

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0020610</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Wabash Christian Retirement</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>216 College Blvd</u> <u>Carmi</u> <u>62821</u>																									
Number City Zip Code																									
County: <u>White</u>																									
Telephone Number: <u>618-382-4644</u> Fax # <u>618-382-2350</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Chuck Schmitz</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Chuck Schmitz</u>	(Title) <u>CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Chuck Schmitz</u>																								
	(Title) <u>CFO</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>6/1/1974</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Kenna Hudson</u> Telephone Number: <u>314-587-7924</u>																									
Email Address: _____																									

Facility Name & ID Number Wabash Christian Retirement

0020610 Report Period Beginning: 7/1/19 Ending: 6/30/20

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>156</u>	Skilled (SNF)	<u>156</u>	<u>57,096</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>156</u>	TOTALS	<u>156</u>	<u>57,096</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>27,498</u>	<u>11,410</u>	<u>8,149</u>	<u>47,057</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>27,498</u>	<u>11,410</u>	<u>8,149</u>	<u>47,057</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.42%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

Meals served to prisoner

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 6/1/1974

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 156 and days of care provided 6,995

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 6/30/20 Fiscal Year: 6/30/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	339,028	26,923	15,929	381,880		381,880		381,880			1
2	Food Purchase		314,427		314,427		314,427	(2,814)	311,613			2
3	Housekeeping	192,045	43,565		235,610		235,610		235,610			3
4	Laundry	81,802	99		81,901		81,901		81,901			4
5	Heat and Other Utilities			206,499	206,499		206,499	(5,327)	201,172			5
6	Maintenance	149,306	8,065	56,278	213,649		213,649	3,042	216,691			6
7	Other (specify):* Trash			7,949	7,949		7,949		7,949			7
8	TOTAL General Services	762,181	393,079	286,655	1,441,915		1,441,915	(5,099)	1,436,816			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	3,480,735	226,774	693,425	4,400,934		4,400,934	(5,881)	4,395,053			10
10a	Therapy			1,419,701	1,419,701		1,419,701		1,419,701			10a
11	Activities	107,864	4,220	1,162	113,246		113,246	(104)	113,142			11
12	Social Services	227,258	72	4,238	231,568		231,568		231,568			12
13	CNA Training											13
14	Program Transportation			135	135		135	(135)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,815,857	231,066	2,128,261	6,175,184		6,175,184	(6,120)	6,169,064			16
	C. General Administration											
17	Administrative	218,605		666,050	884,655		884,655	(552,655)	332,000			17
18	Directors Fees											18
19	Professional Services			86,224	86,224		86,224	9,393	95,617			19
20	Dues, Fees, Subscriptions & Promotions			22,519	22,519		22,519	4,330	26,849			20
21	Clerical & General Office Expenses	266,233	13,066	410,519	689,818		689,818	210,872	900,690			21
22	Employee Benefits & Payroll Taxes			956,283	956,283		956,283	79,064	1,035,347			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,379	16,379		16,379	17,762	34,141			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			178,969	178,969		178,969	37,162	216,131			26
27	Other (specify):* Marketing	102,058	2,145	27,915	132,118		132,118	(132,118)				27
28	TOTAL General Administration	586,896	15,211	2,364,858	2,966,965		2,966,965	(326,190)	2,640,775			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,164,934	639,356	4,779,774	10,584,064		10,584,064	(337,409)	10,246,655			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			368,773	368,773		368,773	59,063	427,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,023	42,023		42,023	(42,023)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,698	22,698		22,698		22,698			35
36	Other (specify):* Def Fin Costs			941	941		941		941			36
37	TOTAL Ownership			434,435	434,435		434,435	17,040	451,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			484,847	484,847		484,847	(23,101)	461,746			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,820	328,820		328,820		328,820			42
