FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 Retirement

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 7/1/16 to 6/30/17 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) Chuck Schmitz
(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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	56,940	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	56,940	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	21,520	13,711	9,270	44,501	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,520	13,711	9,270	44,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.15%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals served to 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 8,047

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: 6/30/17 Fiscal Year: 6/30/17

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	355,494	22,971	14,751	393,216		393,216		393,216			1
2	Food Purchase		277,716		277,716		277,716	(2,924)	274,792			2
3	Housekeeping	164,287	42,655		206,942		206,942		206,942			3
4	Laundry	74,063			74,063		74,063		74,063			4
5	Heat and Other Utilities			203,449	203,449		203,449	(2,199)	201,250			5
6	Maintenance	136,641	20,930	30,862	188,433		188,433	3,161	191,594			6
7	Other (specify):* Trash			5,401	5,401		5,401		5,401			7
8	TOTAL General Services	730,485	364,272	254,463	1,349,220		1,349,220	(1,962)	1,347,258			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	3,059,923	185,855	53,008	3,298,786		3,298,786	(4,845)	3,293,941			10
10a	Therapy			1,031,291	1,031,291		1,031,291		1,031,291			10a
11	Activities	119,217	2,800	85	122,102		122,102	951	123,053			11
12	Social Services	178,161	459	7,069	185,689		185,689		185,689			12
13	CNA Training											13
14	Program Transportation			5,281	5,281		5,281	(5,281)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,357,301	189,114	1,106,334	4,652,749		4,652,749	(9,175)	4,643,574			16
	C. General Administration											
17	Administrative	196,193		649,584	845,777		845,777	(529,373)	316,404			17
18	Directors Fees											18
19	Professional Services			6,631	6,631		6,631	66,099	72,730			19
20	Dues, Fees, Subscriptions & Promotions			39,756	39,756		39,756	(1,633)	38,123			20
21	Clerical & General Office Expenses	129,512	16,206	301,042	446,760		446,760	215,135	661,895			21
22	Employee Benefits & Payroll Taxes			951,602	951,602		951,602	62,486	1,014,088			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,077	29,077		29,077	36,847	65,924			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			142,689	142,689		142,689	37,795	180,484			26
27	Other (specify):* Marketing	93,788	3,886	19,593	117,267		117,267	(117,267)				27
28	TOTAL General Administration	419,493	20,092	2,139,974	2,579,559		2,579,559	(229,911)	2,349,648			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,507,279	573,478	3,500,771	8,581,528		8,581,528	(241,048)	8,340,480			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wabash Christian Retirement #0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			378,947	378,947		378,947	32,574	411,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,068	59,068		59,068	(34,336)	24,732			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,028	21,028		21,028		21,028			35
36	Other (specify):* **Deferred Financing Costs**			223	223		223		223			36
37	**TOTAL Ownership**			459,266	459,266		459,266	(1,762)	457,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			601,883	601,883		601,883	(27,944)	573,939			39
40	Barber and Beauty Shops			18,546	18,546		18,546		18,546			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			306,438	306,438		306,438		306,438			42
43	Other (specify):* **Apt/Congregate**	6,785		64,643	71,428		71,428	(71,428)				43
44	**TOTAL Special Cost Centers**	6,785		991,510	998,295		998,295	(99,372)	898,923			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,514,064	573,478	4,951,547	10,039,089		10,039,089	(342,182)	9,696,907			45

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,539)	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	(34,336)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,845)	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	(186,411)	21		24
25	Fund Raising, Advertising and Promotional	(117,267)	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 Page 5A	(91,579)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (436,977)		$	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)	94,795	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 94,795		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (342,182)		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 Retirement

