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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0020610

Facility Name: Wabash Christian Village

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

County: White

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	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 7/1/17 to 6/30/18 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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	22,333	16,394	9,167	47,894	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,333	16,394	9,167	47,894	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.11%

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 8,113

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: 6/30/18 Fiscal Year: 6/30/18

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	328,597	25,450	17,309	371,356		371,356		371,356			1
2	Food Purchase		286,734		286,734		286,734		286,734			2
3	Housekeeping	173,614		39,560	213,174		213,174		213,174			3
4	Laundry	76,778			76,778		76,778		76,778			4
5	Heat and Other Utilities			197,842	197,842		197,842	1,669	199,511			5
6	Maintenance	143,642	44,204		187,846		187,846	3,454	191,300			6
7	Other (specify):* Trash			5,612	5,612		5,612		5,612			7
8	TOTAL General Services	722,631	356,388	260,323	1,339,342		1,339,342	5,123	1,344,465			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	3,082,485	154,916	254,107	3,491,508		3,491,508		3,491,508			10
10a	Therapy			1,109,393	1,109,393		1,109,393		1,109,393			10a
11	Activities	106,358	4,773		111,131		111,131		111,131			11
12	Social Services	177,904		7,173	185,077		185,077		185,077			12
13	CNA Training											13
14	Program Transportation			6,132	6,132		6,132		6,132			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,366,747	159,689	1,386,405	4,912,841		4,912,841		4,912,841			16
	C. General Administration											
17	Administrative	242,049		597,832	839,881		839,881	(503,662)	336,219			17
18	Directors Fees											18
19	Professional Services			49,573	49,573		49,573	60,969	110,542			19
20	Dues, Fees, Subscriptions & Promotions			38,247	38,247		38,247	(1,482)	36,765			20
21	Clerical & General Office Expenses	136,988	41,867	299,144	477,999		477,999	215,456	693,455			21
22	Employee Benefits & Payroll Taxes			1,005,550	1,005,550		1,005,550	84,541	1,090,091			22
23	Inservice Training & Education											23
24	Travel and Seminar			27,593	27,593		27,593	31,716	59,309			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			130,495	130,495		130,495	979	131,474			26
27	Other (specify):* Marketing	98,302		25,501	123,803		123,803	(123,803)				27
28	TOTAL General Administration	477,339	41,867	2,173,935	2,693,141		2,693,141	(235,286)	2,457,855			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,566,717	557,944	3,820,663	8,945,324		8,945,324	(230,163)	8,715,161			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 Village #0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			390,290	390,290		390,290	35,737	426,027			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,589	10,589		10,589		10,589			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,325	4,325		4,325		4,325			35
36	Other (specify):* Deferred Financing Costs			223	223		223		223			36
37	**TOTAL Ownership**			405,427	405,427		405,427	35,737	441,164			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,436	489,614	515,050		515,050	(24,824)	490,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,904	326,904		326,904		326,904			42
43	Other (specify):* IL Duplex	7,266		68,270	75,536		75,536	(68,733)	6,803			43
44	**TOTAL Special Cost Centers**	7,266	25,436	884,788	917,490		917,490	(93,557)	823,933			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,573,983	583,380	5,110,878	10,268,241		10,268,241	(287,983)	9,980,258			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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,667)	21		24
25	Fund Raising, Advertising and Promotional	(123,803)	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	(85,291)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (422,761)		$	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)	134,778	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 134,778		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (287,983)		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 Village

