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: 0026955

Facility Name: Washington Christian Village

Address: 1201 Newcastle Road (Number) Washington (City) 61571 (Zip Code)

County: Tazewell

Telephone Number: 309-444-3161 **Fax #** 309-444-7397

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1982

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 July 1, 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 Ave, 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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	122	Skilled (SNF)	122	44,530	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	122	TOTALS	122	44,530	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	16,198	10,101	9,182	35,481	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,198	10,101	9,182	35,481	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.68%

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)
None

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 4/1/1982

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 6,708

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: 6/30/2010 Fiscal Year: 6/30/2010

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	279,522	31,889	11,558	322,969		322,969		322,969			1
2	Food Purchase		250,249		250,249		250,249	(5,447)	244,802			2
3	Housekeeping	115,644	21,042		136,686		136,686		136,686			3
4	Laundry	72,871	8,306		81,177		81,177		81,177			4
5	Heat and Other Utilities			137,857	137,857		137,857	(4,977)	132,880			5
6	Maintenance	73,475	15,105	33,067	121,647		121,647	3,898	125,545			6
7	Other (specify):* Trash			8,851	8,851		8,851		8,851			7
8	TOTAL General Services	541,512	326,591	191,333	1,059,436		1,059,436	(6,526)	1,052,910			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,491,797	436,250	14,172	2,942,219	(241,359)	2,700,860		2,700,860			10
10a	Therapy		4,251	806,624	810,875		810,875		810,875			10a
11	Activities	82,043	3,709	545	86,297		86,297		86,297			11
12	Social Services	108,950	1,049	2,069	112,068		112,068		112,068			12
13	CNA Training											13
14	Program Transportation			5,271	5,271		5,271		5,271			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,682,790	445,259	835,881	3,963,930	(241,359)	3,722,571		3,722,571			16
	C. General Administration											
17	Administrative	112,768	3,555	466,919	583,242		583,242	(401,815)	181,427			17
18	Directors Fees											18
19	Professional Services			13,195	13,195		13,195	30,425	43,620			19
20	Dues, Fees, Subscriptions & Promotions			19,869	19,869		19,869		19,869			20
21	Clerical & General Office Expenses	99,113	11,355	125,064	235,532		235,532	112,595	348,127			21
22	Employee Benefits & Payroll Taxes			627,467	627,467		627,467	29,326	656,793			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,858	9,858		9,858	14,313	24,171			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,459	79,459		79,459	1,157	80,616			26
27	Other (specify):* Marketing	63,053	2,634	9,828	75,515		75,515	(75,515)				27
28	TOTAL General Administration	274,934	17,544	1,351,659	1,644,137		1,644,137	(289,514)	1,354,623			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,499,236	789,394	2,378,873	6,667,503	(241,359)	6,426,144	(296,040)	6,130,104			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 Washington Christian Village #0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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			206,031	206,031		206,031	19,200	225,231			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			232,488	232,488		232,488	(176,127)	56,361			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,310	28,310		28,310		28,310			35
36	Other (specify):*											36
37	TOTAL Ownership			466,829	466,829		466,829	(156,927)	309,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			95,620	95,620	241,359	336,979		336,979			39
40	Barber and Beauty Shops	21,946	528		22,474		22,474		22,474			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* Apt & Congregate			99,225	99,225		99,225	(99,225)				43
44	TOTAL Special Cost Centers	21,946	528	261,640	284,114	241,359	525,473	(99,225)	426,248			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,521,182	789,922	3,107,342	7,418,446		7,418,446	(552,192)	6,866,254			45

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,959)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,403)	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	(183,260)	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	(18,600)	21		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	(26,113)	21		24
25	Fund Raising, Advertising and Promotional	(75,515)	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	(113,755)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (433,605)		$	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)	(118,587)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (118,587)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (552,192)		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		241,359	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 241,359		47

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2009

Ending: July 1, 2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (1,488)	2	1
2	Late Fees, Finance Charges	(29)	21	2
3	Miscellaneous	(209)	17	3
4	Apt/Congregate	(99,225)	43	4
5	Charity Care	(12,804)	21	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
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**	(113,755)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village # 0026955 **Report Period Beginning:** July 1, 2009 **Ending:** July 1, 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	
	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	(5,447)	0	0	0	0	0	0	0	0	0	0	(5,447)	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	(12,403)	7,426	0	0	0	0	0	0	0	0	0	(4,977)	5
6	Maintenance	0	3,898	0	0	0	0	0	0	0	0	0	3,898	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,850)	11,324	0	0	0	0	0	0	0	0	0	(6,526)	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	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(209)	(401,606)	0	0	0	0	0	0	0	0	0	(401,815)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,425	0	0	0	0	0	0	0	0	0	30,425	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(57,546)	170,141	0	0	0	0	0	0	0	0	0	112,595	21
22	Employee Benefits & Payroll Taxes	0	29,326	0	0	0	0	0	0	0	0	0	29,326	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,313	0	0	0	0	0	0	0	0	0	14,313	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	1,157	0	0	0	0	0	0	0	0	0	1,157	26
27	Other (specify):*	(75,515)	0	0	0	0	0	0	0	0	0	0	(75,515)	27
28	**TOTAL General Administration**	(133,270)	(156,244)	0	0	0	0	0	0	0	0	0	(289,514)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(151,120)	(144,920)	0	0	0	0	0	0	0	0	0	(296,040)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Christian Village # 0026955 **Report Period Beginning:** July 1, 2009 **Ending:** July 1, 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	19,200	0	0	0	0	0	0	0	0	0	19,200	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(183,260)	7,133	0	0	0	0	0	0	0	0	0	(176,127)	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**	(183,260)	26,333	0	0	0	0	0	0	0	0	0	(156,927)	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):*	(99,225)	0	0	0	0	0	0	0	0	0	0	(99,225)	43
44	**TOTAL Special Cost Centers**	(99,225)	0	0	0	0	0	0	0	0	0	0	(99,225)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(433,605)	(118,587)	0	0	0	0	0	0	0	0	0	(552,192)	45

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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%	$ 7,426	$ 7,426	1
2	V	6	Maintenance				3,898	3,898	2
3	V	17	Administration	466,919			65,313	(401,606)	3
4	V	19	Professional Services				30,425	30,425	4
5	V	21	Clerical				170,141	170,141	5
6	V	22	Employee Benefits				29,326	29,326	6
7	V	24	Travel & Seminar				14,313	14,313	7
8	V	26	Insurance				1,157	1,157	8
9	V	30	Depreciation				19,200	19,200	9
10	V	32	Interest				7,133	7,133	10
11	V								11
12	V								12
13	V								13
14	Total			$ 466,919			$ 348,332	$ * (118,587)	14

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: ıly 1, 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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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		Refinancing debt	$19,374.00	Various	$ 4,409,251	$ 3,933,869	6/30/2032	0.0572	$ 232,488	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$19,374.00		$ 4,409,251	$ 3,933,869			$ 232,488	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,409,251	$ 3,933,869			$ 232,488	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 Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2009 **Ending:** July 1, 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 Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-723-5175 FAX #: ( )

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.	02-02-14-308-001	Devonshire Estates 5th Add Sec 11	$ 7,220.00	$
2.	02-02-14-300-021	Devonshire Estates 5th Addn	$ 15,851.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,071.00	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,956 B. General Construction Type: Exterior Brick Frame 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).

Apartments

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	38,484	1982	$ 50,000	1
2	Home Office Allocation			5,316	2
3	TOTALS	38,484		$ 55,316	3

