FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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 7/1/17 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 Washington Christian Village # 0026955 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	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,240	6,965	4,452	27,657	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,240	6,965	4,452	27,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.11%

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, Lawn & Maint Care, Housekeeping & Laundry 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 3,334

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 Washington Christian Village # 0026955 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	195,602	16,351	6,809	218,762		218,762		218,762			1
2	Food Purchase		196,251		196,251		196,251		196,251			2
3	Housekeeping	93,280		22,720	116,000		116,000		116,000			3
4	Laundry	61,288		2,944	64,232		64,232		64,232			4
5	Heat and Other Utilities			108,389	108,389		108,389	1,105	109,494			5
6	Maintenance	73,393	45,346		118,739		118,739	2,287	121,026			6
7	Other (specify):* Trash			6,247	6,247		6,247		6,247			7
8	**TOTAL General Services**	423,563	257,948	147,109	828,620		828,620	3,392	832,012			8
	B. Health Care and Programs											
9	Medical Director			35,800	35,800		35,800		35,800			9
10	Nursing and Medical Records	2,211,647	99,752	88,967	2,400,366		2,400,366		2,400,366			10
10a	Therapy			537,218	537,218		537,218		537,218			10a
11	Activities	75,046	6,851		81,897		81,897		81,897			11
12	Social Services	108,855		1,923	110,778		110,778		110,778			12
13	CNA Training											13
14	Program Transportation			6,067	6,067		6,067		6,067			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,395,548	106,603	669,975	3,172,126		3,172,126		3,172,126			16
	C. General Administration											
17	Administrative	117,291		500,742	618,033		618,033	(438,979)	179,054			17
18	Directors Fees											18
19	Professional Services			22,189	22,189		22,189	40,367	62,556			19
20	Dues, Fees, Subscriptions & Promotions			35,831	35,831		35,831	(1,128)	34,703			20
21	Clerical & General Office Expenses	165,833	32,000	150,714	348,547		348,547	201,251	549,798			21
22	Employee Benefits & Payroll Taxes			617,810	617,810		617,810	55,974	673,784			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,260	11,260		11,260	24,095	35,355			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,995	98,995		98,995	648	99,643			26
27	Other (specify):* Marketing	75,846		28,672	104,518		104,518	(104,518)				27
28	**TOTAL General Administration**	358,970	32,000	1,466,213	1,857,183		1,857,183	(222,290)	1,634,893			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,178,081	396,551	2,283,297	5,857,929		5,857,929	(218,898)	5,639,031			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: 7/1/17 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			315,797	315,797		315,797	23,661	339,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			135,014	135,014		135,014		135,014			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			692	692		692		692			35
36	Other (specify):* Def Financing Cost			1,018	1,018		1,018		1,018			36
37	**TOTAL Ownership**			452,521	452,521		452,521	23,661	476,182			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,074	291,881	299,955		299,955	(16,092)	283,863			39
40	Barber and Beauty Shops	5,732		449	6,181		6,181		6,181			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			213,810	213,810		213,810		213,810			42
43	Other (specify):* IL Duplex	5,061		86,344	91,405		91,405	(87,255)	4,150			43
44	**TOTAL Special Cost Centers**	10,793	8,074	592,484	611,351		611,351	(103,347)	508,004			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,188,874	404,625	3,328,302	6,921,801		6,921,801	(298,584)	6,623,217			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: 7/1/17 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 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				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	(123)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,099)	21		24
25	Fund Raising, Advertising and Promotional	(104,518)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(94,914)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (282,654)		$	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)	(15,930)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,930)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (298,584)		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: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ (91,404)	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Lobbying Expense	(1,128)	20	3
4	Travel and Seminar	(2,382)	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**	(94,914)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village # 0026955 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	1,105	0	0	0	0	0	0	0	0	0	1,105	5
6	Maintenance	0	2,287	0	0	0	0	0	0	0	0	0	2,287	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	3,392	0	0	0	0	0	0	0	0	0	3,392	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	(438,979)	0	0	0	0	0	0	0	0	0	(438,979)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	40,367	0	0	0	0	0	0	0	0	0	40,367	19
20	Fees, Subscriptions & Promotions	(1,128)	0	0	0	0	0	0	0	0	0	0	(1,128)	20
21	Clerical & General Office Expenses	(83,222)	284,473	0	0	0	0	0	0	0	0	0	201,251	21
22	Employee Benefits & Payroll Taxes	0	55,974	0	0	0	0	0	0	0	0	0	55,974	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,382)	26,477	0	0	0	0	0	0	0	0	0	24,095	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	648	0	0	0	0	0	0	0	0	0	648	26
27	Other (specify):*	(104,518)	0	0	0	0	0	0	0	0	0	0	(104,518)	27
28	**TOTAL General Administration**	(191,250)	(31,040)	0	0	0	0	0	0	0	0	0	(222,290)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(191,250)	(27,648)	0	0	0	0	0	0	0	0	0	(218,898)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Christian Village # 0026955 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	23,661	0	0	0	0	0	0	0	0	0	23,661	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	23,661	0	0	0	0	0	0	0	0	0	23,661	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(16,092)	0	0	0	0	0	0	0	0	0	(16,092)	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):*	(91,404)	4,149	0	0	0	0	0	0	0	0	0	(87,255)	43
44	**TOTAL Special Cost Centers**	(91,404)	(11,943)	0	0	0	0	0	0	0	0	0	(103,347)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(282,654)	(15,930)	0	0	0	0	0	0	0	0	0	(298,584)	45