ID# 0020610

Report Period Beginning: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ (75,536)	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Lobbying Expense	(1,482)	20	3
4	Travel and Seminar	(8,273)	24	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(85,291)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	0	0	0	0	0	0	0	0	0	0	0	0	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	1,669	0	0	0	0	0	0	0	0	0	1,669	5
6	Maintenance	0	3,454	0	0	0	0	0	0	0	0	0	3,454	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	5,123	0	0	0	0	0	0	0	0	0	5,123	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(503,662)	0	0	0	0	0	0	0	0	0	(503,662)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	60,969	0	0	0	0	0	0	0	0	0	60,969	19
20	Fees, Subscriptions & Promotions	(1,482)	0	0	0	0	0	0	0	0	0	0	(1,482)	20
21	Clerical & General Office Expenses	(213,667)	429,123	0	0	0	0	0	0	0	0	0	215,456	21
22	Employee Benefits & Payroll Taxes	0	84,541	0	0	0	0	0	0	0	0	0	84,541	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,273)	39,989	0	0	0	0	0	0	0	0	0	31,716	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	979	0	0	0	0	0	0	0	0	0	979	26
27	Other (specify):*	(123,803)	0	0	0	0	0	0	0	0	0	0	(123,803)	27
28	**TOTAL General Administration**	(347,225)	111,939	0	0	0	0	0	0	0	0	0	(235,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(347,225)	117,062	0	0	0	0	0	0	0	0	0	(230,163)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	35,737	0	0	0	0	0	0	0	0	0	35,737	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	35,737	0	0	0	0	0	0	0	0	0	35,737	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	(24,824)	0	0	0	0	0	0	0	0	0	(24,824)	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):*	(75,536)	6,803	0	0	0	0	0	0	0	0	0	(68,733)	43
44	**TOTAL Special Cost Centers**	(75,536)	(18,021)	0	0	0	0	0	0	0	0	0	(93,557)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(422,761)	134,778	0	0	0	0	0	0	0	0	0	(287,983)	45

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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%	$ 1,669	$ 1,669	1
2	V	6	Maintenance				3,454	3,454	2
3	V	17	Administrative	603,212			99,550	(503,662)	3
4	V	19	Professional Services				60,969	60,969	4
5	V	21	Clerical				385,284	385,284	5
6	V	22	Employee Benefits				84,541	84,541	6
7	V	21	Dues & Subscriptions				9,941	9,941	7
8	V	24	Travel and Seminars				39,989	39,989	8
9	V	26	Insurance				979	979	9
10	V	30	Depreciation				35,737	35,737	10
11	V	21	Other Administrative Expense				33,898	33,898	11
12	V	43	Independent Living				6,803	6,803	12
13	V	39	Pharmacy Services	426,223	Midwest Senior Ministries, Inc. d/b/a Senior Care Pharmacy	0.00%	401,399	(24,824)	13
14	Total			$ 1,029,435			$ 1,164,213	$ * 134,778	14

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bond Fund	X		Debt Relocation	$1,603.75	3/1/05	$ 366,253	$ 159,438	9/1/11	0.5720	$ 6,723	1
2	Illinois Finance Authority		X	Renovation Projects		6/30/07	586,567	840,419	5/15/31	0.0567	43,514	2
3	Illinois Finance Authority		X	Refinance Debt		3/1/16	138,904	150,145	5/15/40	0.0500	6,910	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,603.75		$ 1,091,724	$ 1,150,002			$ 57,147	9
	B. Non-Facility Related*											
10	Interest Income Offset										(46,558)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (46,558)	14
15	TOTALS (line 9+line14)						$ 1,091,724	$ 1,150,002			$ 10,589	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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Village 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			7,563	2
3	TOTALS	60,480		$ 64,246	3

