FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0020610

Facility Name: Wabash Christian Reitrement

Address: 216 College Boulevrd (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 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314-587-7924
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 7/1/15 to 6/30/16 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) Susan McGhee
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	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	156	Skilled (SNF)	156	59,096	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	156	TOTALS	156	59,096	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	21,016	16,841	8,429	46,286	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,016	16,841	8,429	46,286	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.32%

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 6/1/1974

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 156 and days of care provided 7,682

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: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	362,404	21,694	22,403	406,501		406,501		406,501			1
2	Food Purchase		290,635		290,635		290,635	(4,083)	286,552			2
3	Housekeeping	159,085	47,812		206,897		206,897		206,897			3
4	Laundry	68,653			68,653		68,653		68,653			4
5	Heat and Other Utilities			183,474	183,474		183,474	(2,337)	181,137			5
6	Maintenance	136,291	26,449	24,747	187,487		187,487	3,782	191,269			6
7	Other (specify):* Trash			5,150	5,150		5,150		5,150			7
8	TOTAL General Services	726,433	386,590	235,774	1,348,797		1,348,797	(2,638)	1,346,159			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,883,693	179,623	11,963	3,075,279		3,075,279	(10,904)	3,064,375			10
10a	Therapy			953,920	953,920		953,920		953,920			10a
11	Activities	121,688	2,435	1,696	125,819		125,819	279	126,098			11
12	Social Services	178,838	692	7,105	186,635		186,635		186,635			12
13	CNA Training											13
14	Program Transportation			4,638	4,638		4,638	(27,159)	(22,521)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,184,219	182,750	988,922	4,355,891		4,355,891	(37,784)	4,318,107			16
	C. General Administration											
17	Administrative	178,248		611,836	790,084		790,084	(483,956)	306,128			17
18	Directors Fees											18
19	Professional Services			35,610	35,610		35,610	104,236	139,846			19
20	Dues, Fees, Subscriptions & Promotions			34,303	34,303		34,303	(1,309)	32,994			20
21	Clerical & General Office Expenses	159,955	10,452	168,077	338,484		338,484	270,118	608,602			21
22	Employee Benefits & Payroll Taxes			1,121,128	1,121,128		1,121,128	52,523	1,173,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			31,078	31,078		31,078	42,801	73,879			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			111,182	111,182		111,182	28,168	139,350			26
27	Other (specify):* Marketing	97,857	23,907	1,048	122,812		122,812	(122,812)				27
28	TOTAL General Administration	436,060	34,359	2,114,262	2,584,681		2,584,681	(110,231)	2,474,450			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,346,712	603,699	3,338,958	8,289,369		8,289,369	(150,653)	8,138,716			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 Reitrement #0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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			387,812	387,812		387,812	37,132	424,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,893	65,893		65,893	(35,557)	30,336			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,787	19,787		19,787		19,787			35
36	Other (specify):* FIN 47 Accretion/Deferred Financing Costs			(148,319)	(148,319)		(148,319)		(148,319)			36
37	TOTAL Ownership			325,173	325,173		325,173	1,575	326,748			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			463,208	463,208		463,208	(16,014)	447,194			39
40	Barber and Beauty Shops			18,326	18,326		18,326		18,326			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			319,507	319,507		319,507		319,507			42
43	Other (specify):* Apt/fCongregate	6,778		69,191	75,969		75,969	(75,969)				43
44	TOTAL Special Cost Centers	6,778		870,232	877,010		877,010	(91,983)	785,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,353,490	603,699	4,534,363	9,491,552		9,491,552	(241,061)	9,250,491			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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	(3,553)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(35,557)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,904)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,527)	21		24
25	Fund Raising, Advertising and Promotional	(122,812)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(121,223)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (361,576)		$	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)	120,515	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 120,515		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (241,061)		37