Facility Name & ID Number Washington Christian Village # 0026955 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%	$ 1,105	$ 1,105	1
2	V	6	Maintenance				2,287	2,287	2
3	V	17	Administrative	504,890			65,911	(438,979)	3
4	V	19	Professional Services				40,367	40,367	4
5	V	21	Clerical				255,448	255,448	5
6	V	22	Employee Benefits				55,974	55,974	6
7	V	21	Dues & Subscriptions				6,582	6,582	7
8	V	24	Travel and Seminars				26,477	26,477	8
9	V	26	Insurance				648	648	9
10	V	30	Depreciation				23,661	23,661	10
11	V	21	Other Administrative Expense				22,443	22,443	11
12	V	43	Independent Living				4,149	4,149	12
13	V	39	Pharmacy Services	276,298	Midwest Senior Ministries, Inc. d/b/a Senior Care Pharmacy	0.00%	260,206	(16,092)	13
14	Total			$ 781,188			$ 765,258	$ * (15,930)	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: 7/1/17 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 Washington Christian Village # 0026955 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 Washington Christian Village # 0026955 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 Washington Christian Village # 0026955 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bond Fund	X		Refinance Debt	Various	Various	$ 4,409,251	$ 2,091,792	6/30/32	0.0572	$ 82,012	1
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	1,500,000	484,031	5/15/27	0.0600	15,542	2
3	Illinois Finance Authority		X	Refinance Debt		6/30/07	364,417	339,595	5/15/31	0.0567	23,596	3
4	Illinois Finance Authority		X	Refinance Debt		3/1/16	634,172	685,492	5/15/40	0.0500	25,110	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,907,840	$ 3,600,910			$ 146,260	9
	B. Non-Facility Related*											
10	Interest Income Offset										(11,246)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,246)	14
15	TOTALS (line 9+line14)						$ 6,907,840	$ 3,600,910			$ 135,014	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: 7/1/17 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 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 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.	02-02-14-300-021	1110 New Castle Rd	$ 19,596.04	$
2.	02-02-14-308-001	1104 Kingsbury Rd	$ 4,891.80	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,487.84	$

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 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 Washington Christian Village # 0026955 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			5,008	2
3	TOTALS	38,484		$ 55,008	3