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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				73,621	2,575		2,575		60,490	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	20,976		VARIOUS			20,976	13
14	1987 Fixed Assets			1987	1,470		VARIOUS			1,470	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		65,131	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		119,447	25
26	2001 Fixed Assets			2001	20,594		VARIOUS			20,492	26
27	2002 Fixed Assets			2002	19,056		VARIOUS			18,975	27
28	2003 Fixed Assets			2003	145,795	6,159	VARIOUS	6,159		136,918	28
29	2004 Fixed Assets			2004	248,664	13,214	VARIOUS	13,214		231,932	29
30	2005 Fixed Assets			2005	249,116	7,647	VARIOUS	7,647		224,524	30
31	2006 Fixed Assets			2006	86,373	2,894	VARIOUS	2,894		65,719	31
32	2007 Fixed Assets			2007	122,583	226	VARIOUS	226		120,969	32
33	2008 Fixed Assets			2008	334,947	28,677	VARIOUS	28,677		326,213	33
34	2009 Fixed Assets			2009	187,338	18,734	VARIOUS	18,734		162,048	34
35	2010 Fixed Assets			2010	427,982	34,612	VARIOUS	34,612		282,446	35
36	PTAC Units			2011	7,046	705	VARIOUS	705		5,226	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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	Delta Lavatory Faucets - Wide	2011	$ 4,084	$ 408	10	$ 408	$	$ 3,029	37
38	Delta Lavatory Faucets - Regular	2011	1,227	123	10	123		910	38
39	Room 301 - Bathroom remodel	2011	5,858	586	10	586		4,394	39
40	Room 302 - Bathroom Remodel	2011	8,598	860	10	860		6,449	40
41	Room 303 - Bathroom Remodel	2011	8,648	865	10	865		6,486	41
42	Wing 3 - Asbestos Removal	2011	12,348	1,235	10	1,235		9,158	42
43	Wing 3 - Refurb	2011	1,751	175	10	175		1,313	43
44	Wing 3 - Fixtures	2011	426	43	10	43		316	44
45	Wing 3 - Flooring	2011	14,485	1,448	10	1,448		10,622	45
46	Wing 2 - HVACs	2011	5,062	506	10	506		3,586	46
47	Boiler section module, piping valves,	2011	9,790	546	6	546		9,656	47
48	Haven Water Damage-restore floors, wal	2011	47,843	4,784	10	4,784		31,895	48
49	Sealcoat Parking Lot and stripe	2011	2,503		3			2,503	49
50	Medical Building Fire Suppression	2011	6,752	675	10	675		4,727	50
51	WEIL MCCAIN 550 ULTRA BOILERS	2012	84,800	4,240	20	4,240		24,380	51
52	LANDSCAPING PAVERS AND PLANTS	2012	2,672	267	10	267		1,536	52
53	Therapy Gym	2013	306,000	18,715	Various	18,715		102,931	53
54	Electric - Sewer Grinder	2013	5,354	357	15	357		1,904	54
55	10 Ton A/C Roof Unit for Dining Room	2013	6,471	647	10	647		3,235	55
56	Kitchen - (20) 4ft LED Ceiling Lights	2013	5,480	365	15	365		1,796	56
57	Kitchen - Overhead Lights	2013	548	37	15	37		170	57
58	Carpet - Front Office & Conference Roo	2013	3,496	699	5	699		3,322	58
59	Front Entrance - Remodel Railings	2013	2,678	268	10	268		1,295	59
60	Hot Water Heater & Storage Tank	2013	39,447	3,945	10	3,945		19,066	60
61	Front Office Inpro Wall Covering	2013	4,730	946	5	946		4,494	61
62	Install of Walk-in Cooler/Freezer Comb	2013	36,623	2,442	15	2,442		11,190	62
63	Replace 6in Sewer Main sidewalk	2013	5,594	224	25	224		1,100	63
64	Replace kitchen drain	2014	5,400	540	10	540		2,205	64
65	IS3200 Door Kit Accutech	2014	4,286	429	10	429		1,786	65
66	Install vinyl family room	2014	2,000	200	10	200		750	66
67	Install vinyl flooring	2014	2,450	245	10	245		919	67
68	Sealcoat parking lot	2014	6,715	959	7	959		3,757	68
69	Install Generator Steel door	2015	1,345	134	10	134		437	69
70	TOTAL (lines 4 thru 69)		$ 4,826,123	$ 172,061		$ 172,061	$	$ 4,032,434	70

