FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0020610

Facility Name: Wabash Christian Retirement

Address: 216 College Boulevard (Number) Carmi (City) 62821 (Zip Code)

County: White

Telephone Number: 618-382-4644 **Fax #** 618-382-2350

HFS ID Number:

Date of Initial License for Current Owners: 6/1/1974

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Susan McGhee **Telephone Number:** 314-587-7903
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2009 to June 30,2010 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Tim Phillippe
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,617	12,472	8,543	45,632	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,617	12,472	8,543	45,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.13%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 7,958

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	298,229	28,601	10,499	337,329		337,329		337,329			1
2	Food Purchase		237,461		237,461		237,461	(1,718)	235,743			2
3	Housekeeping	164,626	49,266		213,892		213,892		213,892			3
4	Laundry	102,398	15,113		117,511		117,511		117,511			4
5	Heat and Other Utilities			176,335	176,335		176,335	5,937	182,272			5
6	Maintenance	120,529	44,139	46,240	210,908		210,908	4,502	215,410			6
7	Other (specify):* Trash Removal			3,748	3,748		3,748		3,748			7
8	**TOTAL General Services**	685,782	374,580	236,822	1,297,184		1,297,184	8,721	1,305,905			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,629,524	470,287	30,295	3,130,106	(276,082)	2,854,024		2,854,024			10
10a	Therapy			1,153,518	1,153,518		1,153,518		1,153,518			10a
11	Activities	130,281	3,886	365	134,532		134,532	(1,276)	133,256			11
12	Social Services	172,680	2,327	6,027	181,034		181,034		181,034			12
13	CNA Training											13
14	Program Transportation			5,770	5,770		5,770	(17,989)	(12,219)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,932,485	476,500	1,203,175	4,612,160	(276,082)	4,336,078	(19,265)	4,316,813			16
	C. General Administration											
17	Administrative	122,850	1,062	504,052	627,964		627,964	(428,616)	199,348			17
18	Directors Fees											18
19	Professional Services			3,067	3,067		3,067	35,140	38,207			19
20	Dues, Fees, Subscriptions & Promotions			15,371	15,371		15,371		15,371			20
21	Clerical & General Office Expenses	127,347	9,182	106,966	243,495		243,495	161,397	404,892			21
22	Employee Benefits & Payroll Taxes			793,818	793,818		793,818	33,872	827,690			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,348	23,348		23,348	16,532	39,880			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			127,790	127,790		127,790	1,336	129,126			26
27	Other (specify):* Marketing	62,760	2,391	28,844	93,995		93,995	(93,995)				27
28	**TOTAL General Administration**	312,957	12,635	1,603,256	1,928,848		1,928,848	(274,334)	1,654,514			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,931,224	863,715	3,043,253	7,838,192	(276,082)	7,562,110	(284,878)	7,277,232			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.

Facility Name & ID Number Wabash Christian Retirement #0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			321,162	321,162		321,162	22,176	343,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,763	48,763		48,763	(40,524)	8,239			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,136	16,136		16,136		16,136			35
36	Other (specify):* Deferred Financing Costs			1,070	1,070		1,070		1,070			36
37	TOTAL Ownership			387,131	387,131		387,131	(18,348)	368,783			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			95,526	95,526	276,082	371,608		371,608			39
40	Barber and Beauty Shops	43	190	6,768	7,001		7,001		7,001			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):* Apt./Congregate			51,722	51,722		51,722	(51,722)				43
44	TOTAL Special Cost Centers	43	190	240,521	240,754	276,082	516,836	(51,722)	465,114			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,931,267	863,905	3,670,905	8,466,077		8,466,077	(354,948)	8,111,129			45

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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	(2,526)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,640)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(48,763)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	(7,768)	21		24
25	Fund Raising, Advertising and Promotional	(93,995)	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	(97,526)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (253,218)		$	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)	(101,730)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (101,730)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (354,948)		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	X		276,082	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 276,082		47