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

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

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

Wabash Christian Reitrement

ID# 0020610

Report Period Beginning: 7/1/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Revenue	$ (45)	21	1
2	Lobbying Expense	(1,309)	20	2
3	Fines & Penalties	150	21	3
4	Transportation	(27,159)	14	4
5	Charity Care	(4,916)	21	5
6	Activity Revenue	279	11	6
7	Vending Revenue	(530)	2	7
8	Cable TV Revenue	(4,023)	5	8
9	Apt/Congregate Expenses	(83,670)	43	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**	(121,223)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Reitrement # 0020610 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY 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	(4,083)	0	0	0	0	0	0	0	0	0	0	(4,083)	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	(4,023)	1,686	0	0	0	0	0	0	0	0	0	(2,337)	5
6	Maintenance	0	3,782	0	0	0	0	0	0	0	0	0	3,782	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,106)	5,468	0	0	0	0	0	0	0	0	0	(2,638)	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	(10,904)	0	0	0	0	0	0	0	0	0	0	(10,904)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	279	0	0	0	0	0	0	0	0	0	0	279	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	(27,159)	0	0	0	0	0	0	0	0	0	0	(27,159)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(37,784)	0	0	0	0	0	0	0	0	0	0	(37,784)	16
	C. General Administration													
17	Administrative	0	(483,956)	0	0	0	0	0	0	0	0	0	(483,956)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	104,236	0	0	0	0	0	0	0	0	0	104,236	19
20	Fees, Subscriptions & Promotions	(1,309)	0	0	0	0	0	0	0	0	0	0	(1,309)	20
21	Clerical & General Office Expenses	(72,338)	342,456	0	0	0	0	0	0	0	0	0	270,118	21
22	Employee Benefits & Payroll Taxes	0	52,523	0	0	0	0	0	0	0	0	0	52,523	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	42,801	0	0	0	0	0	0	0	0	0	42,801	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	28,168	0	0	0	0	0	0	0	0	0	28,168	26
27	Other (specify):*	(122,812)	0	0	0	0	0	0	0	0	0	0	(122,812)	27
28	**TOTAL General Administration**	(196,459)	86,228	0	0	0	0	0	0	0	0	0	(110,231)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(242,349)	91,696	0	0	0	0	0	0	0	0	0	(150,653)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Reitrement # 0020610 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	37,132	0	0	0	0	0	0	0	0	0	37,132	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,557)	0	0	0	0	0	0	0	0	0	0	(35,557)	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**	(35,557)	37,132	0	0	0	0	0	0	0	0	0	1,575	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	(16,014)	0	0	0	0	0	0	0	0	0	(16,014)	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):*	(83,670)	7,701	0	0	0	0	0	0	0	0	0	(75,969)	43
44	**TOTAL Special Cost Centers**	(83,670)	(8,313)	0	0	0	0	0	0	0	0	0	(91,983)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(361,576)	120,515	0	0	0	0	0	0	0	0	0	(241,061)	45

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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. d/b/a Christian Homes, Inc.	100.00%	$ 1,686	$ 1,686	1
2	V	6	Maintenance				3,782	3,782	2
3	V	17	Administrative	611,836			127,880	(483,956)	3
4	V	19	Professional Services				104,236	104,236	4
5	V	21	Clerical				293,141	293,141	5
6	V	22	Employee Benefits				52,523	52,523	6
7	V	21	Dues & Subscriptions				6,134	6,134	7
8	V	24	Travel and Seiminars				42,801	42,801	8
9	V	26	Insurance				28,168	28,168	9
10	V	30	Depreciation				37,132	37,132	10
11	V	21	Other Administrative Expense				43,181	43,181	11
12	V	43	Independent Living				7,701	7,701	12
13	V	39	Pharmacy Services	424,765	Midwet Senior Ministries d/b/a Senior Care Pharmacy	0.00%	408,751	(16,014)	13
14	Total			$ 1,036,601			$ 1,157,116	$ * 120,515	14

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$1,603.75	3/1/2005	$ 366,253	$ 198,636	9/1/2011	0.0572	$ 7,014	1
2	Illinois Finance Authority		X	Renovation Projects		6/30/2007	586,567	840,419	5/15/2031	0.0567	52,199	2
3												3
4	Illinois Finance Authority		X	Refinance Debt		3/1/2016	138,904	151,645	5/15/2040	0.0500	6,680	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,603.75		$ 1,091,724	$ 1,190,700			$ 65,893	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,091,724	$ 1,190,700			$ 65,893	15

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

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

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Reitrement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT This Page is N/A

TELEPHONE ( ) FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 Building

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			7,335	2
3	TOTALS	60,480		$ 64,018	3