43	Other (specify):* Duplex/Apt	14,172		66,122	80,294		80,294	(80,294)				43
44	TOTAL Special Cost Centers	14,172		879,789	893,961		893,961	(103,395)	790,566			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,179,106	639,356	6,093,998	11,912,460		11,912,460	(423,764)	11,488,696			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,591)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,250)	21		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	(42,023)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,791)	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	(233)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(84,565)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(151,054)	21		24
25	Fund Raising, Advertising and Promotional	(132,118)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,493)		\$	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)			34
35	Other- Attach Schedule	96,354	VII-B	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 96,354		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,139)		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	Miscellaneous Revenue	\$ (3,207)	21	1
2	Lobbying Expense	(426)	20	2
3	Transportation	(135)	14	3
4	Activity Revenue	(104)	11	4
5	Vending Revenue	(1,223)	2	5
6	Cable TV Expense	(7,039)	5	6
7	Duplex Apt	(87,269)	43	7
8	Medical Records Revenue	(90)	10	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
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29				29
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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	(99,493)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,814)	0	0	0	0	0	0	0	0	0	0	(2,814)	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	(7,039)	1,712	0	0	0	0	0	0	0	0	0	(5,327)	5
6	Maintenance	0	3,042	0	0	0	0	0	0	0	0	0	3,042	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,853)	4,754	0	0	0	0	0	0	0	0	0	(5,099)	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	(5,881)	0	0	0	0	0	0	0	0	0	0	(5,881)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	(135)	0	0	0	0	0	0	0	0	0	0	(135)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,120)	0	0	0	0	0	0	0	0	0	0	(6,120)	16
	C. General Administration													
17	Administrative	0	(552,655)	0	0	0	0	0	0	0	0	0	(552,655)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(84,565)	93,958	0	0	0	0	0	0	0	0	0	9,393	19
20	Fees, Subscriptions & Promotions	(426)	4,756	0	0	0	0	0	0	0	0	0	4,330	20
21	Clerical & General Office Expenses	(157,744)	368,616	0	0	0	0	0	0	0	0	0	210,872	21
22	Employee Benefits & Payroll Taxes	0	79,064	0	0	0	0	0	0	0	0	0	79,064	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,762	0	0	0	0	0	0	0	0	0	17,762	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	37,162	0	0	0	0	0	0	0	0	0	37,162	26
27	Other (specify):*	(132,118)	0	0	0	0	0	0	0	0	0	0	(132,118)	27
28	TOTAL General Administration	(374,853)	48,663	0	0	0	0	0	0	0	0	0	(326,190)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(390,826)	53,417	0	0	0	0	0	0	0	0	0	(337,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	59,063	0	0	0	0	0	0	0	0	0	59,063	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,023)	0	0	0	0	0	0	0	0	0	0	(42,023)	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	(42,023)	59,063	0	0	0	0	0	0	0	0	0	17,040	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	(23,101)	0	0	0	0	0	0	0	0	0	(23,101)	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):*	(87,269)	6,975	0	0	0	0	0	0	0	0	0	(80,294)	43
44	TOTAL Special Cost Centers	(87,269)	(16,126)	0	0	0	0	0	0	0	0	0	(103,395)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(520,118)	96,354	0	0	0	0	0	0	0	0	0	(423,764)	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 Horizons	100.00%	\$ 1,712	\$ 1,712	1
2	V	6	Maintenance				3,042	3,042	2
3	V	17	Administrative	666,050			113,395	(552,655)	3
4	V	19	Professional Services				93,958	93,958	4
5	V	21	Clerical				314,668	314,668	5
6	V	22	Employee Benefits				79,064	79,064	6
7	V	20	Dues & Subscriptions				4,756	4,756	7
8	V	24	Travel and Seminars				17,762	17,762	8
9	V	26	Insurance				37,162	37,162	9
10	V	30	Depreciation				59,063	59,063	10
11	V	21	Other Administrative Expense				53,948	53,948	11
12	V	43	Independent Living				6,975	6,975	12
13	V	39	Pharmacy Services	433,056	Midwest Senior Ministries, Inc. d/b/a Senior Care Pharmacy	0.00%	409,955	(23,101)	13
14	Total			\$ 1,099,106			\$ 1,195,460	\$ * 96,354	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/19 Ending: 6/30/20