ID# 0020610

Report Period Beginning: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Revenue	$ (5)	21	1
2	Lobbying Expense	(1,633)	20	2
3	Transportation	(5,281)	14	3
4	Charity Care	(2,908)	21	4
5	Activity Revenue	951	11	5
6	Vending Revenue	(385)	2	6
7	Cable TV Revenue	(3,976)	5	7
8	Apt/Congregate Expenses	(78,342)	43	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**	(91,579)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	(2,924)	0	0	0	0	0	0	0	0	0	0	(2,924)	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	(3,976)	1,777	0	0	0	0	0	0	0	0	0	(2,199)	5
6	Maintenance	0	3,161	0	0	0	0	0	0	0	0	0	3,161	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,900)	4,938	0	0	0	0	0	0	0	0	0	(1,962)	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	(4,845)	0	0	0	0	0	0	0	0	0	0	(4,845)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	951	0	0	0	0	0	0	0	0	0	0	951	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	(5,281)	0	0	0	0	0	0	0	0	0	0	(5,281)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,175)	0	0	0	0	0	0	0	0	0	0	(9,175)	16
	C. General Administration													
17	Administrative	0	(529,373)	0	0	0	0	0	0	0	0	0	(529,373)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	66,099	0	0	0	0	0	0	0	0	0	66,099	19
20	Fees, Subscriptions & Promotions	(1,633)	0	0	0	0	0	0	0	0	0	0	(1,633)	20
21	Clerical & General Office Expenses	(189,324)	404,459	0	0	0	0	0	0	0	0	0	215,135	21
22	Employee Benefits & Payroll Taxes	0	62,486	0	0	0	0	0	0	0	0	0	62,486	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	36,847	0	0	0	0	0	0	0	0	0	36,847	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	37,795	0	0	0	0	0	0	0	0	0	37,795	26
27	Other (specify):*	(117,267)	0	0	0	0	0	0	0	0	0	0	(117,267)	27
28	**TOTAL General Administration**	(308,224)	78,313	0	0	0	0	0	0	0	0	0	(229,911)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(324,299)	83,251	0	0	0	0	0	0	0	0	0	(241,048)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	32,574	0	0	0	0	0	0	0	0	0	32,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34,336)	0	0	0	0	0	0	0	0	0	0	(34,336)	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**	(34,336)	32,574	0	0	0	0	0	0	0	0	0	(1,762)	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	(27,944)	0	0	0	0	0	0	0	0	0	(27,944)	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):*	(78,342)	6,914	0	0	0	0	0	0	0	0	0	(71,428)	43
44	**TOTAL Special Cost Centers**	(78,342)	(21,030)	0	0	0	0	0	0	0	0	0	(99,372)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(436,977)	94,795	0	0	0	0	0	0	0	0	0	(342,182)	45

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Horizons	100.00%	$ 1,777	$ 1,777	1
2	V	6	Maintenance				3,161	3,161	2
3	V	17	Administrative	649,584			120,211	(529,373)	3
4	V	19	Professional Services				66,099	66,099	4
5	V	21	Clerical				366,975	366,975	5
6	V	22	Employee Benefits				62,486	62,486	6
7	V	21	Dues & Subscriptions				8,021	8,021	7
8	V	24	Travel and Seiminars				36,847	36,847	8
9	V	26	Insurance				37,795	37,795	9
10	V	30	Depreciation				32,574	32,574	10
11	V	21	Other Administrative Expense				29,463	29,463	11
12	V	43	Independent Living				6,914	6,914	12
13	V	39	Pharmacy Services	526,677	Midwet Senior Ministries, Inc. d/b/a Senior Care Pharmacy	0.00%	498,733	(27,944)	13
14	Total			$ 1,176,261			$ 1,271,056	$ * 94,795	14

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	This workpaper is N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bond Fund	X		Debt Relocation	$1,603.75	3/1/05	$ 366,253	$ 177,763	9/1/11	0.0572	$ 9,394	1
2	Illinois Finance Authority		X	Renovation Projects		6/30/07	586,567	840,419	5/15/31	0.0567	6,309	2
3	Illinois Finance Authority		X	Refinance Debt		3/1/16	138,904	141,147	5/15/40	0.0500	43,365	3
4												4
5												5
	Working Capital											
6	Interest Offset										(34,336)	6
7												7
8												8
9	TOTAL Facility Related				$1,603.75		$ 1,091,724	$ 1,159,329			$ 24,732	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	$ 1,159,329			$ 24,732	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 Retirement # 0020610 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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			7,318	2
3	TOTALS	60,480		$ 64,001	3

