

		FOR BHF USE					

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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: <u>0026955</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Washington Christian Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2010</u> to <u>June 30, 2011</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>1201 New Castle Road</u> <u>Washington</u> <u>61571</u>																									
Number City Zip Code																									
County: <u>Tazewell</u>																									
Telephone Number: <u>309-444-3161</u> Fax # <u>309-444-7397</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>Chief Financial Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u></td></tr><tr><td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Susan McGhee</u>	(Title) <u>Chief Financial Officer</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u>	(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u>	(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u>	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												
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Date of Initial License for Current Owners: <u>04/01/1982</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501c3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501c3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Susan McGhee</u> Telephone Number: <u>314-587-7903</u>																									
Email Address: _____																									

Facility Name & ID Number Washington Christian Village

0026955 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	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	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,440</u>	<u>9,117</u>	<u>10,756</u>	<u>34,313</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,440</u>	<u>9,117</u>	<u>10,756</u>	<u>34,313</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.06%

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

None (Do not include bed-hold days in Section B.)

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

Meals, Lawn, & Maint. Care, Housekeeping & Laundry Services for IL Residents

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

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

YES ☒ NO ☐

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

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 4/1/1982

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/1/1982 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 122 and days of care provided 7,515

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Washington Christian Village # 0026955 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	270,129	24,846	12,119	307,094		307,094		307,094			1
2	Food Purchase		246,414		246,414		246,414	(3,306)	243,108			2
3	Housekeeping	115,205	19,651		134,856		134,856		134,856			3
4	Laundry	65,263	5,045		70,308		70,308		70,308			4
5	Heat and Other Utilities			127,110	127,110		127,110	(11,665)	115,445			5
6	Maintenance	69,417	13,253	28,988	111,658		111,658	15,196	126,854			6
7	Other (specify):* Trash			9,372	9,372		9,372		9,372			7
8	TOTAL General Services	520,014	309,209	177,589	1,006,812		1,006,812	225	1,007,037			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	2,399,689	168,082	14,546	2,582,317		2,582,317		2,582,317			10
10a	Therapy		3,794	890,509	894,303		894,303		894,303			10a
11	Activities	79,520	4,528	925	84,973		84,973		84,973			11
12	Social Services	102,070	581	1,261	103,912		103,912		103,912			12
13	CNA Training											13
14	Program Transportation			8,699	8,699		8,699		8,699			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,581,279	176,985	922,540	3,680,804		3,680,804		3,680,804			16
	C. General Administration											
17	Administrative	99,397	1,545	500,232	601,174		601,174	(440,692)	160,482			17
18	Directors Fees											18
19	Professional Services			33,641	33,641		33,641	21,416	55,057			19
20	Dues, Fees, Subscriptions & Promotions			21,206	21,206		21,206	4,991	26,197			20
21	Clerical & General Office Expenses	94,969	11,570	161,138	267,677		267,677	41,926	309,603			21
22	Employee Benefits & Payroll Taxes			643,817	643,817		643,817	31,096	674,913			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,730	8,730		8,730	9,966	18,696			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,846	74,846		74,846	852	75,698			26
27	Other (specify):* Marketing	49,019	2,779	8,895	60,693		60,693	(60,693)				27
28	TOTAL General Administration	243,385	15,894	1,452,505	1,711,784		1,711,784	(391,138)	1,320,646			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,344,678	502,088	2,552,634	6,399,400		6,399,400	(390,913)	6,008,487			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			247,950	247,950		247,950	17,951	265,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,716	233,716		233,716	(222,810)	10,906			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,801	26,801		26,801	4,039	30,840			35
36	Other (specify):*											36
37	TOTAL Ownership			508,467	508,467		508,467	(200,820)	307,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			366,711	366,711		366,711	(32,092)	334,619			39
40	Barber and Beauty Shops	14,909	375		15,284		15,284		15,284			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* Apt & Congregate			92,348	92,348		92,348	(92,348)				43
44	TOTAL Special Cost Centers	14,909	375	525,854	541,138		541,138	(124,440)	416,698			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,359,587	502,463	3,586,955	7,449,005		7,449,005	(716,173)	6,732,832			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	(1,864)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,452)	5		5
6	Rented Facility Space				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	(186,238)	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	(37,203)	32		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	(88,483)	21		24
25	Fund Raising, Advertising and Promotional	(60,693)	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	(104,388)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (492,321)		\$	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)	(223,852)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (223,852)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (716,173)		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

