FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0026955

Facility Name: Washington Christian Village

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

County: Tazewell

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1982

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 Washington Christian Village # 0026955 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	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,839	7,231	7,645	30,715	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,839	7,231	7,645	30,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.98%

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, Lawn & Maint Care, Housekeeping & Luandry Services for IL Residents

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/1982

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 5,625

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 Washington Christian Village # 0026955 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	189,266	12,171	7,864	209,301		209,301		209,301			1
2	Food Purchase		206,912		206,912		206,912	(365)	206,547			2
3	Housekeeping	105,099	21,450		126,549		126,549		126,549			3
4	Laundry	41,281	5,674		46,955		46,955		46,955			4
5	Heat and Other Utilities			95,222	95,222		95,222	1,313	96,535			5
6	Maintenance	86,268	8,802	30,511	125,581		125,581	2,335	127,916			6
7	Other (specify):* Trash			9,499	9,499		9,499		9,499			7
8	TOTAL General Services	421,914	255,009	143,096	820,019		820,019	3,283	823,302			8
	B. Health Care and Programs											
9	Medical Director			23,550	23,550		23,550		23,550			9
10	Nursing and Medical Records	2,197,162	115,244	218,296	2,530,702		2,530,702	(2,949)	2,527,753			10
10a	Therapy			679,898	679,898		679,898		679,898			10a
11	Activities	74,521	1,719	1,390	77,630		77,630		77,630			11
12	Social Services	128,428	351	1,603	130,382		130,382		130,382			12
13	CNA Training											13
14	Program Transportation			6,234	6,234		6,234		6,234			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,400,111	117,314	930,971	3,448,396		3,448,396	(2,949)	3,445,447			16
	C. General Administration											
17	Administrative	103,888		599,320	703,208		703,208	(510,525)	192,683			17
18	Directors Fees											18
19	Professional Services			43,408	43,408		43,408	48,824	92,232			19
20	Dues, Fees, Subscriptions & Promotions			38,667	38,667		38,667	(1,381)	37,286			20
21	Clerical & General Office Expenses	96,631	6,369	271,033	374,033		374,033	109,446	483,479			21
22	Employee Benefits & Payroll Taxes			648,483	648,483		648,483	46,155	694,638			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,998	17,998		17,998	27,218	45,216			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			122,539	122,539		122,539	27,918	150,457			26
27	Other (specify):* Marketing	64,907	5,591	11,085	81,583		81,583	(81,583)				27
28	TOTAL General Administration	265,426	11,960	1,752,533	2,029,919		2,029,919	(333,928)	1,695,991			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,087,451	384,283	2,826,600	6,298,334		6,298,334	(333,594)	5,964,740			29

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

Facility Name & ID Number Washington Christian Village #0026955 Report Period Beginning: 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			325,600	325,600		325,600	24,061	349,661			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,223	168,223		168,223	(3,324)	164,899			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,706	18,706		18,706		18,706			35
36	Other (specify):* **Def Financing Cost**			1,018	1,018		1,018		1,018			36
37	**TOTAL Ownership**			513,547	513,547		513,547	20,737	534,284			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			375,618	375,618		375,618	(15,585)	360,033			39
40	Barber and Beauty Shops	13,181	312		13,493		13,493		13,493			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,673	218,673		218,673		218,673			42
43	Other (specify):* **IL Duplex**	5,363		110,825	116,188		116,188	(116,188)				43
44	**TOTAL Special Cost Centers**	18,544	312	705,116	723,972		723,972	(131,773)	592,199			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,105,995	384,595	4,045,263	7,535,853		7,535,853	(444,630)	7,091,223			45

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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				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	(3,324)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,949)	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	(139,415)	21		24
25	Fund Raising, Advertising and Promotional	(81,583)	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	(172,935)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (400,206)		$	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)	(44,424)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,424)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (444,630)		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