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 4,826,123	$ 172,061		$ 172,061	$	$ 4,032,434	1
2	TheraPure Tub w/Lift	2015	13,185	1,319	10	1,319		4,285	2
3	MC Wing Bathroom doors 305, 306 &307	2015	1,476	148	10	148		467	3
4	Install 5' Shower	2015	3,511	351	10	351		1,112	4
5	Wallpaper in main lobby & back hall	2015	1,325	133	10	133		431	5
6	Remove asbestos	2015	13,650	1,365	10	1,365		4,209	6
7	Wing 6 new flooring	2015	19,840	1,984	10	1,984		6,117	7
8	Remodel of bathrooms 1,2 & 3	2015	24,453	2,445	10	2,445		7,336	8
9	Install vinyl flooring MC bathrooms (3)	2015	600	60	10	60		180	9
10	Room 305 vinyl flooring	2015	496	50	10	50		149	10
11	Relocate Fire sprinklers heads	2015	439	44	10	44		132	11
12	Install toilet rails MC bathrooms	2015	782	78	10	78		235	12
13	MC Wing bathrooms wallcovering 1-3	2015	1,312	131	10	131		394	13
14	Curved Tops and Cabinet Tops, Backsplash	2015	10,577	1,058	10	1,058		3,173	14
15	Office Flooring - Dietary	2015	596	60	10	60		169	15
16	Front Lobby office Vinyl Flooring	2015	594	59	10	59		168	16
17	Boiler/HVAC, Pumps, Tanks, Piping	2015	42,750	4,275	10	4,275		11,756	17
18	Remove Asbestos Tile and Glue	2015	22,204	2,220	10	2,220		5,921	18
19	Dining Flooring - Tavertine	2015	27,693	2,769	10	2,769		7,385	19
20	Drywall finishing & supplies New offices	2016	6,924	692	10	692		1,673	20
21	Countertop for new office	2016	116	12	10	12		28	21
22	Cove base new offices	2016	300	30	10	30		73	22
23	Replace sprinker head @ new office	2016	442	44	10	44		107	23
24	Install new locks New offices	2016	261	26	10	26		63	24
25	CP216 Kinetico Water Softner System	2016	3,000	300	10	300		700	25
26	Fire Evacuation floor signs	2016	600	60	10	60		140	26
27	Const. of New Exterior Shed	2016	70,127	7,013	10	7,013		15,778	27
28	Concrete for Bocceball Court	2016	1,805	90	20	90		181	28
29	Install Sprinkler @ Assistant Admin offi	2016	2,027	203	10	203		405	29
30	Flooring office	2016	1,236	124	10	124		227	30
31	Emergency Gas Shut off & Switches	2016	1,775	178	10	178		281	31
32	Wing 2 and Wing 4 - Bathrooms, New Vinyl Flooring, Toilets, Ligl	2017	119,953	11,995	10	11,995		16,993	32
33	Unit 501 Vinyl Flooring	2017	1,995	199	10	199		249	33
34	TOTAL (lines 1 thru 33)		$ 5,222,165	$ 211,576		$ 211,576	$	$ 4,122,951	34