Wabash Christian Retirement

ID# 0020610

Report Period Beginning: July 1, 2009

Ending: June 30,2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Charity Care	$ (22,732)	21	1
2	Vending	808	2	2
3	Activity	(1,276)	11	3
4	Apt/Congregate	(51,722)	43	4
5	Transportation	(17,989)	14	5
6	Late Fees and Penalties	(4,615)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(97,526)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 2009 **Ending:** June 30,2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,718)	0	0	0	0	0	0	0	0	0	0	(1,718)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,640)	8,577	0	0	0	0	0	0	0	0	0	5,937	5
6	Maintenance	0	4,502	0	0	0	0	0	0	0	0	0	4,502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,358)	13,079	0	0	0	0	0	0	0	0	0	8,721	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,276)	0	0	0	0	0	0	0	0	0	0	(1,276)	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	(17,989)	0	0	0	0	0	0	0	0	0	0	(17,989)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,265)	0	0	0	0	0	0	0	0	0	0	(19,265)	16
	C. General Administration													
17	Administrative	0	(428,616)	0	0	0	0	0	0	0	0	0	(428,616)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	35,140	0	0	0	0	0	0	0	0	0	35,140	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(35,115)	196,512	0	0	0	0	0	0	0	0	0	161,397	21
22	Employee Benefits & Payroll Taxes	0	33,872	0	0	0	0	0	0	0	0	0	33,872	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	16,532	0	0	0	0	0	0	0	0	0	16,532	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	1,336	0	0	0	0	0	0	0	0	0	1,336	26
27	Other (specify):*	(93,995)	0	0	0	0	0	0	0	0	0	0	(93,995)	27
28	**TOTAL General Administration**	(129,110)	(145,224)	0	0	0	0	0	0	0	0	0	(274,334)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(152,733)	(132,145)	0	0	0	0	0	0	0	0	0	(284,878)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wabash Christian Retirement** **#** **0020610** **Report Period Beginning:** **July 1, 2009** **Ending:** **June 30,2010**

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	22,176	0	0	0	0	0	0	0	0	0	22,176	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,763)	8,239	0	0	0	0	0	0	0	0	0	(40,524)	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**	(48,763)	30,415	0	0	0	0	0	0	0	0	0	(18,348)	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):*	(51,722)	0	0	0	0	0	0	0	0	0	0	(51,722)	43
44	**TOTAL Special Cost Centers**	(51,722)	0	0	0	0	0	0	0	0	0	0	(51,722)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(253,218)	(101,730)	0	0	0	0	0	0	0	0	0	(354,948)	45

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of board of directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	$ 8,577	$ 8,577	1
2	V	6	Maintenance				4,502	4,502	2
3	V	17	Administration	504,052			75,436	(428,616)	3
4	V	19	Professional Services				35,140	35,140	4
5	V	21	Clerical				196,512	196,512	5
6	V	22	Employee Benefits				33,872	33,872	6
7	V	24	Travel & Seminar				16,532	16,532	7
8	V	26	Insurance				1,336	1,336	8
9	V	30	Depreciation				22,176	22,176	9
10	V	32	Interest				8,239	8,239	10
11	V								11
12	V								12
13	V								13
14	Total			$ 504,052			$ 402,322	$ * (101,730)	14

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: ne 30,2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bond Fund	X		Debt Relocation	$1,393.00	3/1/2005	$ 366,253	$ 299,917	9/1/2011	0.0850	$ 17,730	1
2	Illinois Finance Authority		X	Renovation Projects		6/30/2007	586,567	586,567	6/30/2031	0.0567	31,033	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,393.00		$ 952,820	$ 886,484			$ 48,763	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 952,820	$ 886,484			$ 48,763	15

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

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 2009 **Ending:** June 30,2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	This workpaper is not applicable		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480 B. General Construction Type: Exterior Masonry Frame Wood & Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Duplex Buildings

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	60,480	1974	$ 56,683	1
2	Home Office Allocation			6,139	2
3	TOTALS	60,480		$ 62,822	3