Facility Name & ID Number Washington Christian Village # 0026955 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	122		1982		$ 1,203,052	$		$	$	$ 1,200,235	4
5											5
6											6
7											7
8	Home Office Allocation				48,744	1,705		1,705		40,050	8
	Improvement Type**										
9	1982 Fixed Assets			1982	33,562		Various			33,530	9
10	1983 Fixed Assets			1983	34,486	412	Various	412		34,405	10
11	1984 Fixed Assets			1984	231	7	Various	7		227	11
12	1985 Fixed Assets			1985	361,565	10,330	Various	10,330		345,844	12
13	1988 Fixed Assets			1988	4,693	106	Various	106		4,190	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		Various			1,371	16
17	2002 Fixed Assets			2002	50,136	761	Various	761		47,297	17
18	2003 Fixed Assets			2003	34,619	2,299	Various	2,299		34,427	18
19	2004 Fixed Assets			2004	580		Various			580	19
20	2005 Fixed Assets			2005	214,251	4,556	Various	4,556		177,803	20
21	2006 Fixed Assets			2006	202,900	9,166	Various	9,166		125,947	21
22	2007 Fixed Assets			2007	190,071	8,677	Various	8,677		112,837	22
23	2008 Fixed Assets			2008	76,797	6,285	Various	6,285		76,168	23
24	2009 Fixed Assets			2009	211,981	21,198	Various	21,198		197,200	24
25	2010 Fixed Assets			2010	271,238	27,124	Various	27,124		217,314	25
26	Roof where NE wing meets NW wing			2011	2,952	295	10	295		2,140	26
27	Ceramic for EE rest rooms			2011	3,003	300	10	300		2,177	27
28	Topography of west apt land			2011	3,340	334	10	334		2,422	28
29	60 gal, 120K BTU water heater			2011	6,448	645	10	645		4,782	29
30	B&G hot water circulating pump & kit			2011	3,635	364	10	364		2,727	30
31	Radiator Covers			2011	8,050	805	10	805		5,702	31
32	Paint 31 doors & frames SE Hall			2011	3,318	332	10	332		2,350	32
33	Paint 34 doors & frames SW Hall			2011	3,639	364	10	364		2,577	33
34	Remove Wallpaper & Paint Resident Room			2011	10,194	1,019	10	1,019		7,221	34
35	Remove Wallpaper & Paint SW Hall			2011	1,160	116	10	116		822	35
36	Landscaping Front & Therapy Patios										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: 7/1/17 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	Remove wallpaper & paint SE Hall	2011	$ 1,160	$ 116	10	$ 116	$	$ 822	37
38	Paint Bathrooms 107, 110, 141, 147, 14	2011	1,200	120	10	120		850	38
39	Cultered Marble Top 12 SE Units	2011	2,750	275	10	275		1,948	39
40	Rm 105 & 108 Vanity top, apron & legs	2011	1,320	132	10	132		935	40
41	Rm 107 & 110 Vanity top, apron & legs	2011	1,542	154	10	154		1,092	41
42	Cove Base All Areas	2011	9,601	960	10	960		6,801	42
43	Flooring 10 Resident Bathrooms	2011	5,622	562	10	562		3,982	43
44	Carpet Powerbond Corridors	2011	34,689	3,469	10	3,469		24,572	44
45	Carpet for 19 Resident Rooms	2011	24,111	2,411	10	2,411		17,079	45
46	Dining Room - Armstrong Vinyl Flooring	2011	24,981	2,498	10	2,498		17,695	46
47	Build soffit around exposed piping	2011	4,230	423	10	423		2,996	47
48	Floor Preparation - Ardex skim coat	2011	15,000	1,500	10	1,500		10,625	48
49	Tile - Bath off north center hall	2011	3,322	332	10	332		2,353	49
50	Counters - Activity Room	2011	2,528	253	10	253		1,770	50
51	Courtyard Landscaping (Fountain, Trees	2011	4,100	410	10	410		2,836	51
52	Window Tinting Front of Building & Reh	2011	2,845	285	10	285		1,968	52
53	Prime & Paint Interior Doors	2011	3,538	354	10	354		2,565	53
54	Prime Paint Doors Frames NW Hallway	2011	6,861	686	10	686		4,974	54
55	Prep & Paint, Laundry Rm, Hallway Doors	2011	1,286	129	10	129		922	55
56	Prep & Paint Center Hall	2011	1,460	146	10	146		1,034	56
57	Prep & Paint Doors NE Lounge	2011	321	32	10	32		227	57
58	Prep & Paint Walls NE Lounge	2011	400	40	10	40		283	58
59	Prep & Paint NE & NW Hallways	2011	3,250	325	10	325		2,302	59
60	Prime & Paint Doors, Frames Center Hall	2011	3,330	333	10	333		2,359	60
61	Prep & Paint Shower Room	2011	550	55	10	55		390	61
62	Remodel 5 offices, Baseboard, chair rail	2011	6,541	654	10	654		4,633	62
63	Prep. Paint Admin, DON, Business	2011	2,550	255	10	255		1,806	63
64	Cabinets - North Nurse Station	2011	7,864	786	10	786		5,570	64
65	15' Wall Demential Dining Area	2011	4,457	446	10	446		3,157	65
66	Refurbish 18 Resident Rm & Bathrooms	2011	26,211	2,621	10	2,621		18,566	66
67	NE Corridor air distribustion system,	2012	65,610	4,755	20	4,755		31,004	67
68	Patio Concrete Pad 30'x12'	2012	2,520	168	15	168		1,036	68
69	R&R Shower Floor Southwest Hall	2012	3,552	178	20	178		1,066	69
70	TOTAL (lines 4 thru 69)		$ 3,267,575	$ 123,063		$ 123,063	$	$ 2,864,820	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: 7/1/17 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		$ 3,267,575	$ 123,063		$ 123,063	$	$ 2,864,820	1