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		40			723,806	5
6											6
7											7
8	Home Office Allocation				72,599	2,764		2,764		58,279	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	27,617		VARIOUS			27,617	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	1,650		VARIOUS			1,650	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		62,381	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	7,440		VARIOUS			7,440	24
25	2000 Fixed Assets			2000	249,473	5,955	VARIOUS	5,955		113,492	25
26	2001 Fixed Assets			2001	20,594	299	VARIOUS	299		20,492	26
27	2002 Fixed Assets			2002	19,056	834	VARIOUS	834		18,975	27
28	2003 Fixed Assets			2003	145,795	6,218	VARIOUS	6,218		130,759	28
29	2004 Fixed Assets			2004	248,664	13,214	VARIOUS	13,214		218,718	29
30	2005 Fixed Assets			2005	249,116	7,647	VARIOUS	7,647		216,877	30
31	2006 Fixed Assets			2006	86,373	3,091	VARIOUS	3,091		62,824	31
32	2007 Fixed Assets			2007	122,583	9,771	VARIOUS	9,771		120,687	32
33	2008 Fixed Assets			2008	334,947	33,435	VARIOUS	33,435		297,536	33
34	2009 Fixed Assets			2009	187,337	18,734	VARIOUS	18,734		143,314	34
35	New screens for gutters			2010	2,700	270	10	270		2,025	35
36	Sprinkler System			2010	112,380	11,238	10	11,238		84,285	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		$ 4,763,574	$ 182,910		$ 182,910	$	$ 3,847,778	1
2	Front Office Inpro Wall Covering	2013	4,730	946	5	946		3,548	2
3	Install of Walk-in Cooler/Freezer Comb	2013	36,623	2,442	15	2,442		8,749	3
4	Replace 6in Sewer Main sidewalk	2013	5,594	224	25	224		876	4
5	Replace kitchen drain	2014	5,400	540	10	540		1,665	5
6	IS3200 Door Kit Accutech	2014	4,286	429	10	429		1,357	6
7	Install vinyl family room	2014	2,000	200	10	200		550	7
8	Install vinyl flooring	2014	2,450	245	10	245		674	8
9	Sealcoat parking lot	2014	6,715	959	7	959		2,798	9
10	Install Generator Steel door	2015	1,345	134	10	134		303	10
11	TheraPure Tub w/Lift	2015	13,185	1,319	10	1,319		2,966	11
12	MC Wing Bathroom doors 305, 306 &307	2015	1,476	148	10	148		320	12
13	Install 5' Shower	2015	3,511	351	10	351		761	13
14	Wallpaper in main lobby & back hall	2015	1,325	133	10	133		298	14
15	Remove asbestos	2015	13,650	1,365	10	1,365		2,844	15
16	Wing 6 new flooring	2015	19,840	1,984	10	1,984		4,133	16
17	Remodel of bathrooms 1,2 & 3	2015	24,453	2,445	10	2,445		4,891	17
18	Install vinyl flooring MC bathrooms (3)	2015	600	60	10	60		120	18
19	Room 305 vinyl flooring	2015	496	50	10	50		99	19
20	Relocate Fire sprinklers heads	2015	439	44	10	44		88	20
21	Install toilet rails MC bathrooms	2015	782	78	10	78		156	21
22	MC Wing bathrooms wallcovering 1-3	2015	1,312	131	10	131		262	22
23	Curved Tops and Cabinet Tops, Backsplash	2015	10,577	1,058	10	1,058		2,115	23
24	Office Flooring - Dietary	2015	596	60	10	60		120	24
25	Front Lobby office Vinyl Flooring	2015	594	59	10	59		100	25
26	Boiler/HVAC, Pumps, Tanks, Piping	2015	42,750	4,275	10	4,275		7,481	26
27	Remove Asbestos Tile and Glue	2015	22,204	2,221	10	2,221		3,701	27
28	Dining Flooring - Tavertine	2015	27,693	2,769	10	2,769		4,616	28
29	Drywall finishing & supplies New offices	2016	6,924	692	10	692		981	29
30	Countertop for new office	2016	116	12	10	12		16	30
31	Cove base new offices	2016	300	30	10	30		43	31
32	Replace sprinker head @ new office	2016	442	44	10	44		63	32
33	Install new locks New offices	2016	261	26	10	26		37	33
34	TOTAL (lines 1 thru 33)		$ 5,026,242	$ 208,383		$ 208,383	$	$ 3,904,509	34

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	New Roof - SNF	2010	$ 163,717	$ 8,186	20	$ 8,186	$	$ 58,665	37
38	Beauty Shop Exit Door	2010	7,859	786	10	786		5,305	38
39	Convert Activity Room	2010	4,382	438	10	438		2,958	39
40	Wing 1 - Bathroom	2010	67,815	6,782	10	6,782		47,471	40
41	LSC Corrections	2010	22,567	2,257	10	2,257		15,797	41
42	Dining Room - Fire Doors	2010	4,900	490	10	490		3,267	42
43	Parking Lot	2010	34,607	3,461	10	3,461		23,360	43
44	Medical Records Storage Shed	2010	7,054	705	10	705		4,702	44
45	PTAC Units	2011	7,046	705	10	705		4,521	45
46	Delta Lavatory Faucets - Wide	2011	4,084	408	10	408		2,621	46
47	Delta Lavatory Faucets - Regular	2011	1,227	123	10	123		787	47
48	Room 301 - Bathroom remodel	2011	5,858	586	10	586		3,808	48
49	Room 302 - Bathroom Remodel	2011	8,598	860	10	860		5,589	49
50	Room 303 - Bathroom Remodel	2011	8,648	865	10	865		5,621	50
51	Wing 3 - Asbestos Removal	2011	12,348	1,235	10	1,235		7,923	51
52	Wing 3 - Refurb	2011	1,751	175	10	175		1,138	52
53	Wing 3 - Fixtures	2011	426	43	10	43		273	53
54	Wing 3 - Flooring	2011	14,485	1,448	10	1,448		9,174	54
55	Wing 2 - HVACs	2011	5,062	506	10	506		3,079	55
56	Boiler section module, piping valves,	2011	9,790	1,632	6	1,632		9,110	56
57	Haven Water Damage-restore floors, wal	2011	47,843	4,784	10	4,784		27,111	57
58	Sealcoat Parking Lot and stripe	2011	2,503		3			2,503	58
59	Medical Building Fire Suppression	2011	6,752	675	10	675		4,051	59
60	WEIL MCCAIN 550 ULTRA BOILERS	2012	84,800	4,240	20	4,240		20,140	60
61	LANDSCAPING PAVERS AND PLANTS	2012	2,672	267	10	267		1,269	61
62	Therapy Gym	2013	306,000	18,715	Various	18,715		84,216	62
63	Electric - Sewer Grinder	2013	5,354	357	15	357		1,547	63
64	10 Ton A/C Roof Unit for Dining Room	2013	6,471	647	10	647		2,588	64
65	Kitchen - (20) 4ft LED Ceiling Lights	2013	5,480	365	15	365		1,431	65
66	Kitchen - Overhead Lights	2013	548	37	15	37		134	66
67	Carpet - Front Office & Conference Roo	2013	3,496	699	5	699		2,622	67
68	Front Entrance - Remodel Railings	2013	2,678	268	10	268		1,027	68
69	Hot Water Heater & Storage Tank	2013	39,447	3,945	10	3,945		15,121	69
70	TOTAL (lines 4 thru 69)		$ 4,763,574	$ 182,910		$ 182,910	$	$ 3,847,778	70

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		$ 5,026,242	$ 208,383		$ 208,383	$	$ 3,904,509	1
2	CP216 Kinetico Water Softner System	2016	3,000	300	10	300		400	2
3	Fire Evacuation floor signs	2016	600	60	10	60		80	3
4	Const. of New Exterior Shed	2016	70,127	7,013	10	7,013		8,766	4
5	Concrete for Bocceball Court	2016	1,805	90	20	90		90	5
6	Install Sprinkler @ Assistant Admin offi	2016	2,027	203	10	203		203	6
7	Flooring office	2016	1,236	103	10	103		103	7
8	Emergency Gas Shut off & Switches	2016	1,775	104	10	104		104	8
9	Wing 2 and Wing 4 - Bathrooms, New Vinyl Flooring, Toilets, Ligl	2017	119,953	4,998	10	4,998		4,998	9
10	Unit 501 Vinyl Flooring	2017	1,995	50	10	50		50	10
11	New Carpet - Wing 3 Hallway	2017	22,180	185	10	185		185	11
12	New Carpet - Wing 7 Hallway	2017	22,712	189	10	189		189	12
13	Med Room cabinets & countertops	2017	7,257	60	10	60		60	13
14	30 New Doors for Wing 1-4	2017	9,562	80	10	80		80	14
15	Carpet Wing 8 Hallway & Magnolia Parlor	2017	31,007	258	10	258		258	15
16	Embossed Steel garage door Maint. Shed	2017	1,402	12	10	12		12	16
17	46 New Doors for Wing 5-8	2017	13,664	114	10	114		114	17
18	Main Entrance Mats 4x6 (11)	2017	2,571	21	10	21		21	18
19		2017			10				19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Rounding		4	(5)		(5)			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,339,117	$ 222,217		$ 222,217	$	$ 3,920,222	34

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,077,502	$ 142,895	$ 142,895	$		$ 656,981	71
72	Current Year Purchases	90,041	11,097	11,097			11,097	72
73	Fully Depreciated Assets	387,616					387,616	73
74	Home Office Allocation	237,793	28,614	28,614			181,318	74
75	TOTALS	$ 1,792,952	$ 182,606	$ 182,606	$		$ 1,237,012	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	$ 5,502	$ 5,502	$		$ 95,097	76
77										77
78										78
79	Home Office Allocation			10,512	1,196	1,196			8,948	79
80	TOTALS			$ 114,732	$ 6,698	$ 6,698	$		$ 104,045	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)	$ 7,310,802	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 411,521	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 411,521	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)	$ 5,261,279	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	555,664	19,399	443,782	87
88					88
89					89
90					90
91	TOTALS	$ 564,891	$ 19,399	$ 443,782	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 4,348	92
93	Home Office Allocation	16,928	93
94			94
95		$ 21,276	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 21,028 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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	8,800	$ 405,543	$	8,800	$ 405,543	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,607	153,970		2,607	153,970	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		11,697	471,778		11,697	471,778	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				515,438		515,438	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						33,008		33,008	12
13	Other (specify): Radiology						25,493		25,493	13
14	TOTAL			$	23,104	$ 1,031,291	$ 573,939	23,104	$ 1,605,230	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Wabash Christian Retirement **#** 0020610 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/17 **(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	$ 10,644	$	1
2	Cash-Patient Deposits	17,922		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (196,256))	2,035,528		3
4	Supply Inventory (priced at)	12,664		4
5	Short-Term Investments	1,671,918		5
6	Prepaid Insurance	18,104		6
7	Other Prepaid Expenses	13,079		7
8	Accounts Receivable (owners or related parties)	5,068,539		8
9	Other(specify):	404,324		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,252,722	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	5,721,425		14
15	Leasehold Improvements, at Historical Cost	213,507		15
16	Equipment, at Historical Cost	1,546,629		16
17	Accumulated Depreciation (book methods)	(5,456,516)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	17,863		21
22	Other Long-Term Assets (spe CIP	4,348		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,113,166	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,365,888	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,922		28
29	Short-Term Notes Payable	9,748		29
30	Accrued Salaries Payable	256,716		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 291,263	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,159,329		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	30,617		43
44	Other Liabilities	162,960		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,352,906	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,644,169	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,721,719	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,365,888	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,781,049	1
2	Restatements (describe):		2
3	**Prior Year Correction**	(10,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,771,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(49,335)	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) **Changes in Temp Restricted Net Assets**		15
16	Other (describe) **Rounding**	5	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (49,330)	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)**	$ 9,721,719	24 *