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 5,222,165	$ 211,576		$ 211,576	$	$ 4,122,951	1
2	New Carpet Wing 3, 9 & 7	2017	22,180	2,218	10	2,218		2,403	2
3	Carpet Wing 7	2017	22,712	2,271	10	2,271		2,460	3
4	Med Room cabinets & countertops	2017	7,257	726	10	726		786	4
5	30 New Doors for Wing 1-4	2017	9,562	956	10	956		1,036	5
6	Carpet Wing 8 & Magnolia Parlor	2017	31,007	3,101	10	3,101		3,359	6
7	Embossed Steel garage door Maint. Shed	2017	1,402	140	10	140		152	7
8	46 New Doors for Wing 5-8	2017	13,664	1,366	10	1,366		1,480	8
9	Main Entrance Mats 4x6 (11)	2017	2,571	257	10	257		279	9
10	AC unit Compressor	2017	893	82	10	82		82	10
11	Asphalt & paint lines Parking Lot	2017	7,006	321	20	321		321	11
12	New Name Monument Sign 5x10x14	2017	9,776	448	20	448		448	12
13	Reno Nurse Station Med Room	2017	1,306	109	10	109		109	13
14	Interior Rooms Signage/Vinyl Decals	2017	3,889	324	10	324		324	14
15	AO Smith Gas 100gl Water Heater	2017	3,563	208	10	208		208	15
16	Fire Photo Detector System w/Flash	2018	8,685	434	10	434		434	16
17	Privacy Fence & Pavement dumpster area	2018	24,570	410	20	410		410	17
18	100 Finished Doors W/ locks	2018	19,515	651	10	651		651	18
19	Carrier Rooftop AC unit	2018	10,107	337	10	337		337	19
20	Rounding		(1)						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)		$ 5,421,828	$ 225,935		$ 225,935	$	$ 4,138,230	34

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 1,141,166	$ 148,631	$ 148,631	$		$ 791,517	71
72	Current Year Purchases	98,812	13,049	13,049			13,049	72
73	Fully Depreciated Assets	338,654					338,654	73
74	Home Office Allocation	193,085	31,362	31,362			143,762	74
75	TOTALS	$ 1,771,717	$ 193,042	$ 193,042	$		$ 1,286,982	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	$ 5,250	$ 5,250	$		$ 100,347	76
77										77
78										78
79	Home Office Allocation			10,865	6,041	6,041			9,852	79
80	TOTALS			$ 115,085	$ 11,291	$ 11,291	$		$ 110,199	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)	$ 7,372,876	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 430,268	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 430,268	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)	$ 5,535,411	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	575,989	21,123	464,322	87
88					88
89					89
90					90
91	TOTALS	$ 585,216	$ 21,123	$ 464,322	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 59,881	92
93	Home Office Allocation	43,192	93
94			94
95		$ 103,073	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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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: $ 15,333 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 Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.

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	hrs	$	9,902	$ 451,042	$	9,902	$ 451,042	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		2,495	143,847		2,495	143,847	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		12,768	514,504		12,768	514,504	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				370,128		370,128	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					53,676		53,676	12
13	Other (specify): BILLABLE SUPPLIES	V39					91,247		91,247	13
14	TOTAL			$	25,165	$ 1,109,393	$ 515,051	25,165	$ 1,624,444	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.

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/18 (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	$ 9,336	$	1
2	Cash-Patient Deposits	13,309		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 226,798)	1,527,977		3
4	Supply Inventory (priced at)	13,005		4
5	Short-Term Investments	1,755,597		5
6	Prepaid Insurance	3,919		6
7	Other Prepaid Expenses	18,521		7
8	Accounts Receivable (owners or related parties)	296,635		8
9	Other(specify): Other AR/Acc Int Rec	238,468		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,876,767	$	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	6,032,775		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,574,272		16
17	Accumulated Depreciation (book methods)	(5,785,629)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	14,927		21
22	Other Long-Term Assets (spe CIP	59,881		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,962,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,838,903	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (5,891,871)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,309		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,936		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	Other Liabilities	154,622		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (5,413,127)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,150,002		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	20,901		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,170,903	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (4,242,224)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,081,127	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,838,903	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,721,719	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,721,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	364,118	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) **Temp Restricted Activity**	(4,706)	15
16	Other (describe) **Rounding**	(4)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 359,408	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**		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)**	$ 10,081,127	24 *