ID#

0026955

Report Period Beginning:

July 1, 2010

Ending:

June 30, 2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Vending	\$ (1,442)	2	1
2	Late Fees, Finance Charges	(298)	21	2
3	Miscellaneous	410	17	3
4	Apt/Congregate	(92,348)	43	4
5	Charity Care	(10,710)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(104,388)		49

Summary B

June 30, 2011

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)	
Depreciation	0	17,951	0	0	0	0	0	0	0	0	0	17,951	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	(223,441)	631	0	0	0	0	0	0	0	0	0	(222,810)	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	0	4,039	0	0	0	0	0	0	0	0	0	4,039	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
TOTAL Ownership	(223,441)	22,621	0	0	0	0	0	0	0	0	0	(200,820)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	(32,092)	0	0	0	0	0	0	0	0	0	(32,092)	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	(92,348)	0	0	0	0	0	0	0	0	0	0	(92,348)	43
TOTAL Special Cost Centers	(92,348)	(32,092)	0	0	0	0	0	0	0	0	0	(124,440)	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(492,321)	(223,852)	0	0	0	0	0	0	0	0	0	(716,173)	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 attached listing of board of directors.						

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. dba: Christian Homes, Inc	100.00%	\$ 1,787	\$ 1,787	1
2	V	6	Maintenance				15,196	15,196	2
3	V	17	Administration	500,232			59,130	(441,102)	3
4	V	19	Professional Services				21,416	21,416	4
5	V	21	Clerical				141,417	141,417	5
6	V	22	Employee Benefits				31,096	31,096	6
7	V	24	Travel & Seminar				9,966	9,966	7
8	V	26	Insurance				852	852	8
9	V	30	Depreciation				17,951	17,951	9
10	V	32	Interest				631	631	10
11	V	20	Dues & Subscriptions				4,991	4,991	11
12	V	35	Rental and Leasing				4,039	4,039	12
13	V	39	Pharmacy Services	325,151	Senior Care Pharmacy	0.00%	293,059	(32,092)	13
14	Total			\$ 825,383			\$ 601,531	\$ * (223,852)	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	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 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								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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2010 Ending: ne 30, 2011

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 not applicable				\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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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	Bond Fund	X		Refinance Debt	\$19,374.00	Various	\$ 4,409,251	\$ 3,697,411	6/30/2032	0.0572	\$ 184,260	1	
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	1,500,000	1,500,000	5/15/2027	0.0613	12,253	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$19,374.00		\$ 5,909,251	\$ 5,197,411			\$ 196,513	9	
	B. Non-Facility Related*												
10	Duplex										37,203	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 37,203	14	
15	TOTALS (line 9+line14)						\$ 5,909,251	\$ 5,197,411			\$ 233,716	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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		8	
		2007		9	
		2008		10	
		2009		11	
		2010		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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Washington Christian Village	COUNTY	Tazewell
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FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-723-5175 FAX #: ()

A. Summary of Real Estate Tax Cost

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	02-02-14-308-001	Devonshire Estates 5th Add Sec 11	\$ 7,572.00	\$
2.	02-02-14-300-021	Devonshire Estates 5th Addn	\$ 16,625.00	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 24,197.00	\$

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 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.

X. BUILDING AND GENERAL INFORMATION:

A.	Square Feet:	37,956	B. General Construction Type:	Exterior	Brick	Frame	Steel	Number of Stories	1
----	--------------	--------	-------------------------------	----------	-------	-------	-------	-------------------	---

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

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	38,484	1982	\$ 50,000	1
2	Home Office Allocation			5,478	2
3	TOTALS	38,484		\$ 55,478	3

Facility Name & ID Number Washington Christian Village

0026955

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122		1982		\$ 1,203,052	\$ 34,373	35	\$ 34,373		\$ 1,011,230
5										
6										
7										
8	Home Office Allocation				56,633	3,655		3,655		130,068
	Improvement Type**									
9	1982 Fixed Assets			1982	57,536	396	Various	396		55,161
10	1983 Fixed Assets			1983	36,292	985	Various	985		29,887
11	1984 Fixed Assets			1984	3,947	7	Various	7		3,897
12	1985 Fixed Assets			1985	368,110	10,331	Various	10,331		280,077
13	1986 Fixed Assets			1986	4,603		Various			4,603
14	1988 Fixed Assets			1988	12,623	106	Various	106		11,379
15	1989 Fixed ASSETS			1989	9,092		Various			9,092
16	1991 Fixed Assets			1991	2,395	120	Various	120		2,425
17	1992 Fixed Assets			1992	9,161		Various			9,161
18	1993 Fixed Assets			1993	10,785		Various			10,785
19	1994 Fixed Assets			1994	4,103		Various			4,103
20	1995 Fixed Assets			1995	10,713		Various			10,713
21	1996 Fixed Assets			1996	91,102	3,134	Various	3,134		76,738
22	1997 Fixed Assets			1997	35,910	2,165	Various	2,165		33,022
23	1999 Fixed Assets			1999	4,330		Various			4,330
24	2000 Fixed Assets			2000	6,623	174	Various	174		6,623
25	2001 Fixed Assets			2001	52,160	3,505	Various	3,505		36,606
26	2002 Fixed Assets			2002	259,334	13,623	Various	13,623		187,845
27	2003 Fixed Assets			2003	8,658	1,062	Various	1,062		7,935
28	2004 Fixed Assets			2004	18,733	1,589	Various	1,589		14,265
29	2005 Fixed Assets			2005	133,164	12,569	Various	12,569		87,962
30	2006 Fixed Assets			2006	132,538	9,416	Various	9,416		49,518
31	2007 Fixed Assets			2007	198,096	11,611	Various	11,611		43,601
32	SW/Reclaim unit dining area			2008	922	92	10	92		315
33	Supplies for SW/Nurse station			2008	5,690	569	10	569		1,849
34	SW cooridor AC replacement			2008	33,860	3,386	10	3,386		10,440
35	NW cooridor AC replacement			2008	36,325	3,633	10	3,633		11,200
36	100 gallon water heater - natural gas			2008	6,298	630	10	630		1,575

*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 Washington Christian Village

0026955

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	Replacement windows - NW wing	2008	12,025	1,203	10	1,203		3,007	37
38	Kitchen floor & remodel	2009	37,874	3,787	10	3,787		9,468	38
39	Chapel remodeling	2009	39,238	3,924	10	3,924		8,175	39
40	Carrier roof top AC units - dining room	2009	27,875	2,788	10	2,788		6,752	40
41	Southeast corridor cooling system	2009	35,600	3,560	10	3,560		8,603	41
42	2 cabinet unit heaters - north wing	2009	7,000	700	10	700		1,692	42
43	Upgrade to door alarms	2009	2,465	247	10	247		597	43
44	Windows	2009	12,025	1,203	10	1,203		2,505	44
45	Baseboard, Vanities, Lights, Toilets, Sinks, Outlets, Doors, Piping	2009	53,888	5,389	10	5,389		11,226	45
46	Cooling Fans for New Computer Room	2009		85	10	85			46
47	Patio conversion to Chapel	2009	750	69	10	69		138	47
48	SW AC	2009	2665	267	10	267		534	48
49	SNG Window Replacement	2010	17590	1,759	10	1,759		2,199	49
50	New Flooring- EE Lounge & Frount Entry	2010	12526	1,253	10	1,253		1,357	50
51	Parking Lot & Drive Resurface	2010	35,400	3,540	10	3,540		3,835	51
52	Car/ Bus Port	2010	6,555	656	10	656		875	52
53	Replace Front Sidewalk & Approach	2010	3,195	320	10	320		320	53
54	AC for Business & Admin Office	2010	5,590	559	10	559		559	54
55	Bifold Closet Doors - Resident Rms	2010	348	35	10	35		35	55
56	Paint & Supplies SW Dining Room	2010	901	90	10	90		90	56
57	SW Dining Rm Floor	2010	4,885	488	10	488		488	57
58	Radiator Covers - Resident Rooms	2010	4,218	422	10	422		422	58
59	Asbestos Removal	2010	2,242	224	10	224		224	59
60	Decorative Supports	2010	246	25	10	25		25	60
61	Electrical Work - Conduit, Junction Boxes, & Receptacle	2010	492	49	10	49		49	61
62	Restrooms 4 Oaktowne Flush Bifol	2010	717	72	10	72		72	62
63	Electrical Work - 3 20 Amp Circuits Added, Steam Tables	2010	552	55	10	55		55	63
64	Move Fire Sprinklers	2010	3,340	334	10	334		334	64
65	Asbestos Testing	2010	1,885	189	10	189		189	65
66	Add 2 Windows and Insulated Steel Door	2010	3,039	304	10	304		304	66
67	Add Cat-5 Wiring, Jacks, & Plates	2010	1,141	114	10	114		114	67
68	Bathroom Fixtures	2010	239	24	10	24		24	68
69	Cabinets For Therapy	2010	493	49	10	49		49	69
70	TOTAL (lines 4 thru 69)		\$ 3,149,787	\$ 150,912		\$ 150,912	\$	\$ 2,210,720	70

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

Facility Name & ID Number Washington Christian Village

0026955

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		\$ 3,149,787	\$ 150,912		\$ 150,912	\$	\$ 2,210,720	1
2	Utility Pump & Shelves	2010	364	36	10	36		36	2
3	Hardware, 2x4s, & Conduit	2010	341	34	10	34		34	3
4	Excavate, Concrete Patio, Install 4 Downspouts to Sewer System	2010	6,000	600	10	600		600	4
5	Room Signs	2010	359	36	10	36		36	5
6	Remove Wall/Tile, Install Windows, Cabinets, Tops, Upgrade Plumbing	2010	108,215	10,822	10	10,822		10,822	6
7	Front Door Remodel	2010	4,895	490	10	490		490	7
8	2 Electric Circuits - Server Rm	2010	325	33	10	33		33	8
9	Double Side Front Sign	2010	7,417	742	10	742		742	9
10	Landscaping Front & Therapy Patios	2010	17,815	1,633	10	1,633		1,633	10
11	Front Doors	2010	11,098	925	10	925		925	11
12	Front Door Alarming System	2010	1,845	138	10	138		138	12
13	Sealcoat East Parking Lot	2010	3,950	263	10	263		263	13
14	Window for Conference Room	2010	572	38	10	38		38	14
15	Service & Conference Room Doors	2010	6,439	376	10	376		376	15
16	Attic Insulation for front hallway	2011	503	25	10	25		25	16
17	New wiring for 24 port VIOP	2011	1,240	62	10	62		62	17
18	B&G hot water circulating pump & kit	2011	3,635	182	10	182		182	18
19	60 gal, 120K BTU water heater	2011	6,448	269	10	269		269	19
20	Resident room painting	2011	2,404	80	10	80		80	20
21	Wiring for SW rooms TVs	2011	1,899	63	10	63		63	21
22	Roof where NE wing meets NW wing	2011	2,952	74	10	74		74	22
23	Topography of west apt land	2011	3,340	84	10	84		84	23
24	Ceramic for EE rest rooms	2011	3,003	75	10	75		75	24
25	Prime & Paint Interior Doors	2011	3,538	88	10	88		88	25
26	Prime Paint Doors Frames NW Hallway	2011	6,861	172	10	172		172	26
27	Faucet No Clean Utility Rm	2011	92	2	10	2		2	27
28	Channels for Activity Room	2011	9	0	10	0		0	28
29	Sink w faucet SE Nurse Station	2011	99	2	10	2		2	29
30	Prepare & Paint No Nurse Station	2011	541	9	10	9		9	30
31	12x30 Wall Cabinet No Nurse Station	2011	108	2	10	2		2	31
32	24x30 Wall Cabinet No Nurse Station	2011	247	4	10	4		4	32
33	Prep & Paint, Laundry Rm, Hallway Doors	2011	1,286	21	10	21		21	33
34	TOTAL (lines 1 thru 33)		\$ 3,357,627	\$ 168,292		\$ 168,292	\$	\$ 2,228,100	34

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

Facility Name & ID Number Washington Christian Village

0026955

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	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		\$ 3,357,627	\$ 168,292		\$ 168,292	\$	\$ 2,228,100	1
2 Prep & Paint Laundry Rm, Hallway	2011	600	10	10	10		10	2
3 Countertops - No Nurse Station	2011	69	1	10	1		1	3
4 24" Base Cabinets SE Nurse Station	2011	445	7	10	7		7	4
5 Activity Room - Piping	2011	1,470	25	10	25		25	5
6 Radiator Covers	2011	8,050	67	10	67		67	6
7 Prep & Paint Center Hall	2011	1,460	12	10	12		12	7
8 Prep & Paint Doors NE Lounge	2011	321	3	10	3		3	8
9 Prep & Paint Walls NE Lounge	2011	400	3	10	3		3	9
10 Prep & Paint NE & NW Hallways	2011	3,250	27	10	27		27	10
11 Prime & Paint Doors, Frames Center Hall	2011	3,330	28	10	28		28	11
12 Prep & Paint Shower Room	2011	550	5	10	5		5	12
13 Prep, Paint SW Exterior Door	2011	107	1	10	1		1	13
14 Prep & paint Door Frames SE Nurse Statio	2011	80	1	10	1		1	14
15 Remodel 5 offices, Baseboard, chair rail	2011	6,541	55	10	55		55	15
16 Ceiling tile, 48" light Fixture Soc Ser2	2011	165	1	10	1		1	16
17 Prep & paint SE Nurse Station	2011	600	5	10	5		5	17
18 Vanities, Faucets Employee bathrooms	2011	720	6	10	6		6	18
19 Sink w faucet Activity Room	2011	130	1	10	1		1	19
20 Prep. Paint Admin, DON, Business	2011	2,550	21	10	21		21	20
21 Fire Extinguisher Cabinets	2011	635	5	10	5		5	21
22 Seal, Varnish Closes Doors	2011	1,819	15	10	15		15	22
23 Cabinets - North Nurse Station	2011	7,864	66	10	66		66	23
24 Cabinets - South Nurse Station	2011	1,610	13	10	13		13	24
25 Lights, Fans, Heater Center Hall Shower	2011	1,881	16	10	16		16	25
26 Countertop Socia Ser#2 Office	2011	46	0	10	0		0	26
27 15' Wall Demential Dining Area	2011	4,457	37	10	37		37	27
28 Steel Door Admin Office	2011	1,850	15	10	15		15	28
29 Build Soffit in 10 Bathrooms, Metal Bi-fold Doors, Remove Baseboard	2011	26,211	218	10	218		218	29
30 Activity Room - Painting	2011	1,500	13	10	13		13	30
31 Paint 31 doors & frames SE Hall	2011	3,318	28	10	28		28	31
32 Paint 34 doors & frames SW Hall	2011	3,639	30	10	30		30	32
33 Remove Wallpaper & Paint Resident Rooms	2011	10,194	85	10	85		85	33
34 TOTAL (lines 1 thru 33)		\$ 3,453,489	\$ 169,113		\$ 169,113	\$	\$ 2,228,920	34

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

Facility Name & ID Number Washington Christian Village

0026955

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 12C, Carried Forward		\$ 3,453,489	\$ 169,113		\$ 169,113	\$	\$ 2,228,920	1
2	Remove Wallpaper & Paint SW Hall	2011	1,160	10	10	10		10	2
3	Remove wallpaper & paint SE Hall	2011	1,160	10	10	10		10	3
4	Paint Bathrooms 107, 110, 141, 147, 140	2011	1,200	10	10	10		10	4
5	Cultered Marble Top 12 SE Units	2011	2,750	23	10	23		23	5
6	Vanity & Top Rm 135	2011	401	3	10	3		3	6
7	Rm 105 & 108 Vanity top, apron & legs	2011	1,320	11	10	11		11	7
8	Rm 107 & 110 Vanity top, apron & legs	2011	1,542	13	10	13		13	8
9	Cove Base All Areas	2011	9,601	80	10	80		80	9
10	Flooring 10 Resident Bathrooms	2011	5,622	47	10	47		47	10
11	Carpet Powerbond Corridors	2011	29,254	244	10	244		244	11
12	Carpet Broadloom River Stone Offices	2011	5,435	45	10	45		45	12
13	Rm 148 Paint Walls Border removal	2011	426	4	10	4		4	13
14	Carpet for 19 Resident Rooms	2011	24,111	201	10	201		201	14
15	Dining Room - Armstrong Vinyl Flooring	2011	24,981	208	10	208		208	15
16	Build soffit around exposed piping	2011	4,230	35	10	35		35	16
17	Floor Preparation - Ardex skim coat	2011	15,000	125	10	125		125	17
18	Fire Sprinkler relocated	2011	3,254	27	10	27		27	18
19	Remove wallpaper 12 resident rooms	2011	1,200	10	10	10		10	19
20	New toilets Resident rms 140,138,108,110	2011	2,060	17	10	17		17	20
21	Tile - Bath off north center hall	2011	3,322	28	10	28		28	21
22	Carpet RAC Office	2011	509	4	10	4		4	22
23	Trim throughout building	2011	430	4	10	4		4	23
24	Wood for shelves - SE Nurse Station	2011	106	1	10	1		1	24
25	Suspended Ceiling - Admin & DON Office	2011	1,352	11	10	11		11	25
26	Coutertops - SW Nurse Station	2011	208	2	10	2		2	26
27	Sprinkler Heads - Admin & DON Offices	2011	438	4	10	4		4	27
28	Cabinets - SW Nurse Station	2011	876	7	10	7		7	28
29	24X30 Wall Cabinet SE Nurse Station	2011	456	4	10	4		4	29
30	24" Base Cabinet - SW Nurse Station	2011	147	1	10	1		1	30
31	Project Paint - Sherwin Williams	2011	855	7	10	7		7	31
32	Remodel Central Hall Shower Rm	2011	1,886	16	10	16		16	32
33	Lights 48" - DON Office	2011	88	1	10	1		1	33
34	TOTAL (lines 1 thru 33)		\$ 3,598,869	\$ 170,324		\$ 170,324	\$	\$ 2,230,132	34

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

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 12D, Carried Forward		\$ 3,598,869	\$ 170,324		\$ 170,324	\$	\$ 2,230,132	1
2 Lights 48" - Admin Office	2011	679	6	10	6		6	2
3 Faux Wood Vinyl Floor	2011	11,591	97	10	97		97	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,611,139	\$ 170,426		\$ 170,426	\$	\$ 2,230,234	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	\$539,984	\$41,429	\$41,429	\$	Various	\$174,471	71
72	Current Year Purchases	219,224	14,317	14,317		Various	14,317	72
73	Fully Depreciated Assets	194,830	2,903	2,903			194,830	73
74	Home Office Allocation	268,503	17,327	17,327			29,792	74
75	TOTALS	\$1,222,541	\$75,976	\$75,976	\$		\$413,410	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	2009 Ford Van	2009	\$42,068	\$10,517	\$10,517	\$	4	\$19,281	76
77	Home Office Allocation			33,142	2,139	2,139			13,879	77
78										78
79										79
80	TOTALS			\$75,210	\$12,656	\$12,656	\$		\$33,160	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)	\$4,964,368	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$259,058	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$259,058	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)	\$2,676,804	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	Land	\$120,656	\$	\$	86
87	Land Improvements	8,903		8,903	87
88	Buildings & Equipment	687,834	9,145	500,890	88
89					89
90					90
91	TOTALS	\$817,393	\$9,145	\$509,793	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$52,358	92
93			93
94			94
95		\$52,358	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: \$26,801
- Description: 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.	/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

Washington Christian Village does not train the C NA's because they are already certified when hired.

B. EXPENSES

C. CONTRACTUAL INCOME

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	10A-3	hrs	\$	9,029	\$ 372,361	\$	9,029	\$ 372,361	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,654	125,172		2,654	125,172	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		10,510	392,976		10,510	392,976	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			\$	22,193	\$ 890,509	\$	22,193	\$ 890,509	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,667,144	\$	1
2	Cash-Patient Deposits	12,070		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,163)	1,174,518		3
4	Supply Inventory (priced at)	8,228		4
5	Short-Term Investments			5
6	Prepaid Insurance	183		6
7	Other Prepaid Expenses	10,982		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/Other A/R</u>	135,133		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,008,258	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	4,293,989		14
15	Leasehold Improvements, at Historical Cost	161,354		15
16	Equipment, at Historical Cost	776,999		16
17	Accumulated Depreciation (book methods)	(3,058,192)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	91,677		21
22	Other Long-Term Assets (spe CIP	108,035		22
23	Other(specify): <u>Note Receivable</u>	1,842,199		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,386,717	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,394,975	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 502,964	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,070		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,357		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,689		32
33	Accrued Interest Payable	14,573		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	52,229		36
37	<u>Current Portion Refundable Ent Fees</u>	5,500		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 868,382	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,197,411		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees/Other Liab</u>	45,105		43
44	<u>Apt & Congregate</u>	35,280		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,277,796	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,146,178	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,248,797	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,394,975	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,274,852	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,274,852	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,973,945	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)	\$ 1,973,945	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)	\$ 3,248,797	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village# 0026955Report 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.