Washington Christian Village

ID# 0026955

Report Period Beginning: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (365)	2	1
2	Lobbying Expense	(1,381)	20	2
3	Fines & Penalties	(50,000)	21	3
4	Late Fees	(66)	21	4
5	Duplex	(121,123)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(172,935)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village # 0026955 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(365)	0	0	0	0	0	0	0	0	0	0	(365)	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	0	1,313	0	0	0	0	0	0	0	0	0	1,313	5
6	Maintenance	0	2,335	0	0	0	0	0	0	0	0	0	2,335	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(365)	3,648	0	0	0	0	0	0	0	0	0	3,283	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	(2,949)	0	0	0	0	0	0	0	0	0	0	(2,949)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,949)	0	0	0	0	0	0	0	0	0	0	(2,949)	16
	C. General Administration													
17	Administrative	0	(510,525)	0	0	0	0	0	0	0	0	0	(510,525)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	48,824	0	0	0	0	0	0	0	0	0	48,824	19
20	Fees, Subscriptions & Promotions	(1,381)	0	0	0	0	0	0	0	0	0	0	(1,381)	20
21	Clerical & General Office Expenses	(189,481)	298,927	0	0	0	0	0	0	0	0	0	109,446	21
22	Employee Benefits & Payroll Taxes	0	46,155	0	0	0	0	0	0	0	0	0	46,155	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	27,218	0	0	0	0	0	0	0	0	0	27,218	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	27,918	0	0	0	0	0	0	0	0	0	27,918	26
27	Other (specify):*	(81,583)	0	0	0	0	0	0	0	0	0	0	(81,583)	27
28	**TOTAL General Administration**	(272,445)	(61,483)	0	0	0	0	0	0	0	0	0	(333,928)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(275,759)	(57,835)	0	0	0	0	0	0	0	0	0	(333,594)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Christian Village **#** 0026955 **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	24,061	0	0	0	0	0	0	0	0	0	24,061	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,324)	0	0	0	0	0	0	0	0	0	0	(3,324)	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**	(3,324)	24,061	0	0	0	0	0	0	0	0	0	20,737	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	(15,585)	0	0	0	0	0	0	0	0	0	(15,585)	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):*	(121,123)	4,935	0	0	0	0	0	0	0	0	0	(116,188)	43
44	**TOTAL Special Cost Centers**	(121,123)	(10,650)	0	0	0	0	0	0	0	0	0	(131,773)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(400,206)	(44,424)	0	0	0	0	0	0	0	0	0	(444,630)	45

Facility Name & ID Number Washington Christian Village # 0026955 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%	$ 1,313	$ 1,313	1
2	V	6	Maintenance				2,335	2,335	2
3	V	17	Administrative	599,320			88,795	(510,525)	3
4	V	19	Professional Services				48,824	48,824	4
5	V	21	Clerical				271,239	271,239	5
6	V	22	Employee Benefits				46,155	46,155	6
7	V	21	Dues & Subscriptions				5,925	5,925	7
8	V	24	Travel and Seminars				27,218	27,218	8
9	V	26	Insurance				27,918	27,918	9
10	V	30	Depreciation				24,061	24,061	10
11	V	21	Other Administrative Expense				21,763	21,763	11
12	V	43	Independent Living				4,935	4,935	12
13	V	39	Pharmacy Services	293,743	Midwest Senior Ministries, Inc. d/b/a Senior Care Pharmacy	0.00%	278,158	(15,585)	13
14	Total			$ 893,063			$ 848,639	$ * (44,424)	14

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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
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27								27
28								28
29								29
30								30

Facility Name & ID Number Washington Christian Village # 0026955 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 Washington Christian Village # 0026955 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 [X]

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 Washington Christian Village # 0026955 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** 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		Refinance Debt	Various	Various	$ 4,409,251	$ 2,332,088	6/30/32	0.0572	$ 107,399	1
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	1,500,000	339,595	5/15/27	0.0600	15,542	2
3	Illinois Finance Authority		X	Refinance Debt		6/30/07	364,417	484,031	5/15/31	0.0567	23,597	3
4	Illinois Finance Authority		X	Refinance Debt		3/1/16	634,172	656,894	5/15/40	0.0500	21,685	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,907,840	$ 3,812,608			$ 168,223	9
	B. Non-Facility Related*											
10	Interest Income Offset										(3,324)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,324)	14
15	TOTALS (line 9+line14)						$ 6,907,840	$ 3,812,608			$ 164,899	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 Washington Christian Village **#** 0026955 **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 Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 314-587-7916

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.	02-02-14-300-021	1110 New Castle Rd	$ 19,114.88	$
2.	02-02-14-308-001	1104 Kingsbury Rd	$ 4,771.70	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,886.58	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Washington Christian Village # 0026955 Report Period Beginning: 7/1/16 Ending: 6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,484 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

Duplexes

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,484	1982	$ 50,000	1
2	Home Office Allocation			5,405	2
3	TOTALS	38,484		$ 55,405	3