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		Debt relocation	\$1,603.75	3/1/05	\$ 366,253	\$ 154,821	9/1/11	0.0572	\$ 3,875	1	
2												2	
3	Illinois Finance Authority		X	Refinance Debt		3/1/16	138,904	205,445	5/15/40	0.0500	9,330	3	
4	Illinois Finance Authority		X	Refinance Debt		12/12/18	618,432	618,432	5/15/40	0.0500	28,818	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$1,603.75		\$ 1,123,589	\$ 978,698			\$ 42,023	9	
	B. Non-Facility Related*												
10	Interest Income Offset										(42,023)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (42,023)	14	
15	TOTALS (line 9+line14)						\$ 1,123,589	\$ 978,698			\$	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 2019 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 2020 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:		2015		8	
		2016		9	
		2017		10	
		2018		11	
		2019		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT This page is N/A

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480

B. General Construction Type: ExteriorMasonryFrameWood & SteelNumber of Stories1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Duplex Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	60,480	1974	\$ 56,683	1
2	Home Office Allocation			9,553	2
3	TOTALS	60,480		\$ 66,236	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1984	1958	\$ 1,040,410	\$	40	\$	\$	1,040,410	4
5	78		1976	1976	724,843		40			723,806	5
6											6
7											7
8	Home Office Allocation				125,566	3,460		3,460		71,709	8
	Improvement Type**										
9	1978 Fixed Assets			1978	13,972		VARIOUS			13,972	9
10	1982 Fixed Assets			1982	37,046		VARIOUS			37,046	10
11	1985 Fixed Assets			1985	20,976		VARIOUS			20,976	11
12	1989 Fixed Assets			1989	1,341		VARIOUS			1,341	12
13	1994 Fixed Assets			1994	29,148		VARIOUS			29,148	13
14	1995 Fixed Assets			1995	86,447	2,750	VARIOUS	2,750		70,632	14
15	1998 Fixed Assets			1998	6,101		VARIOUS			6,101	15
16	2000 Fixed Assets			2000	247,165	5,953	VARIOUS	5,953		129,048	16
17	2001 Fixed Assets			2001	20,594		VARIOUS			20,492	17
18	2002 Fixed Assets			2002	15,826		VARIOUS			15,745	18
19	2003 Fixed Assets			2003	145,795	1,670	VARIOUS	1,670		140,593	19
20	2004 Fixed Assets			2004	242,014	2,255	VARIOUS	2,255		240,711	20
21	2005 Fixed Assets			2005	249,116	6,377	VARIOUS	6,377		238,547	21
22	2006 Fixed Assets			2006	86,373	2,894	VARIOUS	2,894		71,507	22
23	2007 Fixed Assets			2007	118,216	88	VARIOUS	88		116,779	23
24	2008 Fixed Assets			2008	314,020		VARIOUS			311,406	24
25	2009 Fixed Assets			2009	187,338	5,232	VARIOUS	5,232		185,802	25
26	2010 Fixed Assets			2010	427,982	27,174	VARIOUS	27,174		344,289	26
27	2011 Fixed Asset			2011	133,917	12,411	VARIOUS	12,411		122,594	27
28	2012 Fixed Asset			2012	87,472	4,507	VARIOUS	4,507		34,931	28
29	Therapy Gym			2013	306,000	18,715	VARIOUS	18,715		140,360	29
30	Electric - Sewer Grinder			2013	5,354	357	15	357		2,617	30
31	10 Ton A/C Roof Unit for Dining Room			2013	6,471	647	10	647		4,530	31
32	Kitchen - (20) 4ft LED Ceiling Lights			2013	5,480	365	15	365		2,527	32
33	Kitchen - Overhead Lights			2013	548	37	15	37		244	33
34	Carpet - Front Office & Conference Roo			2013	3,496		5			3,439	34
35	Front Entrance - Remodel Railings			2013	2,678	268	10	268		1,830	35
36	Hot Water Heater & Storage Tank			2013	39,447	3,945	10	3,945		26,955	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	Front Office Inpro Wall Covering	2013	\$ 4,730	\$	5	\$	\$	\$ 4,653	37
38	Install of Walk-in Cooler/Freezer Comb	2013	36,623	2,442	15	2,442		16,074	38
39	Replace 6in Sewer Main sidewalk	2013	5,594	224	25	224		1,548	39
40	Replace kitchen drain	2014	5,400	540	10	540		3,285	40
41	IS3200 Door Kit Accutech	2014	4,286	429	10	429		2,643	41
42	Install vinyl family room	2014	2,000	200	10	200		1,150	42
43	Install vinyl flooring	2014	2,450	245	10	245		1,409	43
44	Sealcoat parking lot	2014	6,715	959	7	959		5,676	44
45	Wallpaper in main lobby & back hall	2015	1,325	133	10	133		696	45
46	TheraPure Tub w/Lift	2015	13,185	1,319	10	1,319		6,922	46
47	Install Generator Steel door	2015	1,345	134	10	134		706	47
48	MC Wing Bathroom doors 305, 306 &307	2015	1,476	148	10	148		763	48
49	Install 5' Shower	2015	3,511	351	10	351		1,814	49
50	Wing 6 new flooring	2015	19,840	1,984	10	1,984		10,085	50
51	Remove asbestos	2015	13,650	1,365	10	1,365		6,939	51
52	Remodel of bathrooms 1,2 & 3	2015	24,453	2,445	10	2,445		12,227	52
53	Install vinyl flooring MC bathrooms (3)	2015	600	60	10	60		300	53
54	Room 305 vinyl flooring	2015	496	50	10	50		248	54
55	Relocate Fire sprinklers heads	2015	439	44	10	44		219	55
56	Install toilet rails MC bathrooms	2015	782	78	10	78		391	56
57	MC Wing bathrooms wallcovering 1-3	2015	1,312	131	10	131		656	57
58	Curved Tops and Cabinet Tops, Backsplash	2015	10,577	1,058	10	1,058		5,289	58
59	Office Flooring - Dietary	2015	596	60	10	60		288	59
60	Front Lobby office Vinyl Flooring	2015	594	59	10	59		287	60
61	Boiler/HVAC, Pumps, Tanks, Piping	2015	42,750	4,275	10	4,275		20,306	61
62	Remove Asbestos Tile and Glue	2015	22,204	2,220	10	2,220		10,362	62
63	Dining Flooring - Tavertine	2015	27,693	2,769	10	2,769		12,923	63
64	Drywall finishing & supplies New offices	2016	6,924	692	10	692		3,058	64
65	Countertop for new office	2016	116	12	10	12		51	65
66	Cove base new offices	2016	300	30	10	30		133	66
67	Replace sprinkler head @ new office	2016	442	44	10	44		195	67
68	Install new locks New offices	2016	261	26	10	26		115	68
69	CP216 Kinetico Water Softner System	2016	3,000	300	10	300		1,300	69
70	TOTAL (lines 4 thru 69)		\$ 4,996,820	\$ 123,931		\$ 123,931	\$	\$ 4,302,798	70

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,996,820	\$ 123,931		\$ 123,931	\$	\$ 4,302,798	1
2	Fire Evacuation floor signs	2016	600	60	10	60		260	2
3	Const. of New Exterior Shed	2016	70,127	7,013	10	7,013		29,804	3
4	Concrete for Bocceball Court	2016	1,805	90	20	90		361	4
5	Install Sprinkler @ Assistant Admin offi	2016	2,027	203	10	203		811	5
6	Flooring office	2016	1,236	124	10	124		474	6
7	Emergency Gas Shut off & Switches	2016	1,775	178	10	178		636	7
8	Wing 2 Remodel of Residents bathrooms	2017	119,953	11,995	10	11,995		40,984	8
9	Unit 501 Vinyl Flooring	2017	1,995	199	10	199		648	9
10	New Carpet Wing 3, 9 & 7	2017	22,180	2,218	10	2,218		6,839	10
11	Carpet Wing 7	2017	22,712	2,271	10	2,271		7,003	11
12	Med Room cabinets & countertops	2017	7,257	726	10	726		2,238	12
13	30 New Doors for Wing 1-4	2017	9,562	956	10	956		2,948	13
14	Carpet Wing 8 & Magnolia Parlor	2017	31,007	3,101	10	3,101		9,560	14
15	Embossed Steel garage door Maint. Shed	2017	1,402	140	10	140		432	15
16	46 New Doors for Wing 5-8	2017	13,664	1,366	10	1,366		4,213	16
17	Main Entrance Mats 4x6 (11)	2017	2,571	257	10	257		793	17
18	AC unit Compressor	2017	893	89	10	89		260	18
19	Asphalt & paint lines Parking Lot	2017	7,006	350	20	350		1,022	19
20	New Name Monument Sign 5x10x14	2017	9,773	489	20	489		1,425	20
21	Reno Nurse Station Med Room	2017	1,306	131	10	131		370	21
22	Interior Rooms Signage/Vinyl Decals	2017	3,889	389	10	389		1,102	22
23	AO Smith Gas 100gl Water Heater	2017	3,563	356	10	356		920	23
24	Fire Photo Detector System w/Flash	2018	8,685	869	10	869		2,171	24
25	Privacy Fence & Pavement dumpster area	2018	24,570	1,229	20	1,229		2,867	25
26	100 Finished Doors W/ locks	2018	19,515	1,951	10	1,951		4,553	26
27	Carrier Rooftop AC unit	2018	10,107	1,011	10	1,011		2,358	27
28	8X10 Patio Doors (24)	2018	3,509	351	10	351		702	28
29	Drywall Rehab Room	2018	727	145	5	145		267	29
30	Garden Pergola 16x16	2018	2,800	280	10	280		490	30
31	Parking Lot Asphalt Pavement	2018	860	172	5	172		301	31
32	Hallway 400 Carpet Wing 4	2019	5,250	750	7	750		1,125	32
33	Rose Parlor Flooring - Carpet	2019	12,622	1,803	7	1,803		2,705	33
34	TOTAL (lines 1 thru 33)		\$ 5,421,766	\$ 165,193		\$ 165,193	\$	\$ 4,433,439	34