	1	2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,982,780	1
2	Discounts and Allowances for all Levels	(1,890,534)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,092,246	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,043,087	6
7	Oxygen	50,327	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,093,414	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	18,308	13
14	Non-Patient Meals	1,864	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	570,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,708	19
20	Radiology and X-Ray	11,471	20
21	Other Medical Services	21,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 658,242	23
	D. Non-Operating Revenue		
24	Contributions	271,693	24
25	Interest and Other Investment Income***	186,238	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 457,931	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	124,134	28
28a	<u>Miscellaneous</u>	(3,017)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,422,950	30

	2		
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,006,812	31
32	Health Care	3,680,804	32
33	General Administration	1,711,784	33
	B. Capital Expense		
34	Ownership	508,467	34
	C. Ancillary Expense		
35	Special Cost Centers	474,343	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,449,005	40
41	Income before Income Taxes (line 30 minus line 40)**	1,973,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,973,945	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	1,774	2,000	\$ 85,068	\$ 42.53	1
2	Assistant Director of Nursing	1,836	2,034	55,720	27.39	2
3	Registered Nurses	18,957	20,462	562,504	27.49	3
4	Licensed Practical Nurses	16,594	18,235	383,590	21.04	4
5	CNAs & Orderlies	87,858	94,400	1,169,445	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	2,000	24,500	12.25	9
10	Activity Assistants	5,736	5,991	55,020	9.18	10
11	Social Service Workers	4,585	5,243	102,070	19.47	11
12	Dietician					12
13	Food Service Supervisor	1,867	1,967	35,829	18.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,713	25,146	234,300	9.32	15
16	Dishwashers					16
17	Maintenance Workers	4,947	5,318	69,417	13.05	17
18	Housekeepers	11,021	11,961	115,205	9.63	18
19	Laundry	5,780	6,206	65,263	10.52	19
20	Administrator	2,124	2,320	99,397	42.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,936	2,000	35,012	17.51	23
24	Clerical	3,831	4,266	59,957	14.05	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	3,153	3,585	42,469	11.85	31
32	Other Health Care: MDS Coordinator	3,907	4,235	100,893	23.82	32
33	Other(specify) Marketing, Beutic	3,247	3,347	63,928	19.10	33
34	TOTAL (lines 1 - 33)	204,714	220,716	\$ 3,359,587 *	\$ 15.22	34

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	213	\$ 12,119	3.1.3	35
36	Medical Director	120	6,600	3.9.3	36
37	Medical Records Consultant	15	350	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,140	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	305	3.11.3	44
45	Social Service Consultant	18	1,261	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	564	\$ 23,775		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Roger Hermann	Administrator	0	\$ 99,397	Workers' Compensation Insurance	\$	81,018	IDPH License Fee	\$
				Unemployment Compensation Insurance		19,072	Advertising: Employee Recruitment	8,129
				FICA Taxes		246,090	Health Care Worker Background Check	
				Employee Health Insurance		263,568	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Licenses	2,375
				Employee Physicals		12,236	Dues	7,771
				Employee Uniforms		685	Subscriptions	2,707
				Employee Expense		13,065	Petty Cash - NOVA	224
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 99,397	457 Plan Expense		8,083	Home Office Allocation	4,991
(List each licensed administrator separately.)				Home Office Allocation		31,096	Less: Public Relations Expense	()
B. Administrative - Other							Non-allowable advertising	()
Description			Amount				Yellow page advertising	()
Management Fee			\$ 500,232				TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 26,197	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 500,232	TOTAL (agree to Schedule V, line 22, col.8)			\$ 674,913	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
My Innerview	Survey		\$ 1,625			\$	Out-of-State Travel	\$ 2,192
The Finn Group	Consulting		2,413					
Polsinelli Shughart, PC	Legal		7,452					
Armstrong Teasdale	Legal		1,260				In-State Travel	4,793
Davis & Campbell	Legal		20,891					
							Seminar Expense	1,745
							Home Office Allocation	9,966
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 33,641	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	

* 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 - \$6,782
- (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. \$ 34,402 Line 10-3
- (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. \$ 66,795
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. \$ 1,864
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 16,899
c. What percent of all travel expense relates to transportation of nurses and patients? .36
d. Have vehicle usage logs been maintained? Yes
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: 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.