

		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>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, 2011</u> to <u>June 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.																																																	
Address: <u>1201 Newcastle Rd.</u> <u>Washington</u> <u>61571</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Tazewell</u>																																																			
Telephone Number: <u>309-444-3161</u> Fax # <u>309-444-7397</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>04/01/1982</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code <u>501c3</u>																																																			
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: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Susan McGhee</u>																																																	
		(Title) <u>Chief Financial Officer</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Partner</u>																																																	
		(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u>																																																	
		(Telephone) <u>314-925-4379</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																																																	

Facility Name & ID Number Washington Christian Village# 0026955 Report Period Beginning: July 1, 2011 Ending: June 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>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</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>44,652</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>16,025</u>	<u>8,531</u>	<u>9,770</u>	<u>34,326</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>16,025</u>	<u>8,531</u>	<u>9,770</u>	<u>34,326</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.87%

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 ResidentsF. 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 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 6,435Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

* 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	210,897	19,004	94,241	324,142		324,142		324,142		1
2	Food Purchase		209,984		209,984		209,984	(1,370)	208,614		2
3	Housekeeping	91,046	16,302	21,020	128,368		128,368		128,368		3
4	Laundry	57,665	7,286	14,014	78,965		78,965		78,965		4
5	Heat and Other Utilities			133,590	133,590		133,590	(11,815)	121,775		5
6	Maintenance	69,939	17,586	58,732	146,257		146,257	3,268	149,525		6
7	Other (specify):*										7
8	TOTAL General Services	429,547	270,162	321,597	1,021,306		1,021,306	(9,917)	1,011,389		8
	B. Health Care and Programs										
9	Medical Director			20,000	20,000		20,000		20,000		9
10	Nursing and Medical Records	2,589,795	163,747	14,547	2,768,089		2,768,089	(2,552)	2,765,537		10
10a	Therapy		3,870	888,493	892,363		892,363		892,363		10a
11	Activities	83,521	1,527	661	85,709		85,709		85,709		11
12	Social Services	94,297	241	2,067	96,605		96,605		96,605		12
13	CNA Training										13
14	Program Transportation			7,563	7,563		7,563		7,563		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,767,613	169,385	933,331	3,870,329		3,870,329	(2,552)	3,867,777		16
	C. General Administration										
17	Administrative	90,978	1,083	563,661	655,722		655,722	(512,333)	143,389		17
18	Directors Fees										18
19	Professional Services			41,750	41,750		41,750	37,901	79,651		19
20	Dues, Fees, Subscriptions & Promotions			19,170	19,170		19,170		19,170		20
21	Clerical & General Office Expenses	86,745	8,145	289,797	384,687		384,687	(16,128)	368,559		21
22	Employee Benefits & Payroll Taxes			633,760	633,760		633,760	35,800	669,560		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,823	6,823		6,823	13,113	19,936		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,615	72,615		72,615	(7,752)	64,863		26
27	Other (specify):* Marketing	58,960	2,744	16,706	78,410		78,410	(78,410)			27
28	TOTAL General Administration	236,683	11,972	1,644,282	1,892,937		1,892,937	(527,809)	1,365,128		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,433,843	451,519	2,899,210	6,784,572		6,784,572	(540,278)	6,244,294		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			298,885	298,885		298,885	26,219	325,104			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			296,830	296,830		296,830	(222,014)	74,816			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,984	31,984		31,984		31,984			35
36	Other (specify):* FIN 47 Accretion			1,062	1,062		1,062		1,062			36
37	TOTAL Ownership			628,761	628,761		628,761	(195,795)	432,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			306,942	306,942		306,942	(17,730)	289,212			39
40	Barber and Beauty Shops	15,706	677		16,383		16,383		16,383			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			278,014	278,014		278,014		278,014			42
43	Other (specify):* Apt/Congregate			78,359	78,359		78,359	(78,359)				43
44	TOTAL Special Cost Centers	15,706	677	663,315	679,698		679,698	(96,089)	583,609			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,449,549	452,196	4,191,286	8,093,031		8,093,031	(832,162)	7,260,869			45