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 7,772,964	1
2	Discounts and Allowances for all Levels	(5,742,029)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,030,935	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,485,066	6
7	Oxygen	23,781	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,508,847	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	22,563	13
14	Non-Patient Meals	2,539	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	769,848	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,056	19
20	Radiology and X-Ray	50,458	20
21	Other Medical Services	190,299	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,092,763	23
	D. Non-Operating Revenue		
24	Contributions	114,737	24
25	Interest and Other Investment Income***	34,335	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 149,072	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	88,983	28
28a	Miscellaneous	119,154	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 208,137	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,989,754	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,349,220	31
32	Health Care	4,652,749	32
33	General Administration	2,579,559	33
	B. Capital Expense		
34	Ownership	459,266	34
	C. Ancillary Expense		
35	Special Cost Centers	691,857	35
36	Provider Participation Fee	306,438	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,039,089	40
41	**Income before Income Taxes (line 30 minus line 40)****	(49,335)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (49,335)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,336,497	44
45	Private Pay - Net Inpatient Revenue	1,685,419	45
46	Medicare - Net Inpatient Revenue	(1,352,165)	46
47	Other-(specify) HMO/Med Adv/Part B	(1,463,837)	47
48	Other-(specify) Nursing	(174,979)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,030,935	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 Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	2,952	3,176	$ 109,460	$ 34.46	1
2	Assistant Director of Nursing	1,768	1,996	53,434	26.77	2
3	Registered Nurses	23,333	25,221	602,037	23.87	3
4	Licensed Practical Nurses	40,145	42,994	803,182	18.68	4
5	CNAs & Orderlies	114,323	124,468	1,468,282	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,114	2,195	27,569	12.56	9
10	Activity Assistants	9,614	10,566	91,648	8.67	10
11	Social Service Workers	11,182	12,011	178,161	14.83	11
12	Dietician					12
13	Food Service Supervisor	1,737	1,959	30,539	15.59	13
14	Head Cook	6,139	6,505	74,316	11.42	14
15	Cook Helpers/Assistants	24,371	26,137	250,639	9.59	15
16	Dishwashers					16
17	Maintenance Workers	6,784	7,164	136,641	19.07	17
18	Housekeepers	15,406	16,891	164,287	9.73	18
19	Laundry	6,971	7,436	74,063	9.96	19
20	Administrator	1,862	2,037	133,686	65.63	20
21	Assistant Administrator	1,927	2,135	62,507	29.28	21
22	Other Administrative					22
23	Office Manager	3,119	3,273	47,371	14.47	23
24	Clerical	7,086	7,653	82,141	10.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,004	2,179	23,528	10.80	31
32	Other Health C: Marketing	4,932	5,334	93,788	17.58	32
33	Other(specify) Apt/Congregate	250	512	6,785	13.25	33
34	TOTAL (lines 1 - 33)	288,019	311,842	$ 4,514,064 *	$ 14.48	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	277	$ 14,097	V01-3	35
36	Medical Director	72	9,600	V09-3	36
37	Medical Records Consultant	26	1,038	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	3,680	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	70	5,170	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	613	$ 33,585		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	136	$ 9,699	V10-3	50
51	Licensed Practical Nurses	664	30,745	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	800	$ 40,444		53

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bryant	Administrator	0	$ 133,686
Andrea May	Asst Administrator	0	62,507
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 196,193

B. Administrative - Other

Description	Amount
Management Fees	$ 649,584
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 649,584

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 4,256
Polsinelli Shughart	Legal	733
National Research	Professional Services	1,642
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 6,631

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,470
Unemployment Compensation Insurance	(1,670)
FICA Taxes	320,351
Employee Health Insurance	516,704
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	10,636
Employee Uniforms	(1,391)
Employee Expense	14,003
457 Plan Expense	5,499
Home Office Allocation	62,486
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,014,088

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 348)	
Patient Background Checks	3,480
License	6,870
Dues	9,292
Subscriptions	18,481
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,123

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,986
In-State Travel	20,215
Seminar Expense	1,876
Home Office Allocation	36,847
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 65,924

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/16 Ending: 6/30/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LEADING AGE- $10,207**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,364** 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. $ **306,438**
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. $ **NON** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,539**

(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. $ **10,498**
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