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 9,707,090	1
2	Discounts and Allowances for all Levels	(7,315,599)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,391,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,007,032	6
7	Oxygen	20,821	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,027,853	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	4,699	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	639,817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,745	19
20	Radiology and X-Ray	46,540	20
21	Other Medical Services	177,621	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 917,422	23
	D. Non-Operating Revenue		
24	Contributions	120,641	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 120,641	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	92,006	28
28a	Misc Revenue	82,946	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 174,952	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,632,359	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,339,342	31
32	Health Care	4,888,194	32
33	General Administration	2,717,788	33
	B. Capital Expense		
34	Ownership	405,427	34
	C. Ancillary Expense		
35	Special Cost Centers	590,586	35
36	Provider Participation Fee	326,904	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,268,241	40
41	**Income before Income Taxes (line 30 minus line 40)****	364,118	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 364,118	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,846,078	44
45	Private Pay - Net Inpatient Revenue	1,711,752	45
46	Medicare - Net Inpatient Revenue	(1,304,735)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(227,218)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,634,387)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,391,491	49

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

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

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

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

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	2,437	2,657	$ 116,664	$ 43.91	1
2	Assistant Director of Nursing	1,124	1,204	40,807	33.89	2
3	Registered Nurses	14,529	15,619	433,138	27.73	3
4	Licensed Practical Nurses	39,000	41,503	857,231	20.65	4
5	CNAs & Orderlies	117,261	133,224	1,585,343	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,946	2,054	27,619	13.45	9
10	Activity Assistants	8,669	9,101	78,739	8.65	10
11	Social Service Workers	9,541	10,067	177,904	17.67	11
12	Dietician					12
13	Food Service Supervisor	1,493	1,652	27,098	16.40	13
14	Head Cook	5,911	6,203	77,568	12.50	14
15	Cook Helpers/Assistants	20,911	22,041	223,931	10.16	15
16	Dishwashers					16
17	Maintenance Workers	6,688	6,990	143,642	20.55	17
18	Housekeepers	14,965	15,903	173,614	10.92	18
19	Laundry	6,867	7,180	76,778	10.69	19
20	Administrator	1,792	1,964	172,981	88.08	20
21	Assistant Administrator	1,788	1,968	69,068	35.10	21
22	Other Administrative					22
23	Office Manager	4,680	4,959	95,670	19.29	23
24	Clerical	3,978	4,181	65,965	15.78	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	1,857	2,012	24,655	12.25	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/IL Dup	4,733	5,056	105,568	20.88	33
34	TOTAL (lines 1 - 33)	270,170	295,538	$ 4,573,983 *	$ 15.48	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	323	$ 16,596	V01-3	35
36	Medical Director	72	9,600	V09-3	36
37	Medical Records Consultant	32	1,853	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	4,474	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	87	5,744	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	682	$ 38,267		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,366	$ 175,733	V10-3	50
51	Licensed Practical Nurses	1,502	69,617	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,868	$ 245,350		53

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bryant	Executive Director	0	$ 150,010
Andrea May	Administrator	0	92,039
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 242,049

B. Administrative - Other

Description	Amount
Management Fees	$ 597,832
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 597,832

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Professional Services	$ 2,133
Davis & Campbell	Legal	47,383
Polsinelli Shughart	Legal	57
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 49,573

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,829
Unemployment Compensation Insurance	1,722
FICA Taxes	323,356
Employee Health Insurance	511,816
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	14,069
457 Plan Expense	6,618
Employee Uniforms	812
Employee Expense	15,328
Home Office Allocation	84,541
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,090,091

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 378)	
Patient Background Checks	3,780
License	4,718
Dues	11,345
Subscriptions	16,922
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,765

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 7,727
In-State Travel	16,682
Seminar Expense	3,184
Non Allowable Marketing Adj	(8,273)
Home Office Allocation	39,989
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 59,309

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Village # 0020610 Report Period Beginning: 7/1/17 Ending: 6/30/18

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- $10,584**

(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. $ **24,587** 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. $ **326,904**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,054**

(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. $ **13,039**
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