2	2 Fire Doors & Block Wall Generator Rm	2013	5,140	257	20	257		1,392	2
3	12x12 Gazebo Chapel Courtyard	2013	6,731	449	15	449		2,281	3
4	100' White Vinyl Fencing Chapel Courtyar	2013	3,870	258	15	258		1,312	4
5	Install A/C unit dietary area	2014	7,805	781	10	781		3,252	5
6	100 gallon water heater	2015	5,900	590	10	590		1,918	6
7	SW Entrance door replacement	2015	5,067	507	10	507		1,647	7
8	Painting, Wall Art/Decor, Cabinets	2015	8,551	855	10	855		2,565	8
9	HVAC/AC Unit	2015	12,540	1,254	10	1,254		3,762	9
10	100 Gallon Natural Gas Water Heater	2015	6,175	618	10	618		1,853	10
11	Remove Sod, Brick Edging, Plants	2015	12,297	615	20	615		1,845	11
12	SE & SW bathroom flooring and wall tiling	2015	22,589	2,259	10	2,259		6,777	12
13	Install Brick edging @ Chapel courtyard	2015	17,562	878	20	878		2,488	13
14	SE bathroom-plumbing for new valves, piping for new lavatory	2015	1,486	149	10	149		421	14
15	South Hall Haper Confetti fabric Valances	2015	3,374	337	10	337		956	15
16	South Hall Labyrinth Cool blue Valances	2015	2,209	221	10	221		626	16
17	South Hall Painting project	2016	14,325	1,433	10	1,433		3,581	17
18	Staff Lounge 60" sink w/cooktop counters	2016	515	52	10	52		129	18
19	NW Shower Rooms- floor and wall tiling	2016	9,333	933	10	933		2,255	19
20	SE & SW hallways Flooring	2016	70,950	7,095	10	7,095		17,146	20
21	New Blower Motor on Boiler #2	2016	3,407	341	10	341		823	21
22	Install 30x18 Wall cabinet (3)	2016	763	76	10	76		184	22
23	Staff lounge vinyl wood floor	2016	889	89	10	89		215	23
24	Saff lounge Box lockers (24)	2016	896	90	10	90		209	24
25	Room Signs for SE & SW hall rooms	2016	971	97	10	97		218	25
26	SW Parking lot asphalt	2016	15,700	785	20	785		1,635	26
27	Rubber Roof @ WCV	2016	14,684	1,468	10	1,468		3,059	27
28	New Gutters Unit 1115-1123	2016	3,282	328	10	328		629	28
29	AC Unit therapy dept. north 1 1/2 ton	2016	8,950	895	10	895		1,715	29
30	TV Rec Room Mitsubishi AC Unit	2016	6,690	669	10	669		1,282	30
31	North Hall Remodel Flooring & painting	2016	61,930	6,193	10	6,193		9,806	31
32	North Hall Privancy Curtains & blinds	2017	13,890	1,389	10	1,389		1,505	32
33	Building small LED wall mount lights	2017	2,925	293	10	293		317	33
34	TOTAL (lines 1 thru 33)		$ 3,618,971	$ 155,317		$ 155,317	$	$ 2,942,623	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: 7/1/17 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		$ 3,618,971	$ 155,317		$ 155,317	$	$ 2,942,623	1
2	Staff lounge AC-Air Handler Unit	2017	17,490	1,749	10	1,749		1,895	2
3	Parking Lot 6" Plastic Curb Stop Blocks	2017	3,496	175	20	175		175	3
4	Steeple/Front Porch River Rock landscape	2017	4,270	214	20	214		214	4
5	Seal & Stripe 37,000 sq ft parking lot	2017	9,200	345	20	345		345	5
6	100 Hall Resident room flooring LVP	2018	30,417	1,267	10	1,267		1,267	6
7	Edwards Fire Alarm Control Panel 5 zones	2018	2,545	212	5	212		212	7
8	Rounding		1	(2)		(2)		(3)	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		$ 3,686,390	$ 159,277		$ 159,277	$	$ 2,946,728	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: 7/1/17 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	$ 1,134,439	$ 147,113	$ 147,113	$		$ 746,219	71
72	Current Year Purchases	51,271	9,635	9,635			9,635	72
73	Fully Depreciated Assets	118,999					118,999	73
74	Home Office Allocation	127,840	20,764	20,764			95,183	74
75	TOTALS	$ 1,432,549	$ 177,512	$ 177,512	$		$ 970,036	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 Van		$ 47,976	$ 1,477	$ 1,477	$		$ 45,022	76
77										77
78										78
79	Home Office Allocation			7,194	3,999	3,999			6,523	79
80	TOTALS			$ 55,170	$ 5,476	$ 5,476	$		$ 51,545	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)	$ 5,229,117	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 342,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 342,265	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)	$ 3,968,309	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	5,201	284,184	87
88					88
89					89
90					90
91	TOTALS	$ 423,215	$ 5,201	$ 284,184	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 428,798	92
93	Home Office Allocation	28,597	93
94			94
95		$ 457,395	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: 7/1/17 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: $ 11,112 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: 7/1/17 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.

   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	hrs	$	4,605	$ 236,894	$	4,605	$ 236,894	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,304	45,440		1,304	45,440	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		6,846	254,885		6,846	254,885	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				(52,192)		(52,192)	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					30,464		30,464	12
13	Other (specify): BILLABLE SUPPLIES	V39					45,385		45,385	13
14	TOTAL			$	12,755	$ 537,219	$ 23,657	12,755	$ 560,876	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 Washington Christian Village # 0026955 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	$ 13,777	$	1
2	Cash-Patient Deposits	10,196		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 132,357)	919,863		3
4	Supply Inventory (priced at)	9,730		4
5	Short-Term Investments	137,879		5
6	Prepaid Insurance	550		6
7	Other Prepaid Expenses	15,634		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other AR/Acc Int Rec	36,096		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,143,725	$	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	4,199,842		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,093,048		16
17	Accumulated Depreciation (book methods)	(4,110,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	819,173		21
22	Other Long-Term Assets (specify):	428,798		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,600,780	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,744,505	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (4,109,672)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,196		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,096		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	Other Liabilities	149,101		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (3,749,168)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,600,910		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,600,910	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (148,258)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,892,763	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,744,505	$	48

***(See instructions.)**

Facility Name & ID Number Washington Christian Village # 0026955 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**	$ 4,513,886	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,513,886	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,761)	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 Contribution Activity**	(10,362)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (621,123)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	0	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,892,763	24 *