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	122		1982		$ 1,203,052	$ 34,373	35	$ 34,373	$	$ 971,035	4
5											5
6											6
7											7
8	Home Office Allocation				54,826	4,073		4,073		109,297	8
	Improvement Type**										
9	Improvements			1982	57,536	396	various	396		54,765	9
10	Improvements			1983	36,292	985	various	985		28,902	10
11	Improvements			1984	3,947	7	various	7		3,890	11
12	Improvements			1985	368,110	10,331	various	10,331		269,746	12
13	Improvements			1986	4,603					4,603	13
14	Improvements			1988	12,979	106	various	106		11,629	14
15	Improvements			1989	10,671					10,671	15
16	Improvements			1990	1,765					1,765	16
17	Improvements			1991	2,395	120	various	120		2,305	17
18	Improvements			1992	9,161					9,161	18
19	Improvements			1993	10,785					10,785	19
20	Improvements			1994	4,103					4,103	20
21	Improvements			1995	10,713					10,713	21
22	Improvements			1996	91,102	3,134	various	3,134		73,604	22
23	Improvements			1997	35,910	2,165	various	2,165		30,857	23
24	Improvements			1999	14,101					14,101	24
25	Improvements			2000	6,623	554	various	554		6,449	25
26	Improvements			2001	54,579	3,590	various	3,590		35,520	26
27	Improvements			2002	257,264	11,521	various	11,521		187,624	27
28	Improvements			2003	51,264	3,403	various	3,403		32,083	28
29	Improvements			2004	19,642	2,610	various	2,610		13,320	29
30	Improvements			2005	135,940	14,366	various	14,366		77,042	30
31	Improvements			2006	133,049	9,779	various	9,779		40,332	31
32	Window for beauty shop			2007	575	58	10	58		211	32
33	Install relay and buzzer for generator batteries			2007	730	73	10	73		225	33
34	Nurse Call & door alarm			2007	3,198	320	10	320		986	34
35	Install attic rooftop vents			2007	6,440	644	10	644		1,986	35
36	Vestibule remodel			2007	5,915	591	10	591		1,725	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	Air conditioner unit for Activities	2007	$ 1,843	$ 184	10	$ 184	$	$ 537	37
38	Generator and Boiler replacement project	2007	168,200	8,410	20	8,410		23,128	38
39	Miniblinds fro main dining room	2007	598	120	5	120		309	39
40	Generator and Boiler replacement (Architect's specification)	2007	9,498	950	10	950		2,388	40
41	Rehab to home remodeling	2007	985	197	5	197		558	41
42	Courtyard	2007	689	69	10	69		201	42
43	SW/Reclaim unit dining area	2008	922	92	10	92		223	43
44	Supplies for SW/Nurse station	2008	5,690	569	10	569		1,280	44
45	SW cooridor AC replacement	2008	33,860	3,386	10	3,386		7,054	45
46	NW cooridor AC replacement	2008	36,325	3,633	10	3,633		7,567	46
47	100 gallon water heater - natural gas	2008	6,298	630	10	630		945	47
48	Replacement windows - NW wing	2008	12,025	1,203	10	1,203		1,804	48
49	Kitchen floor & remodel	2009	37,874	3,787	10	3,787		5,681	49
50	Carrier roof top AC units - dining room	2009	27,875	2,788	10	2,788		3,964	50
51	Southeast corridor cooling system	2009	35,600	3,560	10	3,560		5,043	51
52	2 cabinet unit heaters - north wing	2009	7,000	700	10	700		992	52
53	Upgrade to door alarms	2009	2,465	247	10	247		350	53
54	Cooling Fans for New Computer Room	2009	923	77	10	77		77	54
55	Patio conversion to Chapel	2009	750	69	10	69		69	55
56	SW AC	2009	2665	267	10	267		267	56
57	Architect fees	2009	5,058	506	10	506		548	57
58	Autocad services	2009	3,500	350	10	350		379	58
59	Drywall & electric	2009	28,050	2,805	10	2,805		3,039	59
60	Door hardware	2009	570	57	10	57		62	60
61	Carpet	2009	1,732	173	10	173		187	61
62	Light	2009	328	33	10	33		36	62
63	Tile work	2009	22,706	2,271	10	2,271		2,460	63
64	Asbestos abatement	2009	40,700	4,070	10	4,070		4,409	64
65	Doors	2009	2,506	250	10	250		271	65
66	SNG Window Replacement	2010	17,590	440	10	440		440	66
67	New Flooring- EE Lounge & Frount Entry	2010	12,526	104	10	104		104	67
68	Parking Lot & Drive Resurface	2010	35,400	295	10	295		295	68
69	Car/ Bus Port	2010	6,555	219	10	219		219	69
70	TOTAL (lines 4 thru 69)		$ 3,176,576	$ 145,710		$ 145,710	$	$ 2,094,320	70

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	$ 281,241	$ 33,764	$ 33,764	$	Various	$ 150,614	71
72	Current Year Purchases	64,970	7,010	7,010		Various	7,010	72
73	Fully Depreciated Assets	202,045	3,250	3,250			202,045	73
74	Home Office Allocation	175,766	13,058	13,058			26,744	74
75	TOTALS	$ 724,022	$ 57,082	$ 57,082	$		$ 386,413	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	2009 Ford Van	2009	$ 42,068	$ 868	$ 868	$	4	$ 8,764	76
77	Home Office Allocation			27,850	2,069	2,069			9,834	77
78										78
79										79
80	TOTALS			$ 69,918	$ 2,937	$ 2,937	$		$ 18,598	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)	$ 4,025,832	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 205,729	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 205,729	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)	$ 2,499,331	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 120,656	$	$	86
87	Land Improvements	8,903	298	8,903	87
88	Buildings & Equipment	687,971	9,122	521,850	88
89					89
90					90
91	TOTALS	$ 817,530	$ 9,420	$ 530,753	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 40,193	92
93			93
94			94
95		$ 40,193	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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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 ☒ X NO
16. Rental Amount for movable equipment: $ 28,310 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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 ____

Washington Christian Village does not train the CNA's because they are aready certified when hired.