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2011 Ending: June 30, 2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(90)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,105)	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	(187,504)	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	(46,512)	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	(207,028)	21		24
25	Fund Raising, Advertising and Promotional	(78,410)	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	(111,930)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (644,579)		\$	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)	(187,583)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (187,583)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (832,162)		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

Washington Christian Village

Report Period Beginning: ID# 0026955

Ending: July 1, 2011

June 30, 2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (1,280)	2	1
2	Late Fees, Finance Charges	(716)	21	2
3	Miscellaneous	(15)	17	3
4	Apt/Congregate	(78,359)	43	4
5	Charity Care	(8,484)	21	5
6	Discounts	(2,552)	10	6
7	Miscellaneous	(20,524)	17	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
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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	(111,930)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2011

Ending:

June 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,370)	0	0	0	0	0	0	0	0	0	0	(1,370)	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	(13,105)	1,290	0	0	0	0	0	0	0	0	0	(11,815)	5
6	Maintenance	0	3,268	0	0	0	0	0	0	0	0	0	3,268	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,475)	4,558	0	0	0	0	0	0	0	0	0	(9,917)	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	(2,552)	0	0	0	0	0	0	0	0	0	0	(2,552)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,552)	0	0	0	0	0	0	0	0	0	0	(2,552)	16
	C. General Administration													
17	Administrative	(20,539)	(491,794)	0	0	0	0	0	0	0	0	0	(512,333)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	37,901	0	0	0	0	0	0	0	0	0	37,901	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(216,228)	200,100	0	0	0	0	0	0	0	0	0	(16,128)	21
22	Employee Benefits & Payroll Taxes	0	35,800	0	0	0	0	0	0	0	0	0	35,800	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,113	0	0	0	0	0	0	0	0	0	13,113	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	(7,752)	0	0	0	0	0	0	0	0	0	(7,752)	26
27	Other (specify):*	(78,410)	0	0	0	0	0	0	0	0	0	0	(78,410)	27
28	TOTAL General Administration	(315,177)	(212,632)	0	0	0	0	0	0	0	0	0	(527,809)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(332,204)	(208,074)	0	0	0	0	0	0	0	0	0	(540,278)	29

STATE OF ILLINOIS

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2011 Ending: Summary B
June 30, 2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	26,219	0	0	0	0	0	0	0	0	0	26,219	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(234,016)	12,002	0	0	0	0	0	0	0	0	0	(222,014)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(234,016)	38,221	0	0	0	0	0	0	0	0	0	(195,795)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(17,730)	0	0	0	0	0	0	0	0	0	(17,730)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(78,359)	0	0	0	0	0	0	0	0	0	0	(78,359)	43
44	TOTAL Special Cost Centers	(78,359)	(17,730)	0	0	0	0	0	0	0	0	0	(96,089)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(644,579)	(187,583)	0	0	0	0	0	0	0	0	0	(832,162)	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 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%	\$ 1,290	\$ 1,290	1
2	V	6	Maintenance				3,268	3,268	2
3	V	17	Administration	563,661			71,867	(491,794)	3
4	V	19	Professional Services				37,901	37,901	4
5	V	21	Clerical				167,741	167,741	5
6	V	22	Employee Benefits				35,800	35,800	6
7	V	24	Travel and Seminar				13,113	13,113	7
8	V	26	Insurance				(7,752)	(7,752)	8
9	V	30	Depreciation				26,219	26,219	9
10	V	32	Interest				12,002	12,002	10
11	V	21	Other Administrative Expenses				32,359	32,359	11
12	V	39	Pharmacy Services	216,219	Senior Care Pharmacy		198,489	(17,730)	12
13	V								13
14	Total			\$ 779,880			\$ 592,297	\$ * (187,583)	14

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2011 Ending: June 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	
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, 2011 Ending: ne 30, 2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	This workpaper is not applicable				\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bond Fund	X		Refinance Debt	\$28,682.00	Various	\$ 4,409,251	\$ 3,511,013	6/30/2032	0.0572	\$ 161,263	1	
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	1,500,000	1,500,000	5/15/2027	0.0613	89,055	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$28,682.00		\$ 5,909,251	\$ 5,011,013			\$ 250,318	9	
	B. Non-Facility Related*												
10	Duplex										46,512	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 46,512	14	
15	TOTALS (line 9+line14)						\$ 5,909,251	\$ 5,011,013			\$ 296,830	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2012 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:		2007 8 2008 9 2009 10 2010 11 2011 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2011 \$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE _____ FAX #: _____