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/19

Ending:

6/30/20

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		\$ 5,421,766	\$ 165,193		\$ 165,193	\$	\$ 4,433,439	1
2	Corridor 5 & Chapel Flooring - Carpet	2019	22,115	3,159	7	3,159		4,739	2
3	Corridor 4 Flooring - Carpet	2019	7,822	1,117	7	1,117		1,676	3
4	Corridor 2 Flooring - Carpet	2019	6,075	868	7	868		1,302	4
5	Kitchen Grease Trap	2019	533	53	10	53		71	5
6	Dish Room Steelcraft Door	2019	1,103	110	10	110		147	6
7	Dry pipe valve & Accelerator Fire Sprink	2019	3,500	350	10	350		408	7
8	Install Water Softener System	2019	545	55	10	55		55	8
9	Lift Station Sewer Grinder Pump	2019	85,306	4,739	15	4,739		4,739	9
10	Automatic Door Opener 8100 Series	2019	1,860	140	10	140		140	10
11	Beverage Area Sink	2020	1,180	49	10	49		49	11
12	Beverage Area Cabinets w/privacy glass	2020	8,656	361	10	361		361	12
13	Nurse Cabinets East Station	2020	1,273	53	10	53		53	13
14	Nurse Cabinets Front Lobby Desk	2020	1,865	78	10	78		78	14
15	Wing 1 Resident Vinyl Flooring Project	2020	18,648	777	10	777		777	15
16	Asbestos Tile Replace Wing One	2020	6,000	250	10	250		250	16
17	Nurse Station Wall Covering Chamois	2020	469	12	10	12		12	17
18	EM Panel Breakers Kitchen	2020	769	64	3	64		64	18
19									19
20	<u>Rounding</u>		2	(1)		(1)		1	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)		\$ 5,589,487	\$ 177,426		\$ 177,426	\$	\$ 4,448,360	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,279,132	\$138,533	\$138,533	\$		\$973,116	71
72	Current Year Purchases	192,273	33,697	33,697			33,697	72
73	Fully Depreciated Assets	341,025	11,190	11,190			341,025	73
74	Home Office Allocation	362,837	53,529	53,529			199,400	74
75	TOTALS	\$2,175,267	\$236,949	\$236,949	\$		\$1,547,238	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See attachment		Various	\$166,842	\$11,387	\$11,387	\$	4	\$105,052	76
77										77
78										78
79	Home Office Allocation			11,299	899	899			10,300	79
80	TOTALS			\$178,141	\$12,286	\$12,286	\$		\$115,352	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)	\$8,009,13181
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$426,66182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$426,66183
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,110,95085

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	\$9,227	\$	\$	86
87	Duplex	594,828	18,116	470,572	87
88					88
89					89
90					90
91	TOTALS	\$604,055	\$18,116	\$470,572	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$976	92
93	Home Office Allocation	153,311	93
94			94
95		\$154,287	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: \$ 22,698 Description: Exam room equip, copier
(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.

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

WCRC ONLY HIRES CERTIFIED CNA'S

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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	V10A-3	hrs	\$	11,513	\$ 552,441	\$	11,513	\$ 552,441	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,917	169,907		2,917	169,907	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		15,718	697,353		15,718	697,353	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				357,048		357,048	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						23,377		23,377	12
13	Other (specify): Radiology						20,418		20,418	13
14	TOTAL			\$	30,148	\$ 1,419,701	\$ 400,843	30,148	\$ 1,820,544	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,251	\$	1
2	Cash-Patient Deposits	32,689		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 450,070)	1,537,080		3
4	Supply Inventory (priced at)	29,835		4
5	Short-Term Investments	1,885,286		5
6	Prepaid Insurance	9,030		6
7	Other Prepaid Expenses	45,362		7
8	Accounts Receivable (owners or related parties)	6,829,643		8
9	Other(specify): <u>Acc Interest Rec/AR Other</u>	4,701		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,383,877	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	5,963,198		14
15	Leasehold Improvements, at Historical Cost	202,075		15
16	Equipment, at Historical Cost	1,872,748		16
17	Accumulated Depreciation (book methods)	(6,300,113)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	13,356		21
22	Other Long-Term Assets (specify) <u>CIP</u>	976		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,818,150	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,202,027	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,689		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	396,305		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,149		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 434,143	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	978,698		41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44	<u>Deferred Entrance Fees</u>	17,925		44
45	<u>Other Liabilities</u>	297,264		45
46	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,293,887	\$	46
47	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,728,030	\$	47
48	TOTAL EQUITY(page 18, line 24)	\$ 10,473,997	\$	48
49	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,202,027	\$	49

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,583,770	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,583,770	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(109,770)	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (109,773)	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)	\$ 10,473,997	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning: 7/1/19

Ending:

6/30/20

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	\$ 8,378,232	1
2	Discounts and Allowances for all Levels	(6,366,331)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,011,901	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,450,027	6
7	Oxygen	16,831	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,466,858	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	5,301	13
14	Non-Patient Meals	1,591	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	638,012	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,939	19
20	Radiology and X-Ray	44,685	20
21	Other Medical Services	145,172	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 877,700	23
	D. Non-Operating Revenue		
24	Contributions	190,902	24
25	Interest and Other Investment Income***	47,424	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 238,326	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Duplex	96,473	28
28a	Miscellaneous	111,432	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 207,905	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,802,690	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,441,915	31
32	Health Care	6,175,184	32
33	General Administration	2,966,965	33
	B. Capital Expense		
34	Ownership	434,435	34
	C. Ancillary Expense		
35	Special Cost Centers	565,141	35
36	Provider Participation Fee	328,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,912,460	40
41	Income before Income Taxes (line 30 minus line 40)**	(109,770)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (109,770)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,292,824	44
45	Private Pay - Net Inpatient Revenue	1,988,290	45
46	Medicare - Net Inpatient Revenue	(1,394,540)	46
47	Other-(specify) <u>HMO/Med Adv/Part B</u>	(2,874,673)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,011,901	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	1,624	2,079	\$ 81,176	\$ 39.05	1
2	Assistant Director of Nursing	1,973	2,101	58,595	27.89	2
3	Registered Nurses	19,127	20,322	465,115	22.89	3
4	Licensed Practical Nurses	41,826	45,167	796,135	17.63	4
5	CNAs & Orderlies	141,903	148,683	2,054,424	13.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,719	1,968	19,575	9.95	9
10	Activity Assistants	7,310	7,822	88,289	11.29	10
11	Social Service Workers	13,048	14,138	227,258	16.07	11
12	Dietician					12
13	Food Service Supervisor	2,466	2,660	30,631	11.52	13
14	Head Cook	6,082	6,469	61,242	9.47	14
15	Cook Helpers/Assistants	24,733	26,903	247,155	9.19	15
16	Dishwashers					16
17	Maintenance Workers	7,695	8,232	149,306	18.14	17
18	Housekeepers	19,427	20,472	192,045	9.38	18
19	Laundry	7,882	8,421	81,802	9.71	19
20	Administrator	1,933	2,080	159,730	76.79	20
21	Assistant Administrator	1,639	1,936	58,875	30.41	21
22	Other Administrative					22
23	Office Manager	1,572	1,592	35,480	22.29	23
24	Clerical	13,001	14,001	230,753	16.48	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	2,332	2,446	25,290	10.34	31
32	Other Health C: Marketing	4,590	5,047	102,058	20.22	32
33	Other(specify) Duplex	1,356	1,363	14,172	10.40	33
34	TOTAL (lines 1 - 33)	323,238	343,902	\$ 5,179,106 *	\$ 15.06	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	256	\$ 12,432	V01-3	35
36	Medical Director	72	9,600	V09-3	36
37	Medical Records Consultant	16	914	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	13,860	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	23	1,162	V11-3	44
45	Social Service Consultant	63	4,238	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	598	\$ 42,206		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,623	\$ 338,478	V10-3	50
51	Licensed Practical Nurses	1,228	55,506	V10-3	51
52	Certified Nurse Assistants/Aides	7,534	277,931	V10-3	52
53	TOTAL (lines 50 - 52)	16,385	\$ 671,915		53

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

** See instructions.

Facility Name & ID Number		Wabash Christian Retirement		STATE OF ILLINOIS		# 0020610		Report Period Beginning:		7/1/19		Page 21		Ending:		6/30/20	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%		Amount		Description		Amount		Description		Amount			
Sandra Bryant		Administrator		0		\$ 159,730		Workers' Compensation Insurance		\$ 94,314		IDPH License Fee		\$			
Andrea May		Asst. Administrator		0		58,875		Unemployment Compensation Insurance		13,019		Advertising: Employee Recruitment					
								FICA Taxes		362,511		Health Care Worker Background Check					
								Employee Health Insurance		442,884		(Indicate # of checks performed)					
								Employee Meals				Patient Background Checks		231 2,310			
								Illinois Municipal Retirement Fund (IMRF)*									
								New Hire Expense		9,578		License		3,335			
								Employee Uniforms		3,788		Dues		8,643			
								Employee Expense		17,318		Subscriptions		7,805			
								457 Plan Expense		12,871		Home Office Allocation		4,756			
												Less: Public Relations Expense		()			
												Non-allowable advertising		()			
								Home Office Allocation		79,064		Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1)						\$ 218,605		TOTAL (agree to Schedule V,		\$ 1,035,347		TOTAL (agree to Sch. V,		\$ 26,849			
(List each licensed administrator separately.)								line 22, col.8)				line 20, col. 8)					
B. Administrative - Other								E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Description						Amount		Description		Line #		Amount		Description		Amount	
Management Fees						\$ 666,050						\$		Out-of-State Travel		\$ 5,093	
														within the allowable distance			
														In-State Travel		10,559	
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 666,050								Seminar Expense		727	
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type				Amount											
National Research		Employee Surveys				\$ 1,501											
Davis & Campbell		Legal				37,656											
Receivable Management Services		Legal				158											
Delaney, Delaney & Voorn		Legal				46,909											
TOTAL (agree to Schedule V, line 19, column 3)						\$ 86,224		TOTAL		\$				Entertainment Expense		()	
(For legal fee disclosure, see page 39 of instructions)														(agree to Sch. V,			
														line 24, col. 8)		\$ 34,141	
* Attach copy of IMRF notifications																	
**See instructions.																	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LEADING AGE- 10,269
- (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? _____
- (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. \$ 24,443 Line 10
- (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. \$ 328,820
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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,591
- (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. \$ 14,328
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: PLANTE MORAN PLLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.