Facility Name & ID Number Washington Christian Village # 0026955 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	122		1982		$ 1,203,052	$ 22,962	35	$ 22,962	$	$ 1,200,235	4
5											5
6											6
7											7
8	Home Office Allocation				53,626	2,041		2,041		43,048	8
	Improvement Type**										
9	1982 Fixed Assets			1982	33,562	362	Various	362		33,530	9
10	1983 Fixed Assets			1983	34,486	985	Various	985		33,993	10
11	1984 Fixed Assets			1984	231	7	Various	7		220	11
12	1985 Fixed Assets			1985	361,565	10,330	Various	10,330		335,513	12
13	1988 Fixed Assets			1988	4,693	106	Various	106		4,084	13
14	1996 Fixed Assets			1996	950		Various			950	14
15	1998 Fixed Assets			1998	1,307		Various			1,307	15
16	2001 Fixed Assets			2001	1,371	10	Various	10		1,361	16
17	2002 Fixed Assets			2002	50,136	6,491	Various	6,491		46,022	17
18	2003 Fixed Assets			2003	34,619	2,308	Various	2,308		32,128	18
19	2004 Fixed Assets			2004	580		Various			580	19
20	2005 Fixed Assets			2005	214,251	4,556	Various	4,556		173,247	20
21	2006 Fixed Assets			2006	202,900	9,166	Various	9,166		116,750	21
22	2007 Fixed Assets			2007	190,071	10,689	Various	10,689		104,160	22
23	2008 Fixed Assets			2008	76,797	7,680	Various	7,680		69,883	23
24	2009 Fixed Assets			2009	211,981	21,198	Various	21,198		176,002	24
25	SNF Window Replacement			2010	17,590	1,759	10	1,759		12,753	25
26	New Flooring - EE Lounge & Front Entry			2010	12,526	1,253	10	1,253		8,873	26
27	Service & Conference Room Doors			2010	6,439	644	10	644		4,239	27
28	Front Doors			2010	11,098	1,110	10	1,110		7,584	28
29	AC for Business & Admin Office			2010	5,590	559	10	559		3,913	29
30	SW Dining Rm Floor			2010	4,885	488	10	488		3,419	30
31	Radiator Covers - Resident Rooms			2010	4,218	422	10	422		2,953	31
32	Sw Dining Rm Remodel			2010	4,250	425	10	425		2,975	32
33	Therapy Gym Remodel			2010	125,416	12,542	10	12,542		87,791	33
34	Front Door Remodel			2010	4,895	490	10	490		3,427	34
35	Parking Lot & Drive Resurface			2010	35,400	3,540	10	3,540		25,075	35
36	Landscaping Front & Therapy Patios			2010	17,815	1,782	10	1,782		12,322	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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	Sealcoat East Parking Lot	2010	$ 3,950	$ 395	10	$ 395	$	$ 2,633	37
38	Replace Front Sidewalk & Approach	2010	3,195	320	10	320		2,237	38
39	Double Side Front Sign	2010	7,417	742	10	742		5,192	39
40	Car/Bus Port	2010	6,555	656	10	656		4,807	40
41	Roof where NE wing meets NW wing	2011	2,952	295	10	295		1,845	41
42	Ceramic for EE rest rooms	2011	3,003	300	10	300		1,877	42
43	Topography of west apt land	2011	3,340	334	10	334		2,088	43
44	60 gal, 120K BTU water heater	2011	6,448	645	10	645		4,138	44
45	B&G hot water circulating pump & kit	2011	3,635	364	10	364		2,363	45
46	Radiator Covers	2011	8,050	805	10	805		4,897	46
47	Paint 31 doors & frames SE Hall	2011	3,318	332	10	332		2,018	47
48	Paint 34 doors & frames SW Hall	2011	3,639	364	10	364		2,214	48
49	Remove Wallpaper & Paint Resident Room	2011	10,194	1,019	10	1,019		6,201	49
50	Remove Wallpaper & Paint SW Hall	2011	1,160	116	10	116		706	50
51	Remove wallpaper & paint SE Hall	2011	1,160	116	10	116		706	51
52	Paint Bathrooms 107, 110, 141, 147, 14	2011	1,200	120	10	120		730	52
53	Cultered Marble Top 12 SE Units	2011	2,750	275	10	275		1,673	53
54	Rm 105 & 108 Vanity top, apron & legs	2011	1,320	132	10	132		803	54
55	Rm 107 & 110 Vanity top, apron & legs	2011	1,542	154	10	154		938	55
56	Cove Base All Areas	2011	9,601	960	10	960		5,841	56
57	Flooring 10 Resident Bathrooms	2011	5,622	562	10	562		3,420	57
58	Carpet Powerbond Corridors	2011	34,689	3,469	10	3,469		21,103	58
59	Carpet for 19 Resident Rooms	2011	24,111	2,411	10	2,411		14,668	59
60	Dining Room - Armstrong Vinyl Flooring	2011	24,981	2,498	10	2,498		15,197	60
61	Build soffit around exposed piping	2011	4,230	423	10	423		2,573	61
62	Floor Preparation - Ardex skim coat	2011	15,000	1,500	10	1,500		9,125	62
63									63
64	Tile - Bath off north center hall	2011	3,322	332	10	332		2,021	64
65	Counters - Activity Room	2011	2,528	253	10	253		1,517	65
66	Courtyard Landscaping (Fountain, Trees	2011	4,100	410	10	410		2,426	66
67	Window Tinting Front of Building & Reh	2011	2,845	285	10	285		1,683	67
68									68
69	Prime & Paint Interior Doors	2011	3,538	354	10	354		2,211	69
70	TOTAL (lines 4 thru 69)		$ 3,135,695	$ 144,846		$ 144,846	$	$ 2,678,188	70

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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		$ 3,135,695	$ 144,846		$ 144,846	$	$ 2,678,188	1
2	Prime Paint Doors Frames NW Hallway	2011	6,861	686	10	686		4,288	2
3	Prep & Paint, Laundry Rm, Hallway Doors	2011	1,286	129	10	129		793	3
4	Prep & Paint Center Hall	2011	1,460	146	10	146		888	4
5	Prep & Paint Doors NE Lounge	2011	321	32	10	32		195	5
6	Prep & Paint Walls NE Lounge	2011	400	40	10	40		243	6
7	Prep & Paint NE & NW Hallways	2011	3,250	325	10	325		1,977	7
8	Prime & Paint Doors, Frames Center Hall	2011	3,330	333	10	333		2,026	8
9	Prep & Paint Shower Room	2011	550	55	10	55		335	9
10	Remodel 5 offices, Baseboard, chair rail	2011	6,541	654	10	654		3,979	10
11	Prep. Paint Admin, DON, Business	2011	2,550	255	10	255		1,551	11
12	Cabinets - North Nurse Station	2011	7,864	786	10	786		4,784	12
13	15' Wall Demential Dining Area	2011	4,457	446	10	446		2,711	13
14	Refurbish 18 Resident Rm & Bathrooms	2011	26,211	2,621	10	2,621		15,945	14
15	NE Corridor air distribustion system,	2012	65,610	4,755	20	4,755		26,249	15
16	Patio Concrete Pad 30'x12'`	2012	2,520	168	15	168		868	16
17	R&R Shower Floor Southwest Hall	2012	3,552	178	20	178		888	17
18	2 Fire Doors & Block Wall Generator Rm	2013	5,140	257	20	257		1,135	18
19	12x12 Gazebo Chapel Courtyard	2013	6,731	449	15	449		1,832	19
20	100' White Vinyl Fencing Chapel Courtyar	2013	3,870	258	15	258		1,054	20
21	Install A/C unit dietary area	2014	7,805	781	10	781		2,472	21
22	100 gallon water heater	2015	5,900	590	10	590		1,328	22
23	SW Entrance door replacement	2015	5,067	507	10	507		1,140	23
24	Painting, Wall Art/Decor, Cabinets	2015	8,551	855	10	855		1,710	24
25	HVAC/AC Unit	2015	12,540	1,254	10	1,254		2,508	25
26	100 Gallon Natural Gas Water Heater	2015	6,175	618	10	618		1,235	26
27	Remove Sod, Brick Edging, Plants	2015	12,297	615	20	615		1,230	27
28	SE & SW bathroom flooring and wall tiling	2015	22,589	2,259	10	2,259		4,518	28
29	Install Brick edging @ Chapel courtyard	2015	17,562	878	20	878		1,610	29
30	SE bathroom-plumbing for new valves, piping for new lavatory	2015	1,486	149	10	149		272	30
31	South Hall Haper Confetti fabric Valances	2015	3,374	337	10	337		619	31
32	South Hall Labyrinth Cool blue Valances	2015	2,209	221	10	221		405	32
33	South Hall Painting project	2016	14,325	1,433	10	1,433		2,149	33
34	TOTAL (lines 1 thru 33)		$ 3,408,079	$ 167,916		$ 167,916	$	$ 2,771,125	34

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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		$ 3,408,079	$ 167,916		$ 167,916	$	$ 2,771,125	1
2	Staff Lounge 60" sink w/cooktop counters	2016	515	52	10	52		77	2
3	NW Shower Rooms- floor and wall tiling	2016	9,333	933	10	933		1,322	3
4	SE & SW hallways Flooring	2016	70,950	7,095	10	7,095		10,051	4
5	New Blower Motor on Boiler #2	2016	3,407	341	10	341		483	5
6	Install 30x18 Wall cabinet (3)	2016	763	76	10	76		108	6
7	Staff lounge vinyl wood floor	2016	889	89	10	89		126	7
8	Saff lounge Box lockers (24)	2016	896	90	10	90		119	8
9	Room Signs for SE & SW hall rooms	2016	971	97	10	97		121	9
10	SW Parking lot asphalt	2016	15,700	785	20	785		850	10
11	Rubber Roof @ WCV	2016	14,684	1,468	10	1,468		1,591	11
12	New Gutters Unit 1115-1123	2016	3,282	301	10	301		301	12
13	AC Unit therapy dept. north 1 1/2 ton	2016	8,950	820	10	820		820	13
14	TV Rec Room Mitsubishi AC Unit	2016	6,690	613	10	613		613	14
15	North Hall Remodel Flooring & painting	2016	61,930	3,613	10	3,613		3,613	15
16	North Hall Privacy Curtains & blinds	2017	13,890	116	10	116		116	16
17	Building small LED wall mount lights	2017	2,925	24	10	24		24	17
18	Staff lounge AC-Air Handler Unit	2017	17,490	146	10	146		146	18
19	Adjust for Rounding		(1)	(5)		(5)		(4)	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)		$ 3,641,343	$ 184,570		$ 184,570	$	$ 2,791,602	34

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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	$ 1,037,126	$ 127,738	$ 127,738	$		$ 585,802	71
72	Current Year Purchases	97,314	13,856	13,856			13,856	72
73	Fully Depreciated Assets	118,999					118,999	73
74	Home Office Allocation	175,647	21,136	21,136			133,932	74
75	TOTALS	$ 1,429,086	$ 162,730	$ 162,730	$		$ 852,589	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	Patient Transportation	2009 Ford Econoline Getaway Va	2009	$ 47,976	$ 1,477	$ 1,477	$	4	$ 43,545	76
77										77
78										78
79	Home Office Allocation			7,765	883	883			6,609	79
80	TOTALS			$ 55,741	$ 2,360	$ 2,360	$		$ 50,154	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,181,575	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 349,660	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 349,660	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,694,345	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 120,656	$	$	86
87	Duplex	302,559	11,206	278,983	87
88					88
89					89
90					90
91	TOTALS	$ 423,215	$ 11,206	$ 278,983	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 381,581	92
93	Home Office Allocation	12,504	93
94			94
95		$ 394,085	95

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

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 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: $ 18,706 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 Washington Christian Village # 0026955 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.

   WCV 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.

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	$	5,642	$ 293,561	$	5,642	$ 293,561	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,680	74,412		1,680	74,412	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		8,220	311,925		8,220	311,925	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				316,855		316,855	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						29,878		29,878	12
13	Other (specify): Radiology						13,300		13,300	13
14	TOTAL			$	15,542	$ 679,898	$ 360,033	15,542	$ 1,039,931	14

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

STATE OF ILLINOIS

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** 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	$ 13,082	$	1
2	Cash-Patient Deposits	15,873		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 166,221)	1,282,804		3
4	Supply Inventory (priced at)	6,551		4
5	Short-Term Investments	130,071		5
6	Prepaid Insurance	13,227		6
7	Other Prepaid Expenses	11,050		7
8	Accounts Receivable (owners or related parties)	4,433,310		8
9	Other(specify): Other AR/ Acc Int Rec	21,331		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,927,299	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	3,980,171		14
15	Leasehold Improvements, at Historical Cost	169,742		15
16	Equipment, at Historical Cost	1,041,777		16
17	Accumulated Depreciation (book methods)	(3,789,739)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	817,601		21
22	Other Long-Term Assets (spe CIP	381,581		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,771,789	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,699,088	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,873		28
29	Short-Term Notes Payable	32,022		29
30	Accrued Salaries Payable	181,269		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,111		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)**	$ 239,275	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,812,608		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Other Liabilities	133,319		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,945,927	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,185,202	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,513,886	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,699,088	$	48

***(See instructions.)**

Facility Name & ID Number Washington Christian Village **#** 0026955 **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**	$ 4,625,061	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,625,061	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,181)	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) **Rounding**	6	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (111,175)	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)**	$ 4,513,886	24 *

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

Facility Name & ID Number Washington Christian Village # 0026955 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	$ 7,844,009	1
2	Discounts and Allowances for all Levels	(5,538,212)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,305,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,332,210	6
7	Oxygen	11,897	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,344,107	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	15,355	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	433,120	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,144	19
20	Radiology and X-Ray	25,216	20
21	Other Medical Services	140,159	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 672,994	23
	D. Non-Operating Revenue		
24	Contributions	34,215	24
25	Interest and Other Investment Income***	3,324	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,539	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	IL Duplex Revenue	57,780	28
28a	Misc Revenue	6,455	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 64,235	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,424,672	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	820,019	31
32	Health Care	3,448,396	32
33	General Administration	2,029,919	33
	B. Capital Expense		
34	Ownership	513,547	34
	C. Ancillary Expense		
35	Special Cost Centers	505,299	35
36	Provider Participation Fee	218,673	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,535,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	(111,181)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (111,181)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,448,556	44
45	Private Pay - Net Inpatient Revenue	1,377,132	45
46	Medicare - Net Inpatient Revenue	(1,420,915)	46
47	Other-(specify) HMO/Med Advantage	(98,976)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,305,797	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 Washington Christian Village # 0026955 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	1,864	2,104	$ 92,907	$ 44.16	1
2	Assistant Director of Nursing	1,596	1,832	54,657	29.83	2
3	Registered Nurses	20,036	20,889	523,499	25.06	3
4	Licensed Practical Nurses	15,757	17,133	389,789	22.75	4
5	CNAs & Orderlies	82,754	88,448	1,110,801	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,627	1,910	32,845	17.20	9
10	Activity Assistants	3,879	4,153	41,676	10.04	10
11	Social Service Workers	6,987	7,597	128,428	16.91	11
12	Dietician					12
13	Food Service Supervisor	1,926	2,096	37,407	17.85	13
14	Head Cook	5,008	5,302	54,105	10.20	14
15	Cook Helpers/Assistants	10,311	10,660	97,754	9.17	15
16	Dishwashers					16
17	Maintenance Workers	4,823	5,074	86,268	17.00	17
18	Housekeepers	10,625	11,734	105,099	8.96	18
19	Laundry	3,523	3,699	41,281	11.16	19
20	Administrator	1,896	2,104	103,888	49.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,981	2,149	40,743	18.96	23
24	Clerical	3,291	3,570	55,888	15.65	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	1,863	2,023	25,509	12.61	31
32	Other Health C: Marketing	2,371	2,488	64,907	26.09	32
33	Other(specify) Duplex, Beauty	1,264	1,340	18,544	13.84	33
34	TOTAL (lines 1 - 33)	183,382	196,305	$ 3,105,995 *	$ 15.82	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	106	$ 6,777	V01-3	35
36	Medical Director	192	23,550	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	64	3,914	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	19	1,529	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	381	$ 35,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,369	$ 133,762	V10-3	50
51	Licensed Practical Nurses	940	36,415	V10-3	51
52	Certified Nurse Assistants/Aides	1,384	31,546	V10-3	52
53	TOTAL (lines 50 - 52)	4,693	$ 201,723		53

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stacy Brenton	Administrator	0	$ 103,888
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,888

B. Administrative - Other

Description	Amount
Management Fees	$ 599,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 599,320
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 1,082
Davis & Campbell	Legal	30,717
Delaney Delaney & Voorn	Legal	3,124
Polsinelli Shughart	Legal	1,985
PMD Advisory	Market Study	6,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 43,408

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,085
Unemployment Compensation Insurance	(2,800)
FICA Taxes	226,954
Employee Health Insurance	311,427
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
457 Plan Expense	8,499
Employee Expense	11,184
Employee Uniforms	449
New Hire Expense	17,685
Home Office Allocation	46,155
TOTAL (agree to Schedule V, line 22, col.8)	$ 694,638

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 306)	
Patient Background Checks	3,060
Licenses	2,707
Dues	11,913
Subscriptions	19,606
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,286

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,796
In-State Travel	8,475
Seminar Expense	2,727
Home Office Allocation	27,218
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 45,216

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Christian Village # 0026955 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- $8,634**

(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. $ **22,171** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **218,673**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(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. $ **45**
c. What percent of all travel expense relates to transportation of nurses and patients? **20**
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? **YES**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees