

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0026955 Facility Name: Washington Christian Village Address: 1201 Newcastle Rd Washington 61571 County: Tazewell Telephone Number: 309-444-3161 Fax # 309-444-7397 HFS ID Number: Date of Initial License for Current Owners: 4/1/1982 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501(c)(3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Kenna Hudson Telephone Number: 314-587-7924

Email Address:

Facility Name & ID Number Washington Christian Village

0026955 Report Period Beginning: 7/1/15 Ending: 6/30/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,574</u>	<u>8,686</u>	<u>4,946</u>	<u>30,206</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>16,574</u>	<u>8,686</u>	<u>4,946</u>	<u>30,206</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.65%

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 & Luandry Services for IL Residents

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 4/1/1982

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/1982 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 122 and days of care provided 3,655

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/16 Fiscal Year: 6/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/15 Ending: 6/30/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	193,058	15,331	6,393	214,782		214,782		214,782			1
2	Food Purchase		210,238		210,238		210,238	(176)	210,062			2
3	Housekeeping	108,291	16,358		124,649		124,649		124,649			3
4	Laundry	24,976	4,993		29,969		29,969		29,969			4
5	Heat and Other Utilities			88,610	88,610		88,610	1,189	89,799			5
6	Maintenance	89,763	9,184	28,524	127,471		127,471	2,668	130,139			6
7	Other (specify):* Trash			8,355	8,355		8,355		8,355			7
8	TOTAL General Services	416,088	256,104	131,882	804,074		804,074	3,681	807,755			8
	B. Health Care and Programs											
9	Medical Director			48,000	48,000		48,000		48,000			9
10	Nursing and Medical Records	2,174,616	98,161	19,077	2,291,854		2,291,854	(5,650)	2,286,204			10
10a	Therapy			560,117	560,117		560,117		560,117			10a
11	Activities	75,951	1,389	1,280	78,620		78,620		78,620			11
12	Social Services	116,576	158	1,953	118,687		118,687		118,687			12
13	CNA Training											13
14	Program Transportation			3,601	3,601		3,601		3,601			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,367,143	99,708	634,028	3,100,879		3,100,879	(5,650)	3,095,229			16
	C. General Administration											
17	Administrative	107,832		561,750	669,582		669,582	(471,693)	197,889			17
18	Directors Fees											18
19	Professional Services			45,755	45,755		45,755	73,514	119,269			19
20	Dues, Fees, Subscriptions & Promotions			36,308	36,308		36,308	(1,306)	35,002			20
21	Clerical & General Office Expenses	99,943	10,246	69,419	179,608		179,608	238,171	417,779			21
22	Employee Benefits & Payroll Taxes			647,700	647,700		647,700	37,043	684,743			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,602	8,602		8,602	30,186	38,788			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,947	88,947		88,947	19,866	108,813			26
27	Other (specify):* Marketing	44,834	34,207	784	79,825		79,825	(79,825)				27
28	TOTAL General Administration	252,609	44,453	1,459,265	1,756,327		1,756,327	(154,044)	1,602,283			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,035,840	400,265	2,225,175	5,661,280		5,661,280	(156,013)	5,505,267			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			333,585	333,585		333,585	26,188	359,773			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,612	192,612		192,612	(4,948)	187,664			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,379	11,379		11,379		11,379			35
36	Other (specify):* Deferred Fin Costs			339	339		339		339			36
37	TOTAL Ownership			537,915	537,915		537,915	21,240	559,155			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			258,749	258,749		258,749		258,749			39
40	Barber and Beauty Shops	15,844	385		16,229		16,229		16,229			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,231	227,231		227,231		227,231			42
43	Other (specify):* Duplex	5,424		126,745	132,169		132,169	(132,169)				43
44	TOTAL Special Cost Centers	21,268	385	612,725	634,378		634,378	(132,169)	502,209			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,057,108	400,650	3,375,815	6,833,573		6,833,573	(266,942)	6,566,631			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(4,948)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,650)	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	(1,288)	21		24
25	Fund Raising, Advertising and Promotional	(79,825)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(141,275)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (232,986)		\$	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)	(33,956)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (33,956)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (266,942)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (176)	2	1
2	Lobbying Expense	(1,306)	20	2
3	Fines & Penalties	(1,409)	21	3
4	Charity Care	(277)	21	4
5	Miscellaneous Revenue	(132)	17	5
6				6
7	Duplex	(137,975)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(141,275)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(176)	0	0	0	0	0	0	0	0	0	0	(176)	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	0	1,189	0	0	0	0	0	0	0	0	0	1,189	5
6	Maintenance	0	2,668	0	0	0	0	0	0	0	0	0	2,668	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(176)	3,857	0	0	0	0	0	0	0	0	0	3,681	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	(5,650)	0	0	0	0	0	0	0	0	0	0	(5,650)	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	(5,650)	0	0	0	0	0	0	0	0	0	0	(5,650)	16
	C. General Administration													
17	Administrative	(132)	(471,561)	0	0	0	0	0	0	0	0	0	(471,693)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	73,514	0	0	0	0	0	0	0	0	0	73,514	19
20	Fees, Subscriptions & Promotions	(1,306)	0	0	0	0	0	0	0	0	0	0	(1,306)	20
21	Clerical & General Office Expenses	(2,974)	241,145	0	0	0	0	0	0	0	0	0	238,171	21
22	Employee Benefits & Payroll Taxes	0	37,043	0	0	0	0	0	0	0	0	0	37,043	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	30,186	0	0	0	0	0	0	0	0	0	30,186	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	19,866	0	0	0	0	0	0	0	0	0	19,866	26
27	Other (specify):*	(79,825)	0	0	0	0	0	0	0	0	0	0	(79,825)	27
28	TOTAL General Administration	(84,237)	(69,807)	0	0	0	0	0	0	0	0	0	(154,044)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(90,063)	(65,950)	0	0	0	0	0	0	0	0	0	(156,013)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	26,188	0	0	0	0	0	0	0	0	0	26,188	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,948)	0	0	0	0	0	0	0	0	0	0	(4,948)	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	(4,948)	26,188	0	0	0	0	0	0	0	0	0	21,240	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(137,975)	5,806	0	0	0	0	0	0	0	0	0	(132,169)	43
44	TOTAL Special Cost Centers	(137,975)	5,806	0	0	0	0	0	0	0	0	0	(132,169)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(232,986)	(33,956)	0	0	0	0	0	0	0	0	0	(266,942)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board of Directors Attachment						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 1,189	\$ 1,189	1
2	V	6	Maintenance				2,668	2,668	2
3	V	17	Administrative	561,750			90,189	(471,561)	3
4	V	19	Professional Services				73,514	73,514	4
5	V	21	Clerical				206,365	206,365	5
6	V	22	Employee Benefits				37,043	37,043	6
7	V	21	Dues & Subscriptions				4,326	4,326	7
8	V	24	Travel and Seminars				30,186	30,186	8
9	V	26	Insurance				19,866	19,866	9
10	V	30	Depreciation				26,188	26,188	10
11	V	21	Other Administrative Expense				30,454	30,454	11
12	V	43	Independent Living				5,806	5,806	12
13	V								13
14	Total			\$ 561,750			\$ 527,794	\$ * (33,956)	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/15 Ending: 6/30/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		This workpaper is N/A				\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bond Fund	X		Refinance Debt	\$21,030.00	Various	\$ 4,409,251	\$ 2,605,788	6/30/32	0.0572	\$ 121,298	1	
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	1,500,000	339,595	5/15/27	0.0600	48,453	2	
3	Illinois Finance Authority		X	Refinance Debt		6/30/07	364,417	484,031	5/15/31	0.0567	19,568	3	
4	Illinois Finance Authority		X	Refinance Debt		3/1/16	634,172	692,342	5/15/40	0.0500	3,293	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,030.00		\$ 6,907,840	\$ 4,121,756			\$ 192,612	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,907,840	\$ 4,121,756			\$ 192,612	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 314-587-7916

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 02-02-14-300-021	1110 New Castle Rd	\$ 19,057.08	\$
2. 02-02-14-308-001	1104 Kingsbury Rd	\$ 4,757.26	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 23,814.34	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

A. Square Feet: 38,484

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).