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1974	1958	$ 1,040,410	$ 37,158	40	$ 37,158	$	$ 966,095	4
5	78		1976	1976	724,843	18,121	40	18,121		624,323	5
6											6
7	Home Office Allocation				63,323	4,704		4,704		126,238	7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1975	10,000					10,000	9
10	IMPROVEMENTS			1978	13,972	399	VARIOUS	399		12,808	10
11	IMPROVEMENTS			1981	10,331					10,331	11
12	IMPROVEMENTS			1982	66,797					66,797	12
13	IMPROVEMENTS			1984	1,432					1,432	13
14	IMPROVEMENTS			1985	35,637	699	VARIOUS	699		32,258	14
15	IMPROVEMENTS			1986	6,061					6,061	15
16	IMPROVEMENTS			1987	8,062					8,062	16
17	IMPROVEMENTS			1989	8,707					8,707	17
18	IMPROVEMENTS			1990	84,849	2,048	VARIOUS	2,048		84,849	18
19	IMPROVEMENTS			1991	21,205					21,205	19
20	IMPROVEMENTS			1992	32,567	1,100	VARIOUS	1,100		30,581	20
21	IMPROVEMENTS			1993	6,910					6,910	21
22	IMPROVEMENTS			1994	35,411	1,387	VARIOUS	1,387		30,153	22
23	IMPROVEMENTS			1995	88,247	2,750	VARIOUS	2,750		44,927	23
24	IMPROVEMENTS			1997	15,171					15,171	24
25	IMPROVEMENTS			1998	9,195					9,195	25
26	IMPROVEMENTS			1999	13,980	100	VARIOUS	100		13,980	26
27	IMPROVEMENTS			2000	279,977	9,271	VARIOUS	9,271		98,471	27
28	IMPROVEMENTS			2001	30,594	1,909	VARIOUS	1,909		19,096	28
29	IMPROVEMENTS			2002	21,468	1,653	VARIOUS	1,653		13,287	29
30	IMPROVEMENTS			2003	215,890	17,370	VARIOUS	17,370		126,171	30
31	IMPROVEMENTS			2004	252,824	18,580	VARIOUS	18,580		107,637	31
32	IMPROVEMENTS			2005	136,695	11,839	VARIOUS	11,839		70,773	32
33	IMPROVEMENTS			2006	261,451	20,236	VARIOUS	20,236		87,963	33
34	13 window treatments 11 rooms painted a			2007	17,960	3,592	5	3,592		11,973	34
35	Bathroom Remodeling ProjectWing 1			2007	6,872	687	10	687		2,119	35
36	Remodeling Wing 1 shower room drywall			2007	1,020	204	5	204		629	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: July 1, 2009 Ending: June 30,2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Plumbing work Wing 1 Bathroom	2007	$ 650	$ 65	10	$ 65	$	$ 200	37
38	Install 5 ft white cast iron bathtub for	2007	2,000	200	10	200		617	38
39	Plumbing work Wing 1 Bathroom remodel	2007	1,666	167	10	167		514	39
40	Plumbing work Wing 1 Bathroom remodel	2007	9,000	900	10	900		2,775	40
41	Wing 1 Remodel	2007	39,868	4,082	10	4,082		13,021	41
42	Install new windows Wing 7 and Wing 5	2007	24,180	2,418	10	2,418		7,053	42
43	Valances	2007	3,421	3,342	10	3,342		969	43
44	Install laminate hardwood flooring Hal	2007	2,688	269	10	269		739	44
45	Wallpaper-wing2,4,5 remodel	2007	504	50	10	50		130	45
46	Asphalt parking lot bumpers & Sidewalk	2007	6,474	809	8	809		4,586	46
47	Drywall repair-wg5 & 14 res.	2008	750	75	10	75		188	47
48	Wing 2,4,5 remodeling project	2008	35,355	3,535	10	3,535		15,442	48
49	Replacement windows	2008	14,917	1,492	10	1,492		2,859	49
50	Therapy Gym	2008	82,950	8,295	10	8,295		27,409	50
51	Land Improvements - Therapy Gym	2008	6,010	601	10	601		952	51
52	Install jacks & cable - Reclaim Unit	2008	2,677	267	10	267		513	52
53	egress lighting	2009	1,238	124	10	124		155	53
54	Light Fixtures	2009	553	55	10	55		69	54
55	Door coding locks	2009	6,745	675	10	675		731	55
56	Roof	2009	144,092	8,405	10	8,405		8,405	56
57	Chapel Roof	2009	1,505	100	10	100		100	57
58	New Windows Wing 7	2009	10,397	953	10	953		953	58
59	New Carpet & Tile for East Lobby	2009	1,178	79	10	79		79	59
60	Sprinkler System	2009	22,000	1,650	10	1,650		1,650	60
61	Seal coat & Striping for Parking Lot	2009	4,714	393	10	393		393	61
62	New screens for gutters	2010	2,700	135	10	135		135	62
63	Sprinkler System	2010	112,380	5,619	10	5,619		5,619	63
64	New Roof - SNF	2010	163,717	1,364	20	1,364		1,364	64
65	New Gutters & Downspouts	2010	720	6	10	6		6	65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 4,226,910**	**$ 199,932**		**$ 199,932**	**$**	**$ 2,765,827**	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: July 1, 2009 Ending: June 30,2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 651,489	$ 74,845	$ 74,845	$	Various	$ 288,179	71
72	Current Year Purchases	92,160	12,016	12,016		Various	12,016	72
73	Fully Depreciated Assets	397,266	2,166	2,166			401,227	73
74	Home Office Allocation	203,009	15,082	15,082			30,889	74
75	TOTALS	$ 1,343,924	$ 104,109	$ 104,109	$		$ 732,311	75

D. Vehicle Depreciation (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	Ford Bus	1993/2008	$ 46,243	$ 1,620	$ 1,620	$	5	$ 43,238	76
77	Patient Transportation	2007 Ford Cargo Van	2007	29,492	7,373	7,373		4	21,505	77
78										78
79	Home office allocation			32,166	2,390	2,390			11,358	79
80	TOTALS			$ 107,901	$ 11,383	$ 11,383	$		$ 76,101	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,741,557	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 315,424	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,424	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)	$ 3,574,239	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplex	$ 550,061	$ 19,854	$ 354,354	86
87	Land	9,227			87
88					88
89					89
90					90
91	TOTALS	$ 559,288	$ 19,854	$ 354,354	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 46,423	92
93			93
94			94
95		$ 46,423	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.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 16,136 Description: Rental charges for copier, PC, dish machine, oxygen equipment, and a Kangaroo pump
(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	N/A		$	$	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.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

Wabash Christian Retirement Center has never applied to be an approved training center.

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	6,195	$ 425,492	$	6,195	$ 425,492	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,710	157,762		1,710	157,762	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		8,395	570,264		8,395	570,264	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			$	16,300	$ 1,153,518	$	16,300	$ 1,153,518	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.

STATE OF ILLINOIS

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30,2010 (last day of reporting year)

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	$ 2,299,077	$	1
2	Cash-Patient Deposits	20,185		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,325)	872,161		3
4	Supply Inventory (priced at)	23,907		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,988		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attachment	528,650		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,753,968	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,452,900		11
12	Long-Term Investments	347,638		12
13	Land	65,910		13
14	Buildings, at Historical Cost	4,782,295		14
15	Leasehold Improvements, at Historical Cost	190,462		15
16	Equipment, at Historical Cost	1,235,669		16
17	Accumulated Depreciation (book methods)	(3,785,238)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	662,526		21
22	Other Long-Term Assets (spe CIP	47,353		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,999,515	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,753,483	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,441	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,785		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	321,272		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,279		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	202,521		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 778,298	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	886,484		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	110,671		43
44	Due life right resident	49,996		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,047,151	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,825,449	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,928,034	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,753,483	$	48

*(See instructions.)