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		1984	1958	$ 1,040,410	$	40	$	$	$ 1,040,410	4
5	78		1976	1976	724,843	11,613	40	11,613		723,806	5
6											6
7											7
8	Home Office Allocation				72,564	2,909		2,909		55,647	8
	Improvement Type**										
9	1975 Fixed Assets			1975	10,000		VARIOUS			10,000	9
10	1978 Fixed Assets			1978	13,972		VARIOUS			13,972	10
11	1981 Fixed Assets			1981	6,683		VARIOUS			6,683	11
12	1982 Fixed Assets			1982	37,046		VARIOUS			37,046	12
13	1985 Fixed Assets			1985	35,240		VARIOUS			35,240	13
14	1987 Fixed Assets			1987	2,447		VARIOUS			2,447	14
15	1989 Fixed Assets			1989	1,341		VARIOUS			1,341	15
16	1990 Fixed Assets			1990	1,231		VARIOUS			1,231	16
17	1991 Fixed Assets			1991	2,189		VARIOUS			2,189	17
18	1992 Fixed Assets			1992	23,667		VARIOUS			23,667	18
19	1993 Fixed Assets			1993	2,395		VARIOUS			2,395	19
20	1994 Fixed Assets			1994	33,141		VARIOUS			33,141	20
21	1995 Fixed Assets			1995	86,447	2,750	VARIOUS	2,750		59,630	21
22	1997 Fixed Assets			1997	736		VARIOUS			736	22
23	1998 Fixed Assets			1998	6,101		VARIOUS			6,101	23
24	1999 Fixed Assets			1999	10,980		VARIOUS			10,980	24
25	2000 Fixed Assets			2000	250,193	5,955	VARIOUS	5,955		108,256	25
26	2001 Fixed Assets			2001	20,594	1,107	VARIOUS	1,107		20,194	26
27	2002 Fixed Assets			2002	19,056	986	VARIOUS	986		18,141	27
28	2003 Fixed Assets			2003	145,795	6,440	VARIOUS	6,440		124,541	28
29	2004 Fixed Assets			2004	248,664	13,214	VARIOUS	13,214		205,503	29
30	2005 Fixed Assets			2005	253,892	16,935	VARIOUS	16,935		214,007	30
31	2006 Fixed Assets			2006	86,373	10,031	VARIOUS	10,031		59,733	31
32	2007 Fixed Assets			2007	147,422	11,379	VARIOUS	11,379		135,707	32
33	2008 Fixed Assets			2008	334,947	33,383	VARIOUS	33,383		263,664	33
34	Chapel remodel-artwork&table			2009	807	81	10	81		599	34
35	Regress lighting			2009	1,238	124	10	124		898	35
36	Light Fixtures			2009	553	55	10	55		401	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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	Door coding locks	2009	$ 6,745	$ 675	10	$ 675	$	$ 4,778	37
38	Roof	2009	144,092	14,409	10	14,409		94,861	38
39	Chapel Roof	2009	1,505	151	10	151		1,003	39
40	New Windows Wing 7	2009	10,397	1,040	10	1,040		7,191	40
41									41
42	Sprinkler System	2009	22,000	2,200	10	2,200		14,850	42
43	Seal coat & Striping for Parking Lot	2009		433	10	433			43
44	New screens for gutters	2010	2,700	270	10	270		1,755	44
45	Sprinkler System	2010	112,380	11,238	10	11,238		73,047	45
46	New Roof - SNF	2010	163,717	8,186	20	8,186		50,479	46
47									47
48	Beauty Shop Exit Door	2010	7,859	786	10	786		4,519	48
49	Convert Activity Room	2010	4,382	438	10	438		2,520	49
50	Wing 1 - Bathroom	2010	67,815	6,782	10	6,782		40,689	50
51	LSC Corrections	2010	22,567	2,257	10	2,257		13,540	51
52									52
53									53
54	Dining Room - Fire Doors	2010	4,900	490	10	490		2,777	54
55	Parking Lot	2010	34,607	3,461	10	3,461		19,899	55
56	Medical Records Storage Shed	2010	7,054	705	10	705		3,997	56
57									57
58	PTAC Units	2011	7,046	705	10	705		3,817	58
59									59
60	Delta Lavatory Faucets - Wide	2011	4,084	408	10	408		2,212	60
61	Delta Lavatory Faucets - Regular	2011	1,227	123	10	123		664	61
62	Room 301 - Bathroom remodel	2011	5,858	586	10	586		3,222	62
63	Room 302 - Bathroom Remodel	2011	8,598	860	10	860		4,729	63
64	Room 303 - Bathroom Remodel	2011	8,648	865	10	865		4,757	64
65	Wing 3 - Asbestos Removal	2011	12,348	1,235	10	1,235		6,689	65
66	Wing 3 - Refurb	2011	1,751	175	10	175		963	66
67	Wing 3 - Fixtures	2011	426	43	10	43		231	67
68	Wing 3 - Flooring	2011	14,485	1,448	10	1,448		7,725	68
69	Wing 2 - HVACs	2011	5,062	506	10	506		2,573	69
70	TOTAL (lines 4 thru 69)		$ 4,303,220	$ 177,437		$ 177,437	$	$ 3,591,793	70

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,303,220	$ 177,437		$ 177,437	$	$ 3,591,793	1
2									2
3	Boiler section module, piping valves,	2011	9,793	1,630	6	1,630		7,527	3
4									4
5									5
6									6
7									7
8	Haven Water Damage-restore floors, wal	2011	47,843	4,784	10	4,784		22,327	8
9									9
10									10
11									11
12	Sealcoat Parking Lot and stripe	2011	2,503		3			2,503	12
13	Medical Building Fire Suppression	2011	6,752	675	10	675		3,376	13
14	WEIL MCCAIN 550 ULTRA BOILERS	2012	84,800	4,240	20	4,240		15,900	14
15									15
16	LANDSCAPING PAVERS AND PLANTS	2012	2,672	267	10	267		1,002	16
17									17
18									18
19	Therapy Gym	2013	306,000	18,715	Various	18,715		65,501	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,763,583	$ 207,749		$ 207,749	$	$ 3,709,929	34

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,763,583	$ 207,749		$ 207,749	$	$ 3,709,929	1
2									2
3									3
4									4
5									5
6	Electric - Sewer Grinder	2013	5,354	357	15	357		1,190	6
7	10 Ton A/C Roof Unit for Dining Room	2013	6,471	647	10	647		1,941	7
8									8
9	Kitchen - (20) 4ft LED Ceiling Lights	2013	5,480	365	15	365		1,066	9
10	Kitchen - Overhead Lights	2013	548	37	15	37		97	10
11									11
12									12
13	Carpet - Front Office & Conference Roo	2013	3,496	699	5	699		1,923	13
14	Front Entrance - Remodel Railings	2013	2,678	268	10	268		759	14
15	Hot Water Heater & Storage Tank	2013	39,447	3,945	10	3,945		11,177	15
16	Front Office Inpro Wall Covering	2013	4,730	946	5	946		2,602	16
17	Install of Walk-in Cooler/Freezer Comb	2013	36,623	2,442	15	2,442		6,307	17
18	Replace 6in Sewer Main sidewalk	2013	5,594	224	25	224		653	18
19	Replace kitchen drain	2014	5,400	540	10	540		1,125	19
20									20
21	IS3200 Door Kit Accutech	2014	4,286	429	10	429		929	21
22	Install vinyl family room	2014	2,000	200	10	200		350	22
23	Install vinyl flooring	2014	2,450	245	10	245		429	23
24									24
25									25
26	Sealcoat parking lot	2014	6,715	959	7	959		1,839	26
27									27
28	Install Generator Steel door	2015	1,345	134	10	134		168	28
29	TheraPure Tub w/Lift	2015	13,185	1,319	10	1,319		1,648	29
30	MC Wing Bathroom doors 305, 306 &307	2015	1,476	148	10	148		172	30
31	Install 5' Shower	2015	3,511	351	10	351		410	31
32	Wallpaper in main lobby & back hall	2015	1,325	133	10	133		166	32
33	Remove asbestos	2015	13,650	1,365	10	1,365		1,479	33
34	TOTAL (lines 1 thru 33)		$ 4,929,347	$ 223,500		$ 223,500	$	$ 3,746,359	34

