

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0020610</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Wabash Christian Retirement</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2011</u> to <u>6/30/2012</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>216 College Boulevard</u> <u>Carmi</u> <u>62821</u>																									
Number City Zip Code																									
County: <u>White</u>																									
Telephone Number: <u>618-382-4644</u> Fax # <u>618-382-2350</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>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Allan B. Larson</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave., Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>314-925-4379</u> Fax # <u>314-925-4350</u></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	(Date) _____	(Print Name and Title) <u>Allan B. Larson</u> <u>Partner</u>	(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave., Suite 1800, St. Louis, MO 63101</u>	(Telephone) <u>314-925-4379</u> Fax # <u>314-925-4350</u>												
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Date of Initial License for Current Owners: <u>6/1/1974</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 _____	
☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.	_____																							
	☐ 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>Susan McGhee</u> Telephone Number: <u>314-587-7903</u> Email Address: _____																									

Facility Name & ID Number Wabash Christian Retirement# 0020610 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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>158</u>	Skilled (SNF)	<u>158</u>	<u>57,828</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>158</u>	TOTALS	<u>158</u>	<u>57,828</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>24,933</u>	<u>12,587</u>	<u>10,145</u>	<u>47,665</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>24,933</u>	<u>12,587</u>	<u>10,145</u>	<u>47,665</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.43%

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 served to prisoners

F. Does the facility maintain a daily midnight census?

YesG. 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 06/01/1974

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

YES ☐ Date _____ NO ☒

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

YES ☒ NO ☐ If YES, enter number
of beds certified 158 and days of care provided 9,525Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

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	322,469	30,540	10,764	363,773		363,773	(26)	363,747		1
2	Food Purchase		280,525		280,525		280,525	(3,950)	276,575		2
3	Housekeeping	155,597	46,688		202,285		202,285		202,285		3
4	Laundry	85,854	2,933		88,787		88,787		88,787		4
5	Heat and Other Utilities			193,967	193,967		193,967	(1,338)	192,629		5
6	Maintenance	121,261	48,797	36,328	206,386		206,386	4,006	210,392		6
7	Other (specify):*										7
8	TOTAL General Services	685,181	409,483	241,059	1,335,723		1,335,723	(1,308)	1,334,415		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,886,167	246,591	10,069	3,142,827		3,142,827	(3,381)	3,139,446		10
10a	Therapy		1,631	1,283,977	1,285,608		1,285,608		1,285,608		10a
11	Activities	131,871	3,825	758	136,454		136,454	(1,456)	134,998		11
12	Social Services	144,429	1,212	7,936	153,577		153,577		153,577		12
13	CNA Training										13
14	Program Transportation			13,259	13,259		13,259	(13,259)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,162,467	253,259	1,323,199	4,738,925		4,738,925	(18,096)	4,720,829		16
	C. General Administration										
17	Administrative	138,520	502	583,334	722,356		722,356	(495,229)	227,127		17
18	Directors Fees										18
19	Professional Services			14,145	14,145		14,145	46,465	60,610		19
20	Dues, Fees, Subscriptions & Promotions			15,376	15,376		15,376		15,376		20
21	Clerical & General Office Expenses	159,047	11,247	236,344	406,638		406,638	30,449	437,087		21
22	Employee Benefits & Payroll Taxes			1,013,581	1,013,581		1,013,581	43,889	1,057,470		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,161	15,161		15,161	16,076	31,237		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,978	113,978		113,978	(9,504)	104,474		26
27	Other (specify):* Marketing	102,806	684	36,042	139,532		139,532	(139,532)			27
28	TOTAL General Administration	400,373	12,433	2,027,961	2,440,767		2,440,767	(507,386)	1,933,381		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,248,021	675,175	3,592,219	8,515,415		8,515,415	(526,790)	7,988,625		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			369,172	369,172		369,172	32,143	401,315			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,848	40,848		40,848	(26,134)	14,714			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,879	57,879		57,879		57,879			35
36	Other (specify):* FIN 47 Accretion			6,234	6,234		6,234		6,234			36
37	TOTAL Ownership			474,133	474,133		474,133	6,009	480,142			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			381,193	381,193		381,193	(22,912)	358,281			39
40	Barber and Beauty Shops		95	13,201	13,296		13,296		13,296			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			376,585	376,585		376,585		376,585			42
43	Other (specify):* Apt/Congregate			52,259	52,259		52,259	(52,259)				43
44	TOTAL Special Cost Centers		95	823,238	823,333		823,333	(75,171)	748,162			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,248,021	675,270	4,889,590	9,812,881		9,812,881	(595,952)	9,216,929			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,687)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,920)	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	(40,848)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,247)	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	(156,671)	21		24
25	Fund Raising, Advertising and Promotional	(139,532)	27		25
	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	(125,590)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (472,495)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,457)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (123,457)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (595,952)		37

