	35
36	Provider Participation Fee	259,771	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,515,041	40
41	Income before Income Taxes (line 30 minus line 40)**	592,122	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 592,122	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,428,891	44
45	Private Pay - Net Inpatient Revenue	2,681,449	45
46	Medicare - Net Inpatient Revenue	(456,562)	46
47	Other-(specify) <u>HMO, Medicare Advantage</u>	(448,624)	47
48	Other-(specify) <u>Part B, Nursing</u>	(1,091,942)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,113,212	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.

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	1,084	1,138	\$ 41,045	\$ 36.07	1
2	Assistant Director of Nursing	1,949	2,115	66,880	31.62	2
3	Registered Nurses	5,845	6,441	174,091	27.03	3
4	Licensed Practical Nurses	32,345	35,529	792,156	22.30	4
5	CNAs & Orderlies	85,372	92,595	1,150,945	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,147	2,374	28,190	11.87	9
10	Activity Assistants	4,281	4,571	47,582	10.41	10
11	Social Service Workers	9,082	10,323	159,840	15.48	11
12	Dietician	1,521	1,766	45,123	25.55	12
13	Food Service Supervisor					13
14	Head Cook	5,094	5,617	58,249	10.37	14
15	Cook Helpers/Assistants	12,119	12,988	129,098	9.94	15
16	Dishwashers					16
17	Maintenance Workers	3,062	3,348	53,467	15.97	17
18	Housekeepers	6,718	7,449	70,219	9.43	18
19	Laundry	3,139	3,362	35,560	10.58	19
20	Administrator	1,992	2,190	90,647	41.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,504	3,878	67,944	17.52	23
24	Clerical	3,314	3,641	60,646	16.66	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	1,633	1,955	30,234	15.46	31
32	Other Health Care Marketing	1,960	2,080	47,546	22.86	32
33	Other(specify) Apt/Duplex	24,052	26,284	332,876	12.66	33
34	TOTAL (lines 1 - 33)	210,213	229,644	\$ 3,482,338 *	\$ 15.16	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	60	3,343	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	2,956	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	91	5,918	V12-3	45
46	Other(specify)				46
47	Contract DON	1,237	112,038	V10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,676	\$ 153,055		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4	\$ 180	V10-3	50
51	Licensed Practical Nurses	341	12,727	V10-3	51
52	Certified Nurse Assistants/Aides	924	22,994	V10-3	52
53	TOTAL (lines 50 - 52)	1,269	\$ 35,901		53

Facility Name & ID Number	Christian Nursing Home
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0004630

Report Period Beginning: 7/1/15

Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jo Hilliard	Administrator	0	\$ 90,647
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,647
B. Administrative - Other			
Description			Amount
Management Fee			\$ 464,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 464,000
C. Professional Services			
Vendor/Payee	Type		Amount
National Research	Employee Surveys		\$ 1,663
Davis & Campbell	Legal		22,078
Delaney Delaney & Voorn	Legal		3,325
Polsinelli Shughart PC	Legal		135
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 27,201
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 130,237
Unemployment Compensation Insurance			7,832
FICA Taxes			223,018
Employee Health Insurance			363,196
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
457 Plan Expense			3,967
Employee Expense			19,096
Employee Uniforms			1,037
New Hire Expense			19,937
Home Office Allocation			47,329
TOTAL (agree to Schedule V, line 22, col.8)			\$ 815,649
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	101		1,010
License			7,126
Dues			12,801
Subscriptions			16,419
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 37,356
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$ 2,948
In-State Travel			3,331
Seminar Expense			3,496
Home Office Allocation			38,568
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 48,343

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Christian Nursing Home</u>	STATE OF ILLINOIS # <u>0004630</u>	Report Period Beginning: <u>7/1/15</u>	Ending: <u>6/30/16</u>
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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 - \$8,017

(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. \$ 36,440 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. \$ 259,771
 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,193

(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