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>02-02-14-300-021</u>	<u>1110 New Castle Rd</u>	\$ <u>16,477.00</u>	\$ _____
2.	<u>02-02-14-308-001</u>	<u>1104 Kingsbury Rd</u>	\$ <u>7,537.00</u>	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>24,014.00</u></u>	\$ <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? 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 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.**

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

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2011 Ending: June 30, 2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1982		\$ 1,203,052	\$ 34,373		\$ 34,373	\$	\$ 1,045,603	4
5											5
6											6
7											7
8	Home Office Allocation				53,877	6,115		6,115		33,198	8
	Improvement Type**										
9	1982 Fixed Assets			1982	57,536	396	Various	396		55,557	9
10	1983 Fixed Assets			1983	36,292	985	Various	985		30,872	10
11	1984 Fixed Assets			1984	3,947	7	Various	7		3,904	11
12	1985 Fixed Assets			1985	368,110	10,331	Various	10,331		290,408	12
13	1986 Fixed Assets			1986	4,603		Various			4,603	13
14	1988 Fixed Assets			1988	12,623	106	Various	106		11,485	14
15	1989 Fixed ASSETS			1989	9,092		Various			9,092	15
16	1991 Fixed Assets			1991	2,395		Various			2,395	16
17	1992 Fixed Assets			1992	9,161		Various			9,161	17
18	1993 Fixed Assets			1993	10,785		Various			10,785	18
19	1994 Fixed Assets			1994	4,103		Various			4,103	19
20	1995 Fixed Assets			1995	10,713		Various			10,713	20
21	1996 Fixed Assets			1996	91,102	3,134	Various	3,134		79,872	21
22	1997 Fixed Assets			1997	35,910	2,165	Various	2,165		35,187	22
23	1999 Fixed Assets			1999	4,330		Various			4,330	23
24	2000 Fixed Assets			2000	6,623		Various			6,623	24
25	2001 Fixed Assets			2001	52,160	3,505	Various	3,505		40,111	25
26	2002 Fixed Assets			2002	259,334	13,623	Various	13,623		201,468	26
27	2003 Fixed Assets			2003	8,658	723	Various	723		8,658	27
28	2004 Fixed Assets			2004	18,733	1,589	Various	1,589		15,854	28
29	2005 Fixed Assets			2005	133,164	12,569	Various	12,569		100,531	29
30	2006 Fixed Assets			2006	132,538	9,416	Various	9,416		58,934	30
31	2007 Fixed Assets			2007	198,096	11,611	Various	11,611		55,212	31
32	SW/Reclaim unit dining area			2/1/2008	922	92	10	92		407	32
33	Supplies for SW/Nurse station			4/1/2008	5,690	569	10	569		2,418	33
34	SW cooridor AC replacement			6/1/2008	33,860	3,386	10	3,386		13,826	34
35	NW cooridor AC replacement			6/1/2008	36,325	3,633	10	3,633		14,833	35
36	100 gallon water heater - natural gas			1/1/2008	6,298	630	10	630		2,205	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 Washington Christian Village

0026955

Report Period Beginning:

July 1, 2011 Ending: June 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	
37	Replacement windows - NW wing	1/1/2008	\$ 12,025	\$ 1,203	10	\$ 1,203	\$	\$ 4,210	37
38	Kitchen floor & remodel	1/1/2009	37,874	3,787	10	3,787		13,255	38
39	Chapel remodeling	6/1/2009	39,238	3,924	10	3,924		12,099	39
40	Carrier roof top AC units - dining room	2/1/2009	27,875	2,788	10	2,788		9,540	40
41	Southeast corridor cooling system	2/1/2009	35,600	3,560	10	3,560		12,163	41
42	2 cabinet unit heaters - north wing	2/1/2009	7,000	700	10	700		2,392	42
43	Upgrade to door alarms	2/1/2009	2,465	247	10	247		844	43
44	Windows	2009	12,025	1,203	10	1,203		3,708	44
45	Baseboard, Vanities, Lights, Toilets, Sinks, Outlets, Doors, Piping,	2009	53,888	5,389	10	5,389		16,615	45
46	Cooling Fans for New Computer Room	9/8/2009		85	10	85			46
47	Patio conversion to Chapel	8/31/2009	750	69	10	69		207	47
48	SW AC	7/8/2009	2665	267	10	267		801	48
49	SNG Window Replacement	4/20/2010	17590	1,759	10	1,759		3,958	49
50	New Flooring- EE Lounge & Frount Entry	6/21/2010	12526	1,253	10	1,253		2,610	50
51	Parking Lot & Drive Resurface	6/30/2010	35,400	3,540	10	3,540		7,375	51
52	Car/ Bus Port	3/31/2010	6,555	656	10	656		1,531	52
53	Replace Front Sidewalk & Approach	7/1/2010	3,195	320	10	320		639	53
54	AC for Business & Admin Office	7/31/2010	5,590	559	10	559		1,118	54
55	Bifold Closet Doors - Resident Rms	7/31/2010	348	35	10	35		70	55
56	Paint & Supplies SW Dining Room	7/31/2010	901	90	10	90		180	56
57	SW Dining Rm Floor	7/31/2010	4,885	488	10	488		977	57
58	Radiator Covers - Resident Rooms	7/31/2010	4,218	422	10	422		844	58
59	Asbestos Removal	2010	2,242	224	10	224		448	59
60	Decorative Supports	2010	246	25	10	25		49	60
61	Electrical Work - Conduit, Junction Boxes, & Receptacle	2010	492	49	10	49		98	61
62	Restrooms 4 Oaktowne Flush Bifol	2010	717	72	10	72		143	62
63	Electrical Work - 3 20 Amp Circuits Added, Steam Tables	2010	552	55	10	55		110	63
64	Move Fire Sprinklers	2010	3,340	334	10	334		668	64
65	Asbestos Testing	2010	1,885	189	10	189		377	65
66	Add 2 Windows and Insulated Steel Door	2010	3,039	304	10	304		608	66
67	Add Cat-5 Wiring, Jacks, & Plates	2010	1,141	114	10	114		228	67
68	Bathroom Fixtures	2010	239	24	10	24		48	68
69	Cabinets For Therapy	2010	493	49	10	49		99	69
70	TOTAL (lines 4 thru 69)		\$ 3,147,031	\$ 152,739		\$ 152,739	\$	\$ 2,260,360	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:

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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 12A, Carried Forward		\$ 3,147,031	\$ 152,739		\$ 152,739	\$	\$ 2,260,360	1
2	Utility Pump & Shelves	2010	364	36	10	36		73	2
3	Hardware, 2x4s, & Conduit	2010	341	34	10	34		68	3
4	Excavate, Concrete Patio, Install 4 Downspouts to Sewer System	2010	6,000	600	10	600		1,200	4
5	Room Signs	2010	359	36	10	36		72	5
6	Remove Wall/Tile, Install Windows, Cabinets, Tops, Upgrade Plun	2010	108,215	10,822	10	10,822		21,643	6
7	Front Door Remodel	7/31/2010	4,895	490	10	490		979	7
8	2 Electric Circuits - Server Rm	7/31/2010	325	33	10	33		65	8
9	Double Side Front Sign	7/31/2010	7,417	742	10	742		1,483	9
10	Landscaping Front & Therapy Patios	8/26/2010	17,815	1,782	10	1,782		3,415	10
11	Front Doors	9/30/2010	11,098	1,110	10	1,110		2,035	11
12	Front Door Alarming System	10/15/2010	1,845	185	10	185		323	12
13	Sealcoat East Parking Lot	11/2/2010	3,950	395	10	395		658	13
14	Window for Conference Room	11/11/2010	572	57	10	57		95	14
15	Service & Conference Room Doors	12/9/2010	6,439	644	10	644		1,020	15
16	Attic Insullation for front hallway	1/1/2011	503	50	10	50		76	16
17	New wiring for 24 port VIOP	1/26/2011	1,240	124	10	124		186	17
18	B&G hot water circulating pump & kit	1/31/2011	3,635	364	10	364		545	18
19	60 gal, 120K BTU water heater	2/14/2011	6,448	645	10	645		913	19
20	Resident room painting	3/15/2011	2,404	240	10	240		321	20
21	Wiring for SW rooms TVS	3/25/2011	1,899	190	10	190		253	21
22	Roof where NE wing meets NW wing	4/1/2011	2,952	295	10	295		369	22
23	Topography of west apt land	4/6/2011	3,340	334	10	334		418	23
24	Ceramic for EE rest rooms	4/11/2011	3,003	300	10	300		375	24
25	Prime & Paint Interior Doors	4/14/2011	3,538	354	10	354		442	25
26	Prime Paint Doors Frames NW Hallway	4/24/2011	6,861	686	10	686		858	26
27	Faucet No Clean Utility Rm	4/27/2011	92	9	10	9		12	27
28	Channels for Activity Room	4/28/2011	9	1	10	1		1	28
29	Sink w faucet SE Nurse Station	4/28/2011	99	10	10	10		12	29
30	Prepare & Paint No Nurse Station	5/17/2011	541	54	10	54		63	30
31	12x30 Wall Cabinet No Nurse Station	5/17/2011	108	11	10	11		13	31
32	24x30 Wall Cabinet No Nurse Station	5/17/2011	247	25	10	25		29	32
33	Prep & Paint, Laundry Rm, Hallway Doors	5/17/2011	1,286	129	10	129		150	33
34	TOTAL (lines 1 thru 33)		\$ 3,354,871	\$ 173,525		\$ 173,525	\$	\$ 2,298,525	34

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

Facility Name & ID Number Washington Christian Village

0026955

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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 12B, Carried Forward		\$ 3,354,871	\$ 173,525		\$ 173,525	\$	\$ 2,298,525	1
2	Prep & Paint Laundry Rm, Hallway	5/17/2011	600	60	10	60		70	2
3	Countertops - No Nurse Station	5/27/2011	69	7	10	7		8	3
4	24" Base Cabinets SE Nurse Station	5/27/2011	445	44	10	44		52	4
5	Activity Room - Piping	5/31/2011	1,470	147	10	147		171	5
6	Radiator Covers	6/3/2011	8,050	805	10	805		872	6
7	Prep & Paint Center Hall	6/4/2011	1,460	146	10	146		158	7
8	Prep & Paint Doors NE Lounge	6/5/2011	321	32	10	32		35	8
9	Prep & Paint Walls NE Lounge	6/5/2011	400	40	10	40		43	9
10	Prep & Paint NE & NW Hallways	6/6/2011	3,250	325	10	325		352	10
11	Prime & Paint Doors, Frames Center Hall	6/6/2011	3,330	333	10	333		361	11
12	Prep & Paint Shower Room	6/6/2011	550	55	10	55		60	12
13	Prep, Paint SW Exterior Door	6/6/2011	107	11	10	11		12	13
14	Prep & paint Door Frames SE Nurse Statio	6/14/2011	80	8	10	8		9	14
15	Remodel 5 offices, Baseboard, chair rail	6/14/2011	6,541	654	10	654		709	15
16	Ceiling tile, 48" light Fixture Soc Ser2	6/16/2011	165	17	10	17		18	16
17	Prep & paint SE Nurse Station	6/21/2011	600	60	10	60		65	17
18	Vanities, Faucets Employee bathrooms	6/21/2011	720	78		78		78	18
19	Sink w faucet Activity Room	6/22/2011	130	13	10	13		14	19
20	Prep. Paint Admin, DON, Business	6/23/2011	2,550	255	10	255		276	20
21	Fire Extinguisher Cabinets	6/23/2011	635	63	10	63		69	21
22	Seal, Varnish Closes Doors	6/27/2011	1,819	182	10	182		197	22
23	Cabinets - North Nurse Station	6/28/2011	7,864	786	10	786		852	23
24	Cabinets - South Nurse Station	6/28/2011	1,610	161	10	161		174	24
25	Lights, Fans, Heater Center Hall Shower	6/28/2011	1,881	188	10	188		204	25
26	Countertop Socia Ser#2 Office	6/28/2011	46	5		5		5	26
27	15' Wall Demential Dining Area	6/29/2011	4,457	446	10	446		483	27
28	Steel Door Admin Office	6/29/2011	1,850	185	10	185		200	28
29	Build Soffit in 10 Bathrooms, Metal Bi-fold Doors, Remove Basebo	6/29/2011	26,211	2,621	10	2,621		2,840	29
30	Activity Room - Painting	6/30/2011	1,500	150	10	150		163	30
31	Paint 31 doors & frames SE Hall	6/30/2011	3,318	332	10	332		359	31
32	Paint 34 doors & frames SW Hall	6/30/2011	3,639	364	10	364		394	32
33	Remove Wallpaper & Paint Resident Rooms	6/30/2011	10,194	1,019	10	1,019		1,104	33
34	TOTAL (lines 1 thru 33)		\$ 3,450,733	\$ 183,117		\$ 183,117	\$	\$ 2,308,932	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, 2011 Ending: June 30, 2012

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		\$ 3,450,733	\$ 183,117		\$ 183,117	\$	\$ 2,308,932	1
2	Remove Wallpaper & Paint SW Hall	6/30/2011	1,160	116	10	116		126	2
3	Remove wallpaper & paint SE Hall	6/30/2011	1,160	116	10	116		126	3
4	Paint Bathrooms 107, 110, 141, 147, 140	6/30/2011	1,200	120	10	120		130	4
5	Cultered Marble Top 12 SE Units	6/30/2011	2,750	275	10	275		298	5
6	Vanity & Top Rm 135	6/30/2011	401	40	10	40		43	6
7	Rm 105 & 108 Vanity top, apron & legs	6/30/2011	1,320	132	10	132		143	7
8	Rm 107 & 110 Vanity top, apron & legs	6/30/2011	1,542	165		165		167	8
9	Cove Base All Areas	6/30/2011	9,601	960	10	960		1,040	9
10	Flooring 10 Resident Bathrooms	6/30/2011	5,622	562	10	562		609	10
11	Carpet Powerbond Corridors	6/30/2011	29,254	2,925	10	2,925		3,169	11
12	Carpet Broadloom River Stone Offices	6/30/2011	5,435	544	10	544		589	12
13	Rm 148 Paint Walls Border removal	6/30/2011	426	43	10	43		46	13
14	Carpet for 19 Resident Rooms	6/30/2011	24,111	2,411	10	2,411		2,612	14
15	Dining Room - Armstrong Vinyl Flooring	6/30/2011	24,981	2,498	10	2,498		2,706	15
16	Build soffit around exposed piping	6/30/2011	4,230	423	10	423		458	16
17	Floor Preparation - Ardex skim coat	6/30/2011	15,000	1,500	10	1,500		1,625	17
18	Fire Sprinkler relocated	6/30/2011	3,254	325	10	325		353	18
19	Remove wallpaper 12 resident rooms	6/30/2011	1,200	120	10	120		130	19
20	New toilets Resident rms 140,138,108,110	6/30/2011	2,060	206	10	206		223	20
21	Tile - Bath off north center hall	6/30/2011	3,322	332	10	332		360	21
22	Carpet RAC Office	6/30/2011	509	51	10	51		55	22
23	Trim throughout building	6/30/2011	430	43	10	43		47	23
24	Wood for shelves - SE Nurse Station	6/30/2011	106	11	10	11		11	24
25	Suspended Ceiling - Admin & DON Office	6/30/2011	1,352	135	10	135		146	25
26	Coutertops - SW Nurse Station	6/30/2011	208	21	10	21		23	26
27	Sprinkler Heads - Admin & DON Offices	6/30/2011	438	44	10	44		47	27
28	Cabinets - SW Nurse Station	6/30/2011	876	88	10	88		95	28
29	24X30 Wall Cabinet SE Nurse Station	6/30/2011	456	46	10	46		49	29
30	24" Base Cabinet - SW Nurse Station	6/30/2011	147	15	10	15		16	30
31	Project Paint - Sherwin Williams	6/30/2011	855	86	10	86		93	31
32	Remodel Central Hall Shower Rm	6/30/2011	1,886	189	10	189		204	32
33	Lights 48" - DON Office	6/30/2011	88	9	10	9		9	33
34	TOTAL (lines 1 thru 33)		\$ 3,596,113	\$ 197,668		\$ 197,668	\$	\$ 2,324,680	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 12D, Carried Forward		\$ 3,596,113	\$ 197,668		\$ 197,668	\$	\$ 2,324,680	1
2	Lights 48" - Admin Office	6/30/2011	679	68	10	68		74	2
3	Faux Wood Vinyl Floor	6/30/2011	11,591	1,159	10	1,159		1,256	3
4	Counters - Activity Room	7/1/2011	2,528	253	10	253		253	4
5	Plumbing Counters Activity Ro	7/1/2011	354	35	10	35		35	5
6	Window Tinting Front of Building	8/17/2011	2,845	261	10	261		261	6
7	7.5 ton Carrier 13 seer SW Corri	12/28/2011	29,495	1,721	10	1,721		1,721	7
8	NE Corridor air distribustion sy	2/2/2012	36,115	752	20	752		752	8
9	Connect RTU to BAS System Cntrl	5/14/2012	875	15	10	15		15	9
10	Courtyard Landscaping (Fountain,	8/12/2011	4,100	376	10	376		376	10
11	Gazebo Concrete Pad 12'x12'	5/24/2012	900	10	15	10		10	11
12	Sidewalks to Gazebo & Landscapin	5/24/2012	900	10	15	10		10	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)		\$ 3,686,495	\$ 202,328		\$ 202,328	\$	\$ 2,329,443	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	\$516,495	\$63,436	\$63,436	\$		\$243,579	71
72	Current Year Purchases	21,987	6,975	6,975			6,975	72
73	Fully Depreciated Assets	210,968	1,316	1,316			210,968	73
74	Home Office Allocation	217,798	18,247	18,247			93,203	74
75	TOTALS	\$967,248	\$89,974	\$89,974	\$		\$554,725	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	\$29,798	76
77										77
78										78
79	Home Office Allocation			16,362	1,857	1,857			6,082	79
80	TOTALS			\$58,430	\$12,374	\$12,374	\$		\$35,880	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)	\$4,767,65181
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$304,67682
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$304,67683**
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)	\$2,920,04885

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	10,120	510,035	88
89					89
90					90
91	TOTALS	\$817,393	\$10,120	\$518,938	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$76,175	92
93			93
94			94
95		\$76,175	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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

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

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?
16. Rental Amount for movable equipment: \$ 31,984 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

* 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.

WCV only hires certified CNAs

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

12345678										
	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	\$	7,622	\$ 351,631	\$	7,622	\$ 351,631	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,102	108,835		2,102	108,835	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		11,398	428,027		11,398	428,027	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			\$	21,122	\$ 888,493	\$	21,122	\$ 888,493	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,784,143	\$	1
2	Cash-Patient Deposits	17,611		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 257,536)	1,685,480		3
4	Supply Inventory (priced at)	4,188		4
5	Short-Term Investments			5
6	Prepaid Insurance	550		6
7	Other Prepaid Expenses	15,177		7
8	Accounts Receivable (owners or related parties)	11,943		8
9	Other(specify): <u>Accrued Interest/Other AR</u>	244,110		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,763,202	\$	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	4,362,081		14
15	Leasehold Improvements, at Historical Cost	169,774		15
16	Equipment, at Historical Cost	791,331		16
17	Accumulated Depreciation (book methods)	(3,359,788)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	87,980		21
22	Other Long-Term Assets (specify):	121,070		22
23	Other(specify): <u>Note Receivable</u>	1,842,199		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,185,303	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,948,505	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 402,672	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,611		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	246,954		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	12,110		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	404,563		36
37	<u>Current Portion Refundable Ent Fees</u>	5,400		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,101,999	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,995,113		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees/Other Liab</u>	25,892		43
44	<u>Apt & Congregate</u>	34,713		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,055,718	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,157,717	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,790,788	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,948,505	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,248,797	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,248,797	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	541,991	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)	\$ 541,991	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)	\$ 3,790,788	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village# 0026955Report Period Beginning: July 1, 2011Ending: June 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	\$ 7,546,170	1
2	Discounts and Allowances for all Levels	(3,192,240)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,353,930	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,344,830	6
7	Oxygen	21,468	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,366,298	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	18,556	13
14	Non-Patient Meals	90	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	435,185	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,521	19
20	Radiology and X-Ray	9,753	20
21	Other Medical Services	47,447	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 561,552	23
	D. Non-Operating Revenue		
24	Contributions	45,109	24
25	Interest and Other Investment Income***	187,504	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 232,613	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	94,428	28
28a	<u>Miscellaneous</u>	26,201	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 120,629	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,635,022	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,021,306	31
32	Health Care	3,870,329	32
33	General Administration	1,892,937	33
	B. Capital Expense		
34	Ownership	628,761	34
	C. Ancillary Expense		
35	Special Cost Centers	401,684	35
36	Provider Participation Fee	278,014	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,093,031	40
41	Income before Income Taxes (line 30 minus line 40)**	541,991	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 541,991	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,079,123	44
45	Private Pay - Net Inpatient Revenue	1,837,899	45
46	Medicare - Net Inpatient Revenue	157,605	46
47	Other-(specify) <u>HMO</u>	279,303	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,353,930	49

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

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

Tax Return? _____ If not, please attach a reconciliation.

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,780	2,074	\$ 91,838	\$ 44.28	1
2	Assistant Director of Nursing	1,856	2,101	58,276	27.74	2
3	Registered Nurses	19,790	29,756	636,606	21.39	3
4	Licensed Practical Nurses	18,023	18,164	415,502	22.88	4
5	CNAs & Orderlies	93,104	94,782	1,239,083	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	1,876	32,171	17.15	9
10	Activity Assistants	5,079	5,728	51,350	8.96	10
11	Social Service Workers	4,963	5,339	94,297	17.66	11
12	Dietician					12
13	Food Service Supervisor	1,700	1,774	27,666	15.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,905	19,624	183,231	9.34	15
16	Dishwashers					16
17	Maintenance Workers	4,635	5,068	69,939	13.80	17
18	Housekeepers	7,935	8,903	91,046	10.23	18
19	Laundry	4,764	5,662	57,665	10.18	19
20	Administrator	1,819	2,127	90,978	42.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,001	2,150	35,971	16.73	23
24	Clerical	3,483	3,899	50,774	13.02	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	3,470	3,632	43,748	12.05	31
32	Other Health Care MDS Coordinator	3,740	4,247	104,742	24.66	32
33	Other(specify) Marketing/Beautician	2,885	3,324	74,666	22.46	33
34	TOTAL (lines 1 - 33)	200,757	220,230	\$ 3,449,549 *	\$ 15.66	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	112	\$ 7,091	3.1.3	35
36	Medical Director	138	20,000	3.9.3	36
37	Medical Records Consultant	24	1,560	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,480	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				44
45	Social Service Consultant	27	1,982	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	493	\$ 34,113		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

Washington Christian Village

0026955

Report Period Beginning:

July 1, 2011

Page 21

Ending:

June 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	
Roger Herman	Administrator	0	\$ 2,331	Workers' Compensation Insurance	\$ 83,520	IDPH License Fee	\$ 3,127	
Stacy Brenton	Administrator	0	88,647	Unemployment Compensation Insurance	24,407	Advertising: Employee Recruitment		
				FICA Taxes	252,237	Health Care Worker Background Check		
				Employee Health Insurance	241,680	(Indicate # of checks performed 44)	1,232	
				Employee Meals		Patient Background Checks	304 3,040	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	1,918	
				Employee Physicals	14,098	Dues	8,493	
				Employee Uniforms	638	Subscriptions	920	
				Employee Expense	13,180	Petty Cash - NOVA	440	
				457 Plan Expense	4,000			
				Home Office Allocation	35,800			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 90,978	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		\$ 19,170		
Description			Amount					
Management Fee			\$ 563,661					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 563,661				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
My Innerview	Survey		\$ 1402	N/A			Out-of-State Travel	
Polaris Group	Survey		9,661					
Cejka Search	Consulting		21,400					
Davis & Campbell	Legal		5,226				In-State Travel	
Polsinelli Shughart, PC	Legal		4,061					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	Seminar Expense	
\$ 41,750							1,559	
							Home Office Allocation	
							13,113	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 19,936	

* 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 & AAHSA \$6907
- (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.

\$ 38,945

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.

\$ 278,014

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.

\$ 90
- (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.

\$ 12,012

c. What percent of all travel expense relates to transportation of nurses and patients?

.20

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?

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?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.