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

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

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

Wabash Christian Retirement

ID# 0020610

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Charity Care	\$ (11,450)	21	1
2	Vending	(263)	2	2
3	Activity	(1,456)	11	3
4	Apt/Congregate	(52,259)	43	4
5	Transportation	(13,259)	14	5
6	Late Fees and Penalties	(14)	21	6
7	Miscellaneous	(342)	21	7
8				8
9	Insurance Gain	(46,387)	21	9
10	Late Fees	(26)	1	10
11	Late Fees	(134)	10	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(125,590)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(26)	0	0	0	0	0	0	0	0	0	0	(26)	1
2	Food Purchase	(3,950)	0	0	0	0	0	0	0	0	0	0	(3,950)	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	(2,920)	1,582	0	0	0	0	0	0	0	0	0	(1,338)	5
6	Maintenance	0	4,006	0	0	0	0	0	0	0	0	0	4,006	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,896)	5,588	0	0	0	0	0	0	0	0	0	(1,308)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,381)	0	0	0	0	0	0	0	0	0	0	(3,381)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,456)	0	0	0	0	0	0	0	0	0	0	(1,456)	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	(13,259)	0	0	0	0	0	0	0	0	0	0	(13,259)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(18,096)	0	0	0	0	0	0	0	0	0	0	(18,096)	16
	C. General Administration													
17	Administrative	0	(495,229)	0	0	0	0	0	0	0	0	0	(495,229)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	46,465	0	0	0	0	0	0	0	0	0	46,465	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(214,864)	245,313	0	0	0	0	0	0	0	0	0	30,449	21
22	Employee Benefits & Payroll Taxes	0	43,889	0	0	0	0	0	0	0	0	0	43,889	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	16,076	0	0	0	0	0	0	0	0	0	16,076	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	(9,504)	0	0	0	0	0	0	0	0	0	(9,504)	26
27	Other (specify):*	(139,532)	0	0	0	0	0	0	0	0	0	0	(139,532)	27
28	TOTAL General Administration	(354,396)	(152,990)	0	0	0	0	0	0	0	0	0	(507,386)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(379,388)	(147,402)	0	0	0	0	0	0	0	0	0	(526,790)	29

Summary B

6/30/2012

[illegible]

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 1,582	\$ 1,582	1
2	V	6	Maintenance				4,006	4,006	2
3	V	17	Administrative	583,334			88,105	(495,229)	3
4	V	19	Professional Fees				46,465	46,465	4
5	V	21	Clerical				205,642	205,642	5
6	V	22	Employee Benefits				43,889	43,889	6
7	V	32	Interest				14,714	14,714	7
8	V	24	Travel & Seminars				16,076	16,076	8
9	V	26	Insurance				(9,504)	(9,504)	9
10	V	30	Depreciation				32,143	32,143	10
11	V	21	Other Administrative Expense				39,671	39,671	11
12	V	35							12
13	V	39	Pharmacy Supply	279,420	Senior Care Pharmacy	0.00%	256,508	(22,912)	13
14	Total			\$ 862,754			\$ 739,297	\$ * (123,457)	14

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

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		Debt Relocation	\$1,551.00	3/1/2005	\$ 366,253	\$ 267,668	9/1/2011	0.0572	\$ 15,845	1	
2	Illinois Finance Authority		X	Renovation Projects		6/30/2007	586,567	554,700	6/30/2031	0.0567	25,003	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$1,551.00		\$ 952,820	\$ 822,368			\$ 40,848	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 952,820	\$ 822,368			\$ 40,848	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

[illegible]

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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. <u>This workpaper is not applicable</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 60,480

B. General Construction Type: Exterior Masonry Frame Wood & 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).

Duplex Buildings

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	60,480	1974	\$ 56,683	1
2	Home Office Allocation			6,741	2
3	TOTALS	60,480		\$ 63,424	3

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	80		1974	1958	\$ 1,040,410	\$ 37,157	40	\$ 37,157	\$	\$ 1,040,410	4
5	78		1976	1976	724,843	18,121	40	18,121		660,565	5
6											6
7	Home Office Allocation				66,051	7,496		7,496		40,700	7
8											8
	Improvement Type**										
9	1975 Fixed Assets		1975		10,000		Various			10,000	9
10	1978 Fixed Assets		1978		13,972	399	Various	399		13,606	10
11	1981 Fixed Assets		1981		10,331		Various			10,331	11
12	1982 Fixed Assets		1982		46,613		Various			46,613	12
13	1985 Fixed Assets		1985		35,240	699	Various	699		33,958	13
14	1987 Fixed Assets		1987		2,447		Various			2,447	14
15	1989 Fixed Assets		1989		1,341		Various			1,341	15
16	1990 Fixed Assets		1990		2,539		Various			2,539	16
17	1991 Fixed Assets		1991		3,839		Various			3,839	17
18	1992 Fixed Assets		1992		23,667		Various			23,667	18
19	1993 Fixed Assets		1993		2,395		Various			2,395	19
20	1994 Fixed Assets		1994		35,411	1,343	Various	1,343		32,839	20
21	1995 Fixed Assets		1995		86,447	2,750	Various	2,750		48,628	21
22	1997 Fixed Assets		1997		14,771		Various			14,771	22
23	1998 Fixed Assets		1998		8,211		Various			8,211	23
24	1999 Fixed Assets		1999		13,980		Various			13,980	24
25	2000 Fixed Assets		2000		275,890	6,585	Various	6,585		108,294	25
26	2001 Fixed Assets		2001		30,594	1,909	Various	1,909		24,823	26
27	2002 Fixed Assets		2002		21,468	1,089	Various	1,089		16,575	27
28	2003 Fixed Assets		2003		215,986	17,369	Various	17,369		160,200	28
29	2004 Fixed Assets		2004		249,324	18,230	Various	18,230		142,085	29
30	2005 Fixed Assets		2005		131,730	6,871	Various	6,871		81,490	30
31	2006 Fixed Assets		2006		260,821	19,711	Various	19,711		127,823	31
32	2007 Fixed Assets		2007		116,303	14,681	Various	14,681		75,901	32
33	Drywall repair-wg5 & 14 res.		2008		750	75	10	75		338	33
34	Wing 2,4,5 remodeling project		2008		35,355	3,535	10	3,535		22,512	34
35	Replacement windows		2008		14,917	1,492	10	1,492		5,843	35
36	Install jacks & cable - Reclaim Unit		2008		2,677	267	10	267		1,047	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 Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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 Therapy Gym	2008	\$ 82,950	\$ 8,295	10	\$ 8,295	\$	\$ 43,999	37
38 Land Improvements - Therapy Gym	2008	6,010	601	10	601		2,154	38
39 egress lighting	2009	1,238	124	10	124		403	39
40 Light Fixtures	2009	553	55	10	55		179	40
41 Door coding locks	2009	6,745	675	10	675		2,081	41
42 New Windows Wing 7	2009	10,397	1,040	10	1,040		3,032	42
43 Seal coat & Striping for Parking Lot	2009	4,714	471	10	471		1,336	43
44 Sprinkler System	2009	22,000	2,200	10	2,200		6,050	44
45 New Carpet & Tile for East Lobby	2009	1,178	118	10	118		314	45
46 Chapel Roof	2009	1,505	151	10	151		401	46
47 Roof	2009	144,092	14,409	10	14,409		37,224	47
48 New screens for gutters	2010	2,700	270	10	270		675	48
49 Sprinkler System	2010	112,380	11,238	10	11,238		28,095	49
50 New Roof - SNF	2010	163,717	8,186	20	8,186		17,736	50
51 New Gutters & Downspouts	2010	720	72	10	72		150	51
52 Tile/grout, Drain, Cabinets, Flooring, Paint, Rail, Doors, Build New Wall	2010	23,441	2,344	10	2,344		4,688	52
53 Limited Asbestos Inspection, Collection, Analysis of Samples	2010	1,725	173	10	173		345	53
54 Replace Concrete Floors	2010	2,500	250	10	250		500	54
55 Flourescent 2 Bulb Cloud-1	2010	110	11	10	11		22	55
56 Ceiling Cloud 2 Bulb Light-9	2010	990	99	10	99		198	56
57 Resin Fan	2010	172	17	10	17		34	57
58 Exhaust Grille	2010	114	11	10	11		23	58
59 Flex Duct	2010	29	3	10	3		6	59
60 A/C Parts	2010	187	19	10	19		37	60
61 Floor Removal	2010	3,442	344	10	344		688	61
62 Medicine Cabinet	2010	104	10	10	10		21	62
63 Floor Ceramic Tile	2010	1,909	191	10	191		382	63
64 Plumbing and Drywall	2010	18,024	1,802	10	1,802		3,605	64
65 Tear Out and Build Walls	2010	4,000	400	10	400		800	65
66 Duct Tape, PVC Wall Box, Voltage Tester	2010	47	5	10	5		9	66
67 Electric Wire, Switch Box, Emt Conduit	2010	124	12	10	12		25	67
68 Rebar, SPF-STD/BTR	2010	9	1	10	1		2	68
69 Single Pole Switch	2010	22	2	10	2		4	69
70 TOTAL (lines 4 thru 69)		\$ 4,116,172	\$ 213,379		\$ 213,379	\$	\$ 2,932,989	70

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,116,172	\$ 213,379		\$ 213,379	\$	\$ 2,932,989	1
2	Visqueen	2010	43	4	10	4		9	2
3	Bolt, Screw	2010	6	1	10	1		2	3
4	Cable Tie	2010	26	3	10	3		6	4
5	Cable Tie, Pipe, Elbow	2010	112	11	10	11		22	5
6	Tear Out and Build Walls, Stain & Clear Coat 6 Doors	2010	7,200	720	10	720		1,440	6
7	Tear Off Tile, Cut Off Doors	2010	1,060	106	10	106		212	7
8	Drywall Finishing	2010	680	68	10	68		136	8
9	Grout Sealer, Marble Threshold	2010	212	21	10	21		42	9
10	Conduit & Wire	2010	189	19	10	19		38	10
11	Wire Screws, & Wingnut	2010	132	13	10	13		26	11
12	Hinged Folding Rails	2010	606	61	10	61		121	12
13	Tile/Grout - 2 Bathrooms	2010	600	60	10	60		120	13
14	Cut Back Shelves	2010	2,285	229	10	229		457	14
15	Plane Doors	2010	2,160	216	10	216		432	15
16	Fireproof Attic Doors	2010	2,300	230	10	230		460	16
17	Locks/Doors Handles	2010	2,040	204	10	204		408	17
18	Planer	2010	264	26	10	26		52	18
19	Sprinkler/Fire Hatches	2010	4,215	422	10	422		843	19
20	Double Doors w/90 Min Fire Protection and Replace 2 Room Doors w/	2010	6,250	625	10	625		1,250	20
21	Slide Panel Sign	2010	75	8	10	8		15	21
22	Replace Air Compressor	2010	2,979	298	10	298		596	22
23	Beauty Shop Exit Door	10/31/2010	7,859	786	10	786		1,965	23
24	Oak Trim	2010	100	10	10	10		26	24
25	Wire	2010	399	40	10	40		100	25
26	Paint	2010	211	21	10	21		53	26
27	Table and 4 Chairs	2010	2,000	200	10	200		499	27
28	Wire	2010	65	7	10	7		16	28
29	Valve & Flex SS Connector	2010	94	9	10	9		22	29
30	Light & Sink	2010	199	20	10	20		50	30
31	Wallpaper	2010	420	42	10	42		106	31
32	Take Up Floor By Door and Replace, Vinyl Base, Morter	2010	329	33	10	33		83	32
33	Wire	2010	41	4	10	4		10	33
34	TOTAL (lines 1 thru 33)		\$ 4,161,322	\$ 217,895		\$ 217,895	\$	\$ 2,942,606	34

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,161,322	\$ 217,895		\$ 217,895	\$	\$ 2,942,606	1
2	Repair Hole in Ceiling and Walls	2010	278	28	10	28		70	2
3	Plumbing Supplies	2010	111	11	10	11		27	3
4	Outlet, Universal Trap	2010	24	2	10	2		6	4
5	Sizing Adhesive	2010	111	11	10	11		27	5
6	Parking Lot	2010	34,607	3,461	10	3,461		8,652	6
7	Dining Room - Fire Doors	2010	4,900	490	10	490		1,143	7
8	Medical Records Storage Shed	2010	7,860	786	10	786		1,310	8
9	BTU Furnace	2010	563	56	10	56		122	9
10	Wing 3 - Lighting	2010	375	38	10	38		60	10
11	Tile & Grout	2011	350	35	10	35		53	11
12	Repair Walls	2011	43	4	10	4		6	12
13	Tear Out and Build Walls, Finish Doors	2011	2,500	250	10	250		375	13
14	Plumbing, Heat Register, Floor Drain, Faucet	2011	2,565	257	10	257		385	14
15	Drywall	2011	400	40	10	40		60	15
16	Tile & Grout	2011	380	38	10	38		57	16
17	Repair Walls	2011	43	4	10	4		6	17
18	Tear Out and Build Walls, Finish Doors	2011	2,625	263	10	263		394	18
19	Install Shower Stall, Faucets, Comodes, & Seats	2011	5,150	515	10	515		773	19
20	Drywall	2011	400	40	10	40		60	20
21	Tile & Grout	2011	380	38	10	38		57	21
22	Repair Walls	2011	43	4	10	4		6	22
23	Tear Out and Build Walls, Finish Doors	2011	2,625	263	10	263		394	23
24	Install Shower Stall, Faucets, Comodes, & Seats	2011	5,150	515	10	515		773	24
25	Drywall	2011	400	40	10	40		60	25
26	Repair Insulation Holes	2011	50	5	10	5		7	26
27	Wing 3 - Refurb	2011	1,751	175	10	175		263	27
28	PTAC Units	2011	7,046	705	10	705		999	28
29	Delta Lavatory Faucets - Wide	2011	4,084	408	10	408		578	29
30	Delta Lavatory Faucets - Regular	2011	1,227	123	10	123		174	30
31	Wing 3 - Asbestos Removal	2011	12,348	1,235	10	1,235		1,750	31
32	Wing 3 - Fixtures	2011	426	43	10	43		61	32
33	Bathroom Flooring	2011	739	74	10	74		99	33
34	TOTAL (lines 1 thru 33)		\$ 4,260,877	\$ 227,852		\$ 227,852	\$	\$ 2,961,413	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,260,877	\$ 227,852		\$ 227,852	\$	\$ 2,961,413	1
2	Wing 3 - Flooring	3/31/2011	14,485	1,448	10	1,448		1,931	2
3	Public Bathrooms - Wallpaper	4/30/2011	159	16	10	16		20	3
4	Wing 2 - HVACs	6/30/2011	5,062	506	10	506		548	4
5	Wing 9 - HVACs	6/30/2011	2,247	225	10	225		244	5
6	Garden Homes Landscaping	6/30/2011	2,129	213	10	213		231	6
7	Garden Homes Sidewalk	6/30/2011	1,049	105	10	105		114	7
8	Boiler module section, burners,	9/15/2011	6,890	957	6	957		957	8
9	Boiler section module, piping va	12/1/2011	9,790	952	6	952		952	9
10	Duct Booster AXC150B 6", ventila	9/21/2011	1,073	179	5	179		179	10
11	Wall Cabinets -ADON office conco	11/15/2011	978	43	15	43		43	11
12	Wall Cabinets - Nurses station w	11/15/2011	489	22	15	22		22	12
13	Door - Steel & Frame - Haven Hou	12/27/2011	1,112	32	20	32		32	13
14	Haven Water Damage-restore floor	11/4/2011	47,843	3,190	10	3,190		3,190	14
15	Medical Building Fire Suppressio	7/7/2011	6,752	675	10	675		675	15
16	Garden Home Sidewalk Concrete	7/19/2011	870	87	10	87		87	16
17	Sealcoat Parking Lot and Stripe	9/8/2011	5,007	1,391	3	1,391		1,391	17
18	Landscape - Wall Block	3/14/2012	832	28	10	28		28	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,367,644	\$ 237,921		\$ 237,921	\$	\$ 2,972,057	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	\$ 720,892	\$ 96,846	\$ 96,846	\$		\$ 417,324	71
72	Current Year Purchases	29,503	5,238	5,238		Various	4,806	72
73	Fully Depreciated Assets	291,912	4,685	4,685			291,912	73
74	Home Office Allocation	267,011	22,370	22,370			114,263	74
75	TOTALS	\$ 1,309,318	\$ 129,139	\$ 129,139	\$		\$ 828,305	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	See Attachment			\$ 122,215	\$ 13,006	\$ 13,006	\$		\$ 88,092	76
77										77
78										78
79	Home Office Allocation			20,059	2,277	2,277			7,456	79
80	TOTALS			\$ 142,274	\$ 15,283	\$ 15,283	\$		\$ 95,548	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)	\$ 5,882,660	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 382,343	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 382,343	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,895,910	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	Duplex	\$ 577,451	\$ 196,045	\$ 381,406	86
87	Land	9,227			87
88					88
89					89
90					90
91	TOTALS	\$ 586,678	\$ 196,045	\$ 381,406	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 93,387	92
93	Residential Bathroom Remodel	39,722	93
94			94
95		\$ 133,109	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.
- ☐ 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: \$57,879
- Description: See Attachment

(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 EndingAnnual Rent

12. /2013\$
13. /2014\$
14. /2015\$

* 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_____

Wabash Christian Retirement Center only hires certified CNAs.

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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.

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	10A-3	hrs	\$	12,073	\$ 458,695	\$	12,073	\$ 458,695	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,838	200,551		3,838	200,551	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		17,656	624,731		17,656	624,731	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			\$	33,567	\$ 1,283,977	\$	33,567	\$ 1,283,977	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,727,198	\$	1
2	Cash-Patient Deposits	22,185		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,913)	1,618,169		3
4	Supply Inventory (priced at)	18,869		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,197		6
7	Other Prepaid Expenses	9,820		7
8	Accounts Receivable (owners or related parties)	175,251		8
9	Other(specify): <u>Accrued Interest Receivable</u>	200,394		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,775,083	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,452,900		11
12	Long-Term Investments	432,752		12
13	Land	65,910		13
14	Buildings, at Historical Cost	4,903,486		14
15	Leasehold Improvements, at Historical Cost	232,096		15
16	Equipment, at Historical Cost	1,186,112		16
17	Accumulated Depreciation (book methods)	(4,183,242)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	758,858		21
22	Other Long-Term Assets (specify: <u>CIP</u>)	39,722		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,888,594	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,663,677	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 485,655	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,785		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,304		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,612		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Expenses</u>	570,692		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,480,048	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	822,368		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	77,160		43
44	<u>Due Life Right Residents</u>	43,983		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 943,511	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,423,559	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,240,118	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,663,677	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,615,247	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,615,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	624,871	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)	\$ 624,871	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)	\$ 8,240,118	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wabash Christian Retirement# 0020610Report Period Beginning: 7/1/2011Ending: 6/30/2012

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
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,162,215	1
2	Discounts and Allowances for all Levels	(1,868,885)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,293,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,850,954	6
7	Oxygen	79,663	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,930,617	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	17,567	13
14	Non-Patient Meals	3,687	14
15	Telephone, Television and Radio	2,920	15
16	Rental of Facility Space		16
17	Sale of Drugs	558,719	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,392	19
20	Radiology and X-Ray	26,405	20
21	Other Medical Services	73,257	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 712,947	23
	D. Non-Operating Revenue		
24	Contributions	147,482	24
25	Interest and Other Investment Income***	178,023	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 325,505	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apt./Congregate</u>	77,654	28
28a	<u>Miscellaneous</u>	97,699	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 175,353	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,437,752	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,335,723	31
32	Health Care	4,738,925	32
33	General Administration	2,440,767	33
	B. Capital Expense		
34	Ownership	474,133	34
	C. Ancillary Expense		
35	Special Cost Centers	446,748	35
36	Provider Participation Fee	376,585	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,812,881	40
41	Income before Income Taxes (line 30 minus line 40)**	624,871	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 624,871	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,878,502	44
45	Private Pay - Net Inpatient Revenue	1,764,712	45
46	Medicare - Net Inpatient Revenue	48,870	46
47	Other-(specify) <u>HMO/Nursing</u>	104,972	47
48	Other-(specify) <u>Medicare Advantage/Outpatient Part B</u>	(503,726)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,293,330	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? N/A If not, please attach a reconciliation.

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,769	3,046	\$ 109,677	\$ 36.01	1
2	Assistant Director of Nursing	2,422	2,638	68,695	26.04	2
3	Registered Nurses	16,514	17,335	410,369	23.67	3
4	Licensed Practical Nurses	35,849	36,245	684,233	18.88	4
5	CNAs & Orderlies	132,554	133,827	1,467,810	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,107	2,292	34,220	14.93	9
10	Activity Assistants	10,222	10,363	97,651	9.42	10
11	Social Service Workers	11,014	11,631	144,429	12.42	11
12	Dietician					12
13	Food Service Supervisor	1,754	2,122	32,734	15.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,253	31,282	289,735	9.26	15
16	Dishwashers					16
17	Maintenance Workers	5,271	5,998	121,261	20.22	17
18	Housekeepers	16,131	16,655	155,597	9.34	18
19	Laundry	8,809	8,917	85,854	9.63	19
20	Administrator	1,808	1,989	138,520	69.64	20
21	Assistant Administrator					21
22	Other Administrative	1,949	2,166	47,143	21.77	22
23	Office Manager	1,896	2,080	47,986	23.07	23
24	Clerical	5,357	5,478	63,918	11.67	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	4,058	4,462	54,708	12.26	31
32	Other Health Care MDS Coordinator	3,608	3,658	90,675	24.79	32
33	Other(specify) Marketing	3,608	4,235	102,806	24.28	33
34	TOTAL (lines 1 - 33)	297,953	306,419	\$ 4,248,021 *	\$ 13.86	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	187	\$ 10,479	3.1.3	35
36	Medical Director	72	7,200	3.9.3	36
37	Medical Records Consultant	40	2,964	3.10.3	37
38	Nurse Consultant	1	50	3.10.3	38
39	Pharmacist Consultant	180	4,500	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	7	438	3.11.2	44
45	Social Service Consultant	90	5,816	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	577	\$ 31,447		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

STATE OF ILLINOIS

Facility Name & ID Number

Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/2011

Page 21

Ending:

6/30/2012

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	
Sandra Bryant	Administrator	0	\$ 138,520	Workers' Compensation Insurance	\$ 90,420	IDPH License Fee	\$	
				Unemployment Compensation Insurance	17,439	Advertising: Employee Recruitment	1,397	
				FICA Taxes	300,954	Health Care Worker Background Check		
				Employee Health Insurance	537,510	(Indicate # of checks performed 17)	170	
				Employee Meals		Patient Background Checks	112 1,120	
				Illinois Municipal Retirement Fund (IMRF)*		License	2,084	
				Employee Expense	17,058	Dues	9,122	
				Employee Physical	5,494	Subscriptions	1,257	
				Employee Uniforms	(4,824)	Other	226	
				457 Plan Expense	9,250			
				Net Earned PTO	40,280	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
				Home Office Allocation	43,889	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 138,520	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 583,334				Out-of-State Travel	\$
							In-State Travel	12,918
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
My Innerview	Professional Services		\$ 2,381					
Polaris Group	Mock Survey		9,600					
Davis & Campbell	Legal		2,055					
Receivable Management Services	Legal		109					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			Seminar Expense	
							2,243	
							Home Office Allocation	
							16,076	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 31,237	

* Attach copy of IMRF notifications

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable.		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN & Leading Age/\$7,772

(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. \$ 54,156 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. \$ 376,585
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. \$ 3,687

(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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 32,553
c. What percent of all travel expense relates to transportation of nurses and patients? None
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: CliftonLarsonAllen LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.