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 Washington Christian Village STATE OF ILLINOIS # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$	5,065	$ 321,745	$	5,065	$ 321,745	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,507	108,462		1,507	108,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		5,912	376,417		5,912	376,417	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			$	12,484	$ 806,624	$	12,484	$ 806,624	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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of July 1, 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	$ 141,850	$	1
2	Cash-Patient Deposits	13,976		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 46,312)	1,177,873		3
4	Supply Inventory (priced at)	8,500		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,039		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/Other A/R	549,107		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,904,345	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	3,880,734		14
15	Leasehold Improvements, at Historical Cost	128,977		15
16	Equipment, at Historical Cost	600,268		16
17	Accumulated Depreciation (book methods)	(2,921,762)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	76,374		21
22	Other Long-Term Assets (spe CIP	158,653		22
23	Other(specify): Note Receivable	1,842,199		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,936,099	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,840,444	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 206,753	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,976		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	270,250		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,535		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	44,319		36
37	Current Portion Refundable Ent Fees	6,400		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 553,233	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,933,869		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees/Other Liab	43,048		43
44	Apt & Congregate	35,442		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,012,359	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,565,592	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,274,852	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,840,444	$	48

*(See instructions.)

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2009 **Ending:** July 1, 2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 320,191	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 320,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	954,661	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)**	$ 954,661	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)**	$ 1,274,852	24 *

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	$ 7,526,553	1
2	Discounts and Allowances for all Levels	(2,269,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,256,884	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,540,663	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,540,663	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	25,490	13
14	Non-Patient Meals	3,959	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,007	17
18	Sale of Supplies to Non-Patients	1,653	18
19	Laboratory	14,397	19
20	Radiology and X-Ray	17,866	20
21	Other Medical Services	31,203	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 186,575	23
	D. Non-Operating Revenue		
24	Contributions	36,082	24
25	Interest and Other Investment Income***	183,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 219,342	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	167,577	28
28a	Miscellaneous	2,066	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 169,643	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,373,107	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,059,436	31
32	Health Care	3,963,930	32
33	General Administration	1,644,137	33
	B. Capital Expense		
34	Ownership	466,829	34
	C. Ancillary Expense		
35	Special Cost Centers	217,319	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,418,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	954,661	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 954,661	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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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	1,844	1,844	$ 86,397	$ 46.85	1
2	Assistant Director of Nursing	1,769	1,769	49,836	28.17	2
3	Registered Nurses	16,875	18,783	561,706	29.91	3
4	Licensed Practical Nurses	17,767	19,191	353,796	18.44	4
5	CNAs & Orderlies	90,107	97,265	1,208,600	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,855	1,855	24,897	13.42	8
9	Activity Director	1,840	1,840	23,200	12.61	9
10	Activity Assistants	6,110	6,110	58,843	9.63	10
11	Social Service Workers	3,710	4,591	68,923	15.01	11
12	Dietician					12
13	Food Service Supervisor	1,791	1,791	34,997	19.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,176	26,666	244,525	9.17	15
16	Dishwashers					16
17	Maintenance Workers	5,659	5,994	73,475	12.26	17
18	Housekeepers	11,479	12,179	115,644	9.50	18
19	Laundry	6,631	7,117	72,871	10.24	19
20	Administrator	1,862	1,862	112,768	60.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,938	1,938	34,140	17.62	23
24	Clerical	4,296	4,981	64,973	13.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,888	1,888	40,027	21.20	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,515	3,515	37,811	10.76	31
32	Other Health C: MDS, transportati	8,720	8,720	168,754	19.35	32
33	Other(specify) Comm Liaison,Ma	4,105	4,173	84,999	20.37	33
34	TOTAL (lines 1 - 33)	218,937	234,072	$ 3,521,182 *	$ 15.04	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	235	$ 11,428	3.1.3	35
36	Medical Director	36	7,200	3.9.3	36
37	Medical Records Consultant	32	788	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,445	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	28	1,963	3.12.3	45
46	Other(specify)				46
47	Methodist Med Center (Chart Audit)	8	375	3.10.3	47
48					48
49	TOTAL (lines 35 - 48)	531	$ 25,199		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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roger Hermann	Administrator	0	$ 112,768
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,768

B. Administrative - Other

Description	Amount
Management Fee	$ 466,919
TOTAL (agree to Schedule V, line 17, col. 3)	$ 466,919
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Inner View	Consulting	$ 1,455
Polsinelli	Survey	972
Davis & Campbell	Legal	10,768
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,195

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,768
Unemployment Compensation Insurance	10,763
FICA Taxes	257,929
Employee Health Insurance	234,971
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	16,362
Employee Expense	15,666
457 Plan Expense	10,833
W C Medical Expense	84
Employee Uniforms	(909)
Home Office Allocation	29,326
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,793

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	10,408
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Advertising & Promotion	
Licenses	595
Dues	7,664
Subscriptions	1,194
Other	8
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,966
Seminar Expense	4,892
Home Office Allocation	14,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,171

**See instructions.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 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 Washington Christian Village # 0026955 Report Period Beginning: July 1, 2009 Ending: July 1, 2010

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 Services Network - $6,770**

(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. $ **30,349** Line **10-3**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **66,795**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,959**

(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. $ **10216**
c. What percent of all travel expense relates to transportation of nurses and patients? **.27**
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.