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,929,347	$ 223,500		$ 223,500	$	$ 3,746,359	1
2	Wing 6 new flooring	2015	19,840	1,984	10	1,984		2,149	2
3	Remodel of bathrooms 1,2 & 3	2015	24,453	2,445	10	2,445		2,445	3
4	Install vinyl flooring MC bathrooms (3)	2015	600	60	10	60		60	4
5	Room 305 vinyl flooring	2015	496	50	10	50		50	5
6	Relocate Fire sprinklers heads	2015	439	44	10	44		44	6
7	Install toilet rails MC bathrooms	2015	782	78	10	78		78	7
8	MC Wing bathrooms wallcovering 1-3	2015	1,312	131	10	131		131	8
9	Curved Tops and Cabinet Tops, Backsplash	2015	10,577	1,058	10	1,058		1,058	9
10	Office Flooring - Dietary	2015	596	50	10	50		50	10
11	Front Lobby office Vinyl Flooring	2015	594	49	10	49		49	11
12	Boiler/HVAC, Pumps, Tanks, Piping	2015	42,750	3,206	10	3,206		3,206	12
13	Remove Asbestos Tile and Glue	2015	22,204	1,480	10	1,480		1,480	13
14	Dining Flooring - Tavertine	2015	27,693	1,846	10	1,846		1,846	14
15	Drywall finishing & supplies New offices	2016	6,924	289	10	289		289	15
16	Countertop for new office	2016	116	5	10	5		5	16
17	Cove base new offices	2016	300	13	10	13		13	17
18	Replace sprinker head @ new office	2016	442	18	10	18		18	18
19	Install new locks New offices	2016	261	11	10	11		11	19
20	CP216 Kinetico Water Softner System	2016	3,000	100	10	100		100	20
21	Fire Evacuation floor signs	2016	600	20	10	20		20	21
22	Const. of New Exterior Shed	2016	70,127	1,753	10	1,753		1,753	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,163,452	$ 238,190		$ 238,190	$	$ 3,761,214	34

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 938,180	$ 127,788	$ 127,788	$		$ 510,215	71
72	Current Year Purchases	151,694	15,419	15,419			15,419	72
73	Fully Depreciated Assets	424,359	2,574	2,574			424,359	73
74	Home Officed Allocation	267,019	31,927	31,927			197,113	74
75	TOTALS	$ 1,781,252	$ 177,708	$ 177,708	$		$ 1,147,106	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attachment		Various	$ 104,220	$ 6,750	$ 6,750	$		$ 89,595	76
77										77
78										78
79	Home Office Allocation			10,537	2,296	2,296			7,770	79
80	TOTALS			$ 114,757	$ 9,046	$ 9,046	$		$ 97,365	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)	$ 7,123,479	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 424,944	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 424,944	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)	$ 5,005,685	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	$ 9,227	$	$	86
87	Duplex	552,853	19,648	428,125	87
88					88
89					89
90					90
91	TOTALS	$ 562,080	$ 19,648	$ 428,125	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 4,669	92
93			93
94			94
95		$ 4,669	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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 19,787 Description: See Attachment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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.

   WCRC only hires certified CNAs

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	V10A-3	hrs	$	13,172	$ 373,637	$	13,172	$ 373,637	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,395	175,092		3,395	175,092	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		19,125	405,191		19,125	405,191	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			$	35,692	$ 953,920	$	35,692	$ 953,920	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 Reitrement **#** 0020610 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(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	$ 5,444,536	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (117,486))	1,745,430		3
4	Supply Inventory (priced at)	20,085		4
5	Short-Term Investments	523,003		5
6	Prepaid Insurance	17,298		6
7	Other Prepaid Expenses	14,180		7
8	Accounts Receivable (owners or related parties)	256,608		8
9	Other(specify): Accrued Interest Receivable/Oth	6,094		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,027,234	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	500,000		11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	5,551,299		14
15	Leasehold Improvements, at Historical Cost	211,702		15
16	Equipment, at Historical Cost	1,499,193		16
17	Accumulated Depreciation (book methods)	(5,173,280)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,095,374		21
22	Other Long-Term Assets (spe Deferred Financing C	3,475		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,753,673	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,780,907	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 203,008	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	389,903		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,877		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	134,386		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 734,174	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,190,700		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	84,984		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,275,684	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,009,858	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,781,049	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,790,907	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,559,710	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,559,710	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	222,784	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)**	$ 222,784	17
	B. Transfers (Itemize):		
18	**Restricted Contributions**	1,592	18
19	**Net Assets Released from Restriction**	(3,039)	19
20			20
21			21
22	**Rounding**	2	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,445)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,781,049	24 *