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 2009 **Ending:** June 30,2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,360,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,360,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	567,921	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 567,921	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)**	$ 6,928,034	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,198,229	1
2	Discounts and Allowances for all Levels	(1,315,144)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,883,085	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,594,320	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,594,320	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	10,345	13
14	Non-Patient Meals	2,526	14
15	Telephone, Television and Radio	2,640	15
16	Rental of Facility Space		16
17	Sale of Drugs	35,209	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,488	19
20	Radiology and X-Ray	17,398	20
21	Other Medical Services	60,893	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 156,499	23
	D. Non-Operating Revenue		
24	Contributions	91,816	24
25	Interest and Other Investment Income***	183,033	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 274,849	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	77,047	28
28a	Mgmt Fees/Gains & Losses on Investments/Other	48,198	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 125,245	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,033,998	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,297,184	31
32	Health Care	4,612,160	32
33	General Administration	1,928,848	33
	B. Capital Expense		
34	Ownership	387,131	34
	C. Ancillary Expense		
35	Special Cost Centers	154,249	35
36	Provider Participation Fee	86,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,466,077	40
41	**Income before Income Taxes (line 30 minus line 40)****	567,921	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 567,921	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,772	1,772	$ 83,569	$ 47.16	1
2	Assistant Director of Nursing	1,760	1,760	46,418	26.37	2
3	Registered Nurses	13,134	15,441	325,698	21.09	3
4	Licensed Practical Nurses	32,881	35,388	584,494	16.52	4
5	CNAs & Orderlies	109,544	119,695	1,422,196	11.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,455	4,455	48,108	10.80	8
9	Activity Director	2,636	2,635	24,522	9.31	9
10	Activity Assistants	8,415	8,415	91,958	10.93	10
11	Social Service Workers	8,035	9,558	117,272	12.27	11
12	Dietician					12
13	Food Service Supervisor	1,888	1,888	30,842	16.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,197	29,494	267,387	9.07	15
16	Dishwashers					16
17	Maintenance Workers	5,957	6,607	120,529	18.24	17
18	Housekeepers	16,701	18,054	164,626	9.12	18
19	Laundry	10,832	11,429	102,398	8.96	19
20	Administrator	1,777	1,777	122,850	69.13	20
21	Assistant Administrator					21
22	Other Administrative	1,400	1,400	23,643	16.89	22
23	Office Manager	1,831	1,831	42,334	23.12	23
24	Clerical	4,385	5,533	61,370	11.09	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	6,219	6,219	47,876	7.70	31
32	Other Health C: Director of Admiss	10,969	10,969	118,168	10.77	32
33	Other(specify) Vol. Coord, MDS	3,598	3,603	85,009	23.59	33
34	TOTAL (lines 1 - 33)	275,386	297,923	$ 3,931,267 *	$ 13.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	211	$ 10,499	3.1.3	35
36	Medical Director	72	7,200	3.9.3	36
37	Medical Records Consultant	90	2,169	3.10.3	37
38	Nurse Consultant	2	100	3.10.3	38
39	Pharmacist Consultant	180	4,198	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	99	6,027	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	654	$ 30,193		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bryant	Administrator	0	$ 122,850
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,850

B. Administrative - Other

Description	Amount
Management Expense	$ 504,052
TOTAL (agree to Schedule V, line 17, col. 3)	$ 504,052
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Inner View	Consulting	$ 1,731
Armstrong Teasdale LLP	Legal	510
Davis & Campbell LLC	Legal	826
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,067

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,512
Unemployment Compensation Insurance	5,011
FICA Taxes	279,806
Employee Health Insurance	383,801
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	20,067
Employee Physicals	5,407
457 Plan Expense	11,000
Empolyee Uniforms	214
Home Office Allocation	33,872
TOTAL (agree to Schedule V, line 22, col.8)	$ 827,690

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,015
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Advertising & Promotion	
Licenses	2,255
Dues	8,826
Subscriptions	2,194
Other	81
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,371

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	15,967
Seminar Expense	7,381
Home Office Allocation	16,532
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 39,880

**See instructions.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2009 Ending: June 30,201

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. **Life Svc Network- $7,775**

(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. $ **25,437** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **86,505**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,526**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **17,989**
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: **LarsonAllen LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.