Duplexes

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			5,173	2
3	TOTALS	38,484		\$ 55,173	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122		1982		\$ 1,203,052	\$ 34,373	35	\$ 34,373	\$	\$ 1,177,272
5										
6										
7										
8	Home Office Allocation				51,177	2,052		2,052		39,245
	Improvement Type**									
9	1982 Fixed Assets			1982	33,861	396	Various	396		33,466
10	1983 Fixed Assets			1983	34,486	985	Various	985		33,008
11	1984 Fixed Assets			1984	231	7	Various	7		213
12	1985 Fixed Assets			1985	361,990	10,330	Various	10,330		325,608
13	1988 Fixed Assets			1988	4,693	106	Various	106		3,978
14	1996 Fixed Assets			1996	1,572	1,572	Various	1,572		1,572
15	1998 Fixed Assets			1998	1,307		Various			1,307
16	1999 Fixed Assets			1999	875		Various			875
17	2000 Fixed Assets			2000	5,204		Various			5,204
18	2001 Fixed Assets			2001	3,126	2,212	Various	2,212		3,106
19	2002 Fixed Assets			2002	144,052	9,148	Various	9,148		133,448
20	2003 Fixed Assets			2003	34,619	2,308	Various	2,308		29,820
21	2004 Fixed Assets			2004	580		Various			580
22	2005 Fixed Assets			2005	214,251	4,556	Various	4,556		168,691
23	2006 Fixed Assets			2006	206,630	11,967	Various	11,967		111,314
24	2007 Fixed Assets			2007	190,071	10,754	Various	10,754		93,471
25	2008 Fixed Assets			2008	76,797	7,680	Various	7,680		62,203
26	Kitchen Floor & Remodel			2009	37,874	3,787	10	3,787		28,406
27	Replacement Windows - NW wing			2009	12,025	1,203	10	1,203		9,019
28	Chapel remodeling			2009	39,238	3,924	10	3,924		27,793
29	Carrier Roof Top AC Units - Dining Roo			2009	27,975	2,798	10	2,798		20,748
30	Southeast Corridor Cooling System			2009	35,600	3,560	10	3,560		26,403
31	2 Cabinet unit heaters - North wing			2009	7,000	700	10	700		5,192
32	Upgrade to Door Alarms			2009	2,465	247	10	247		1,828
33	North Room Renovation			2009	47,139	4,714	10	4,714		33,549
34	SW AC			2009	2,665	267	10	267		1,866
35	SNF Window Replacement			2010	17,590	1,759	10	1,759		10,994
36	New Flooring - EE Lounge & Front Entry			2010	12,526	1,253	10	1,253		7,620

*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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Service & Conference Room Doors	2010	\$ 6,439	\$ 644	10	\$ 644	\$	\$ 3,595	37
38	Front Doors	2010	11,098	1,110	10	1,110		6,474	38
39	AC for Business & Admin Office	2010	5,590	559	10	559		3,354	39
40	SW Dining Rm Floor	2010	4,885	488	10	488		2,931	40
41	Radiator Covers - Resident Rooms	2010	4,218	422	10	422		2,531	41
42	Sw Dining Rm Remodel	2010	4,250	425	10	425		2,550	42
43	Therapy Gym Remodel	2010	125,416	12,542	10	12,542		75,249	43
44	Front Door Remodel	2010	4,895	490	10	490		2,937	44
45	Parking Lot & Drive Resurface	2010	35,400	3,540	10	3,540		21,535	45
46	Landscaping Front & Therapy Patios	2010	17,815	1,782	10	1,782		10,541	46
47	Sealcoat East Parking Lot	2010	3,950	395	10	395		2,238	47
48	Replace Front Sidewalk & Approach	2010	3,195	320	10	320		1,917	48
49	Double Side Front Sign	2010	7,417	742	10	742		4,450	49
50	Car/Bus Port	2010	6,555	656	10	656		4,152	50
51	Roof where NE wing meets NW wing	2011	2,952	295	10	295		1,550	51
52	Ceramic for EE rest rooms	2011	3,003	300	10	300		1,576	52
53	Topography of west apt land	2011	3,340	334	10	334		1,754	53
54	60 gal, 120K BTU water heater	2011	6,448	645	10	645		3,493	54
55	B&G hot water circulating pump & kit	2011	3,635	364	10	364		1,999	55
56	Radiator Covers	2011	8,050	805	10	805		4,092	56
57	Paint 31 doors & frames SE Hall	2011	3,318	332	10	332		1,686	57
58	Paint 34 doors & frames SW Hall	2011	3,639	364	10	364		1,850	58
59	Remove Wallpaper & Paint Resident Room	2011	10,194	1,019	10	1,019		5,182	59
60	Remove Wallpaper & Paint SW Hall	2011	1,160	116	10	116		590	60
61	Remove wallpaper & paint SE Hall	2011	1,160	116	10	116		590	61
62	Paint Bathrooms 107, 110, 141, 147, 14	2011	1,200	120	10	120		610	62
63	Cultered Marble Top 12 SE Units	2011	2,750	275	10	275		1,398	63
64	Rm 105 & 108 Vanity top, apron & legs	2011	1,320	132	10	132		671	64
65	Rm 107 & 110 Vanity top, apron & legs	2011	1,542	154	10	154		784	65
66	Cove Base All Areas	2011	9,601	960	10	960		4,881	66
67	Flooring 10 Resident Bathrooms	2011	5,622	562	10	562		2,858	67
68	Carpet Powerbond Corridors	2011	34,689	3,469	10	3,469		17,634	68
69	Carpet for 19 Resident Rooms	2011	24,111	2,411	10	2,411		12,257	69
70	TOTAL (lines 4 thru 69)		\$ 3,179,528	\$ 159,546		\$ 159,546	\$	\$ 2,607,708	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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,179,528	\$ 159,546		\$ 159,546	\$	\$ 2,607,708	1
2	Dining Room - Armstrong Vinyl Flooring	2011	24,981	2,498	10	2,498		12,699	2
3	Build soffit around exposed piping	2011	4,230	423	10	423		2,150	3
4	Floor Preparation - Ardex skim coat	2011	15,000	1,500	10	1,500		7,625	4
5	Fire Sprinkler relocated	2011		299	10	299			5
6	Tile - Bath off north center hall	2011	3,322	332	10	332		1,688	6
7	Counters - Activity Room	2011	2,528	253	10	253		1,264	7
8	Courtyard Landscaping (Fountain, Trees	2011	4,100	410	10	410		2,016	8
9	Window Tinting Front of Building & Reh	2011	2,845	285	10	285		1,399	9
10	Faux Wood Vinyl Floor	2011		1,064	10	1,064			10
11	Prime & Paint Interior Doors	2011	3,538	354	10	354		1,857	11
12	Prime Paint Doors Frames NW Hallway	2011	6,861	686	10	686		3,602	12
13	Prep & Paint, Laundry Rm, Hallway Doors	2011	1,286	129	10	129		664	13
14	Prep & Paint Laundry Rm, Hallway	2011		55	10	55			14
15	Prep & Paint Center Hall	2011	1,460	146	10	146		742	15
16	Prep & Paint Doors NE Lounge	2011	321	32	10	32		163	16
17	Prep & Paint Walls NE Lounge	2011	400	40	10	40		203	17
18	Prep & Paint NE & NW Hallways	2011	3,250	325	10	325		1,652	18
19	Prime & Paint Doors, Frames Center Hall	2011	3,330	333	10	333		1,693	19
20	Prep & Paint Shower Room	2011	550	55	10	55		280	20
21	Prep, Paint SW Exterior Door	2011		10	10	10			21
22	Remodel 5 offices, Baseboard, chair rail	2011	6,541	654	10	654		3,325	22
23	Prep. Paint Admin, DON, Business	2011	2,550	255	10	255		1,296	23
24	Cabinets - North Nurse Station	2011	7,864	786	10	786		3,998	24
25	15' Wall Demential Dining Area	2011	4,457	446	10	446		2,266	25
26	Refurbish 18 Resident Rm & Bathrooms	2011	26,211	2,621	10	2,621		13,324	26
27	NE Corridor air distribution system,	2012	65,610	4,756	20	4,756		21,494	27
28	Patio Concrete Pad 30'x12'	2012	2,520	168	15	168		700	28
29	R&R Shower Floor Southwest Hall	2012	3,552	178	20	178		710	29
30	2 Fire Doors & Block Wall Generator Rm	2013	5,140	257	20	257		878	30
31	12x12 Gazebo Chapel Courtyard	2013	6,731	449	15	449		1,384	31
32	100' White Vinyl Fencing Chapel Courtyar	2013	3,870	258	15	258		796	32
33	Install A/C unit dietary area	2014	7,805	781	10	781		1,691	33
34	TOTAL (lines 1 thru 33)		\$ 3,400,381	\$ 180,384		\$ 180,384	\$	\$ 2,699,267	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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,400,381	\$ 180,384		\$ 180,384	\$	\$ 2,699,267	1
2	100 gallon water heater	2015	5,900	590	10	590		738	2
3	SW Entrance door replacement	2015	5,067	507	10	507		633	3
4	Painting, Wall Art/Decor, Cabinets	2015	8,551	855	10	855		855	4
5	HVAC/AC Unit	2015	12,540	1,254	10	1,254		1,254	5
6	100 Gallon Natural Gas Water Heater	2015	6,175	618	10	618		618	6
7	Remove Sod, Brick Edging, Plants	2015	12,297	615	20	615		615	7
8	SE & SW bathroom flooring and wall tiling	2015	22,589	2,259	10	2,259		2,259	8
9	Install Brick edging @ Chapel courtyard	2015	17,562	732	20	732		732	9
10	SE bathroom-plumbing for new valves, piping for new lavatory	2015	1,486	124	10	124		124	10
11	South Hall Haper Confetti fabric Valances	2015	3,374	281	10	281		281	11
12	South Hall Labyrinth Cool blue Valances	2015	2,209	184	10	184		184	12
13	South Hall Painting project	2016	14,325	716	10	716		716	13
14	Staff Lounge 60" sink w/cooktop counters	2016	515	25	10	25		25	14
15	NW Shower Rooms- floor and wall tiling	2016	9,333	389	10	389		389	15
16	SE & SW hallways Flooring	2016	70,950	2,956	10	2,956		2,956	16
17	New Blower Motor on Boiler #2	2016	3,407	142	10	142		142	17
18	Install 30x18 Wall cabinet (3)	2016	763	32	10	32		32	18
19	Staff lounge vinyl wood floor	2016	889	37	10	37		37	19
20	Saff lounge Box lockers (24)	2016	896	30	10	30		30	20
21	Room Signs for SE & SW hall rooms	2016	971	24	10	24		24	21
22	SW Parking lot asphalt	2016	15,700	65	20	65		65	22
23	Rubber Roof @ WCV	2016	14,684	122	10	122		122	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Adjust to tie to FS		(1)	(6)		(6)		(2)	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,630,563	\$ 192,935		\$ 192,935	\$	\$ 2,712,096	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	\$963,543	\$132,614	\$132,614	\$		\$479,916	71
72	Current Year Purchases	102,797	7,361	7,361			7,361	72
73	Fully Depreciated Assets	139,479	2,727	2,727			139,479	73
74	Home Office Allocation	188,319	22,517	22,517			139,016	74
75	TOTALS	\$1,394,138	\$165,219	\$165,219	\$		\$765,772	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 Econoline Van	2009	\$42,068	\$	\$	\$		\$42,068	76
77										77
78										78
79	Home Office Allocation			7,431	1,620	1,620			5,480	79
80	TOTALS			\$49,499	\$1,620	\$1,620	\$		\$47,548	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)	\$5,129,373	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$359,774	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$359,774	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)	\$3,525,416	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$120,656	\$	\$	86
87	Duplex	326,445	13,241	291,663	87
88					88
89					89
90					90
91	TOTALS	\$447,101	\$13,241	\$291,663	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$249,330	92
93	Home Office Allocation	3,293	93
94			94
95		\$252,623	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: \$ 11,379 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 Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

WC only hires certified CNAs

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	4,324	\$ 224,483	\$	4,324	\$ 224,483	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,635	81,676		1,635	81,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		7,286	253,958		7,286	253,958	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			\$	13,245	\$ 560,117	\$	13,245	\$ 560,117	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	\$ 5,114,660	\$	1
2	Cash-Patient Deposits	10,977		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 114,267)	1,371,399		3
4	Supply Inventory (priced at)	5,838		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,567		6
7	Other Prepaid Expenses	14,578		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	354		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,528,373	\$	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	3,994,461		14
15	Leasehold Improvements, at Historical Cost	169,742		15
16	Equipment, at Historical Cost	989,514		16
17	Accumulated Depreciation (book methods)	(3,633,339)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	940,521		21
22	Other Long-Term Assets (spe CIP)	249,330		22
23	Other(specify): <u>Deferred Financing Costs</u>	15,864		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,896,749	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,425,122	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 180,575	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,977		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	292,579		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,756		32
33	Accrued Interest Payable	10,111		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Expenses</u>	171,307		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 678,305	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,121,756		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,121,756	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,800,061	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,625,061	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,425,122	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,722,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,722,175	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,880)	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) Change in Temp Restricted Contributions	2,766	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (97,114)	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)	\$ 4,625,061	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: 7/1/15

Ending:

6/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,160,065	1
2	Discounts and Allowances for all Levels	(4,416,955)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,743,110	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,456,252	6
7	Oxygen	8,510	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,464,762	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	16,597	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	314,958	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,725	19
20	Radiology and X-Ray	11,803	20
21	Other Medical Services	42,451	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 417,534	23
	D. Non-Operating Revenue		
24	Contributions	31,668	24
25	Interest and Other Investment Income***	4,948	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,616	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Duplex</u>	54,260	28
28a	<u>Miscellaneous</u>	17,411	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 71,671	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,733,693	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	804,074	31
32	Health Care	3,100,879	32
33	General Administration	1,756,327	33
	B. Capital Expense		
34	Ownership	537,915	34
	C. Ancillary Expense		
35	Special Cost Centers	407,147	35
36	Provider Participation Fee	227,231	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,833,573	40
41	Income before Income Taxes (line 30 minus line 40)**	(99,880)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (99,880)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,936,738	44
45	Private Pay - Net Inpatient Revenue	1,533,506	45
46	Medicare - Net Inpatient Revenue	(687,323)	46
47	Other-(specify) <u>HMO/Med Advantage/ Part B</u>	(736,836)	47
48	Other-(specify) <u>Nursing</u>	(302,975)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,743,110	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	1,852	2,080	\$ 86,110	\$ 41.40	1
2	Assistant Director of Nursing	1,884	2,088	63,966	30.64	2
3	Registered Nurses	17,472	19,199	499,610	26.02	3
4	Licensed Practical Nurses	14,783	16,161	352,401	21.81	4
5	CNAs & Orderlies	79,170	84,882	1,094,147	12.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,764	2,044	35,994	17.61	9
10	Activity Assistants	3,314	3,569	39,957	11.20	10
11	Social Service Workers	8,014	8,694	116,576	13.41	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,140	37,735	17.63	13
14	Head Cook	6,431	7,242	76,329	10.54	14
15	Cook Helpers/Assistants	7,725	8,149	78,994	9.69	15
16	Dishwashers					16
17	Maintenance Workers	5,015	5,496	89,763	16.33	17
18	Housekeepers	10,713	11,706	108,291	9.25	18
19	Laundry	2,037	2,562	24,976	9.75	19
20	Administrator	1,888	2,092	107,832	51.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,080	40,448	19.45	23
24	Clerical	2,739	2,974	59,495	20.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,631	1,812	23,581	13.01	31
32	Other Health Care MDS Coordinator	1,591	1,623	54,801	33.77	32
33	Other(specify) Marketing, Beauty	2,347	2,566	66,102	25.76	33
34	TOTAL (lines 1 - 33)	174,218	189,159	\$ 3,057,108 *	\$ 16.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	72	\$ 4,663	V01-3	35
36	Medical Director	104	48,000	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	135	8,539	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	19	1,562	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	330	\$ 62,764		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 NumberWashington Christian Village

0026955

Report Period Beginning:7/1/15

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Stacy Brenton

Administrator

0

\$ 107,832

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 107,832

B. Administrative - Other

Description

Amount

Management Fees

\$ 561,750

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 561,750

C. Professional Services

Vendor/Payee

Type

Amount

National Research

Employee Surveys

\$ 1,061

Davis & Campbell

Legal

40,829

Delaney Delaney & Voorn

Legal

3,235

Polsinelli Shughart

Legal

630

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 45,755

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 103,547

Unemployment Compensation Insurance

1,689

FICA Taxes

224,347

Employee Health Insurance

288,177

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

457 Plan Expense

8,495

Employee Expense

5,138

Employee Uniforms

(761)

New Hire Expense

17,068

Home Office Allocation

37,043

TOTAL (agree to Schedule V, line 22, col.8)

\$ 684,743

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check (Indicate # of checks performed)

Patient Background Checks

79

790

Licenses

2,917

Dues

12,808

Subscriptions

18,487

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 35,002

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$ 3,597

In-State Travel

4,762

Seminar Expense

243

Home Office Allocation

30,186

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 38,788

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Washington Christian Village</u>	STATE OF ILLINOIS # <u>0026955</u>	Report Period Beginning: <u>7/1/15</u>	Ending: <u>6/30/16</u>
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
 If YES, give association name and amount. LEADING AGE - \$9,680

(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. \$ 27,490 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. \$ 227,231
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A

(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. \$ 2,323
 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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
 Firm Name: PLANTE MORAN PLLC

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? YES
 See page 39 of the instructions for details. YES
 Attach invoices and a summary of services for all architect and appraisal fees