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,377,800	1
2	Discounts and Allowances for all Levels	(3,982,041)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,395,759	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,153,146	6
7	Oxygen	17,076	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,170,222	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	23,027	13
14	Non-Patient Meals	3,553	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	643,513	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,736	19
20	Radiology and X-Ray	37,903	20
21	Other Medical Services	94,896	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 850,628	23
	D. Non-Operating Revenue		
24	Contributions	157,864	24
25	Interest and Other Investment Income***	35,557	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 193,421	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	85,724	28
28a	Miscellaneous	18,582	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 104,306	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,714,336	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,348,797	31
32	Health Care	4,355,891	32
33	General Administration	2,584,681	33
	B. Capital Expense		
34	Ownership	325,173	34
	C. Ancillary Expense		
35	Special Cost Centers	557,503	35
36	Provider Participation Fee	319,507	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,491,552	40
41	**Income before Income Taxes (line 30 minus line 40)****	222,784	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 222,784	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,211,547	44
45	Private Pay - Net Inpatient Revenue	1,905,602	45
46	Medicare - Net Inpatient Revenue	(2,276,447)	46
47	Other-(specify) HMO/Medicare Advantage/Outpatient Part B	(404,887)	47
48	Other-(specify) Nursing	(40,056)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,395,759	49

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

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

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

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

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	2,180	2,406	$ 114,131	$ 47.44	1
2	Assistant Director of Nursing	1,750	2,080	56,607	27.21	2
3	Registered Nurses	35,739	36,907	804,121	21.79	3
4	Licensed Practical Nurses	26,515	29,365	526,474	17.93	4
5	CNAs & Orderlies	114,391	124,555	1,361,289	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,065	25,960	12.57	9
10	Activity Assistants	6,882	7,867	95,728	12.17	10
11	Social Service Workers	11,485	12,399	178,838	14.42	11
12	Dietician					12
13	Food Service Supervisor	2,068	2,765	33,126	11.98	13
14	Head Cook	5,103	5,878	66,421	11.30	14
15	Cook Helpers/Assistants	25,053	27,744	262,857	9.47	15
16	Dishwashers					16
17	Maintenance Workers	6,196	7,066	136,291	19.29	17
18	Housekeepers	12,894	13,980	159,085	11.38	18
19	Laundry	5,555	6,205	68,653	11.06	19
20	Administrator	1,856	2,120	128,931	60.82	20
21	Assistant Administrator	1,892	2,080	49,317	23.71	21
22	Other Administrative					22
23	Office Manager	3,123	4,303	39,646	9.21	23
24	Clerical	7,550	8,322	120,309	14.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,936	2,087	21,072	10.10	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/Apt-Co	3,380	7,324	104,634	14.29	33
34	TOTAL (lines 1 - 33)	277,457	307,518	$ 4,353,490 *	$ 14.16	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	414	$ 20,881	V01-3	35
36	Medical Director	72	9,600	V09-3	36
37	Medical Records Consultant	99	2,351	V10-3	37
38	Nurse Consultant	3	160	V10-3	38
39	Pharmacist Consultant	180	3,780	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	71	4,454	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	839	$ 41,226		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 Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bryant	Administrator	0	$ 128,931
Andrea May	Asst Administrator	0	49,317
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 178,248

B. Administrative - Other

Description	Amount
Management Fees	$ 611,836
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 611,836

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 31,521
Daniel Maher Law Offices	Legal	240
National Research	Professional Services	1,618
Managed Care Partners	Professional Services	1,500
Adam Lawler Law Firm	Legal	731
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 35,610

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,646
Unemployment Compensation Insurance	2,511
FICA Taxes	311,896
Employee Health Insurance	624,227
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	9,496
Employee Uniforms	3,683
Employee Expense	18,173
457 Plan Expense	8,496
Home Office Allocation	52,523
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,173,651

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 255)	
Patient Background Checks	2,550
License	5,515
Dues	8,966
Subscriptions	15,963
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,994

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,266
In-State Travel	17,119
Seminar Expense	7,693
Home Office Allocation	42,801
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 73,879

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Reitrement # 0020610 Report Period Beginning: 7/1/15 Ending: 6/30/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Leading Age- $9,463.47**

(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. $ **45,672** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **319,507**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,553**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **11,608**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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