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

Facility Name & ID Number Washington Christian Village # 0026955 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	$ 7,200,571	1
2	Discounts and Allowances for all Levels	(4,906,151)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,294,420	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,427,346	6
7	Oxygen	9,104	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,436,450	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	341,399	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,055	19
20	Radiology and X-Ray	29,125	20
21	Other Medical Services	82,013	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 486,592	23
	D. Non-Operating Revenue		
24	Contributions	39,033	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,033	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	49,774	28
28a	Misc Revenue	4,771	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54,545	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,311,040	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	828,620	31
32	Health Care	3,172,126	32
33	General Administration	1,857,183	33
	B. Capital Expense		
34	Ownership	452,521	34
	C. Ancillary Expense		
35	Special Cost Centers	397,541	35
36	Provider Participation Fee	213,810	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,921,801	40
41	**Income before Income Taxes (line 30 minus line 40)****	(610,761)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (610,761)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,591,804	44
45	Private Pay - Net Inpatient Revenue	1,226,209	45
46	Medicare - Net Inpatient Revenue	(598,395)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(141,940)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(783,258)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,294,420	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 Washington Christian Village # 0026955 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	1,872	1,964	$ 86,329	$ 43.96	1
2	Assistant Director of Nursing	1,376	1,470	45,536	30.98	2
3	Registered Nurses	18,640	20,395	560,819	27.50	3
4	Licensed Practical Nurses	15,049	16,655	394,838	23.71	4
5	CNAs & Orderlies	71,702	77,839	1,093,372	14.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,729	1,876	37,138	19.80	9
10	Activity Assistants	3,420	3,689	37,909	10.28	10
11	Social Service Workers	5,401	6,008	108,584	18.07	11
12	Dietician					12
13	Food Service Supervisor	1,876	2,082	39,130	18.79	13
14	Head Cook	5,008	5,427	64,025	11.80	14
15	Cook Helpers/Assistants	8,691	9,115	92,447	10.14	15
16	Dishwashers					16
17	Maintenance Workers	3,424	3,834	73,393	19.14	17
18	Housekeepers	8,172	8,972	93,280	10.40	18
19	Laundry	5,020	5,396	61,288	11.36	19
20	Administrator	1,965	2,145	117,291	54.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,162	8,265	165,833	20.06	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	1,893	2,040	30,752	15.07	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing, Duplex	3,943	4,265	86,910	20.38	33
34	TOTAL (lines 1 - 33)	166,343	181,437	$ 3,188,874 *	$ 17.58	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	83	$ 5,323	V01-3	35
36	Medical Director	208	35,800	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	2,596	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	14	1,177	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	365	$ 44,896		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	794	$ 38,452	V10-3	50
51	Licensed Practical Nurses	478	21,008	V10-3	51
52	Certified Nurse Assistants/Aides	729	17,649	V10-3	52
53	TOTAL (lines 50 - 52)	2,001	$ 77,109		53

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stacy Brenton	Administrator	0	$ 13,512
Brandy Cooper	Administrator	0	103,779
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 117,291

B. Administrative - Other

Description	Amount
Management Fees	$ 500,742
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 500,742

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 1,433
PMD Advisory	Market Study	10,999
Davis & Campbell	Legal	19,128
Delaney Delaney & Voorn	Legal	(9,509)
Polsinelli Shughart	Legal	138
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 22,189

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,840
Unemployment Compensation Insurance	13,493
FICA Taxes	234,184
Employee Health Insurance	255,490
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
457 Plan Expense	1,988
New Hire Expense	24,207
Employee Uniforms	190
Employee Expense	9,418
Home Office Allocation	55,974
TOTAL (agree to Schedule V, line 22, col.8)	$ 673,784

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 274)	
Patient Background Checks	2,740
Licenses	2,325
Dues	12,601
Subscriptions	17,037
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,703

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,166
In-State Travel	3,916
Seminar Expense	2,178
Non Allowable Marketing Adj	(2,382)
Home Office Allocation	26,477
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,355

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Christian Village # 0026955 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- $8,054**

(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. $ **15,369** 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. $ **213,810**
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? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
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? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees