



Facility Name & ID Number Wabash Christian Retirement# 0020610 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

## 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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF	27,996	16,780	6,770	51,546	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,996	16,780	6,770	51,546	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.38%D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

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

Meals served to prisonersF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO I. On what date did you start providing long term care at this location?  
Date started 06/01/1974J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 153 and days of care provided 6,008Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	258,915	22,490	11,997	293,402		293,402	(4)	293,398		1
2	Food Purchase		236,829		236,829		236,829	(2,301)	234,528		2
3	Housekeeping	225,496	53,010		278,506		278,506		278,506		3
4	Laundry										4
5	Heat and Other Utilities			200,374	200,374		200,374	4,497	204,871		5
6	Maintenance	72,683	32,596	48,883	154,162		154,162	10,673	164,835		6
7	Other (specify):* <b>Trash Removal</b>			5,480	5,480		5,480		5,480		7
8	<b>TOTAL General Services</b>	557,094	344,925	266,734	1,168,753		1,168,753	12,865	1,181,618		8
<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,183,824	338,569	62,278	2,584,671		2,584,671	(32)	2,584,639		10
10a	Therapy			497,044	497,044		497,044		497,044		10a
11	Activities	11,786			11,786		11,786		11,786		11
12	Social Services	187,581	1,725	9,879	199,185		199,185	914	200,099		12
13	CNA Training										13
14	Program Transportation			2,997	2,997		2,997	(7,136)	(4,139)		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,383,191	340,294	579,398	3,302,883		3,302,883	(6,254)	3,296,629		16
<b>C. General Administration</b>											
17	Administrative	108,795	832	352,536	462,163		462,163	(283,701)	178,462		17
18	Directors Fees										18
19	Professional Services			25,608	25,608		25,608	18,579	44,187		19
20	Dues, Fees, Subscriptions & Promotions			55,245	55,245		55,245	(14,384)	40,861		20
21	Clerical & General Office Expenses	136,226	9,581	84,420	230,227		230,227	90,677	320,904		21
22	Employee Benefits & Payroll Taxes			656,519	656,519		656,519	23,973	680,492		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,268	24,268		24,268	15,188	39,456		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			127,679	127,679		127,679	2,932	130,611		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	245,021	10,413	1,326,275	1,581,709		1,581,709	(146,736)	1,434,973		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,185,306	695,632	2,172,407	6,053,345		6,053,345	(140,125)	5,913,220		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 &amp; ID Number

Wabash Christian Retirement

#0020610

Report Period Beginning:

July 1, 2005

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			176,617	176,617		176,617	25,531	202,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,338	39,338		39,338	(16,594)	22,744			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Deferred Bond Costs</b>			1,834	1,834		1,834		1,834			36
37	<b>TOTAL Ownership</b>			217,789	217,789		217,789	8,937	226,726			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			21,110	21,110		21,110		21,110			39
40	Barber and Beauty Shops		298	4,509	4,807		4,807		4,807			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):* <b>Apt/Congregate</b>			48,146	48,146		48,146	(48,146)				43
44	<b>TOTAL Special Cost Centers</b>		298	160,270	160,568		160,568	(48,146)	112,422			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,185,306	695,930	2,550,466	6,431,702		6,431,702	(179,334)	6,252,368			45

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

Facility Name & ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning: July 1, 2005

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**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,465)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,377)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(41,307)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,419)	21		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				24
25	Fund Raising, Advertising and Promotional				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	(104,707)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (154,275)		\$	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	2	
		Amount	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)	(25,059)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (25,059)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (179,334)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Wabash Christian Retirement

ID# 0020610

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous	\$ (13,421)	17	1
2	Vending	164	2	2
3	Activity	914	12	3
4	Exempt Interest Income - Endowment	24,370	32	4
5	Gain on Disposal	5,245	21	5
6	Transportation	(7,136)	14	6
7	Advertising	(14,384)	20	7
8	Late Fees	(4)	1	8
9	Late Fees	(469)	6	9
10	Late Fees	(32)	10	10
11	Late Fees	(315)	21	11
12	Marketing Salaries	(49,329)	21	12
13	Marketing Other Expenses	(2,164)	21	13
14	Apt/Congregate	(48,146)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(104,707)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement# 0020610

Report Period Beginning:

July 1, 2005

Ending:

June 30, 2006

## 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)	
	<b>A. General Services</b>													
1	Dietary	(4)	0	0	0	0	0	0	0	0	0	0	(4)	1
2	Food Purchase	(2,301)	0	0	0	0	0	0	0	0	0	0	(2,301)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,377)	8,874	0	0	0	0	0	0	0	0	0	4,497	5
6	Maintenance	(469)	11,142	0	0	0	0	0	0	0	0	0	10,673	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,151)</b>	<b>20,016</b>	<b>0</b>	<b>12,865</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(32)	0	0	0	0	0	0	0	0	0	0	(32)	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	914	0	0	0	0	0	0	0	0	0	0	914	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(7,136)	0	0	0	0	0	0	0	0	0	0	(7,136)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(6,254)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,254)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(13,421)	(270,280)	0	0	0	0	0	0	0	0	0	(283,701)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18,579	0	0	0	0	0	0	0	0	0	18,579	19
20	Fees, Subscriptions & Promotions	(14,384)	0	0	0	0	0	0	0	0	0	0	(14,384)	20
21	Clerical & General Office Expenses	(47,982)	138,659	0	0	0	0	0	0	0	0	0	90,677	21
22	Employee Benefits & Payroll Taxes	0	23,973	0	0	0	0	0	0	0	0	0	23,973	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	15,188	0	0	0	0	0	0	0	0	0	15,188	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	2,932	0	0	0	0	0	0	0	0	0	2,932	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(75,787)</b>	<b>(70,949)</b>	<b>0</b>	<b>(146,736)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(89,192)</b>	<b>(50,933)</b>	<b>0</b>	<b>(140,125)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Retirement# 0020610

Report Period Beginning:

July 1, 2005 Ending:

June 30, 2006

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	25,531	0	0	0	0	0	0	0	0	0	25,531	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,937)	343	0	0	0	0	0	0	0	0	0	(16,594)	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	<b>TOTAL Ownership</b>	<b>(16,937)</b>	<b>25,874</b>	<b>0</b>	<b>8,937</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(48,146)	0	0	0	0	0	0	0	0	0	0	(48,146)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(48,146)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48,146)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(154,275)</b>	<b>(25,059)</b>	<b>0</b>	<b>(179,334)</b>	<b>45</b>								

Facility Name & ID Number Wabash Christian Retirement

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Report Period Beginning: July 1, 2005 Ending: June 30, 2006

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of board of directors.						

**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.**  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	\$	Christian Homes, Inc	100.00%	\$ 8,874	\$ 8,874	1
2	V	6 Maintenance				11,142	11,142	2
3	V	17 Administrative	352,536			82,256	(270,280)	3
4	V	19 Professional Services				18,579	18,579	4
5	V	21 Clerical				138,659	138,659	5
6	V	22 Employee Benefits				23,973	23,973	6
7	V	24 Travel & Seminar				15,188	15,188	7
8	V	26 Insurance				2,932	2,932	8
9	V	30 Depreciation				25,531	25,531	9
10	V	32 Interest				343	343	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 352,536			\$ 327,477	\$ * (25,059)	14

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

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	This workpaper is not applicable.								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2005 Ending: ne 30, 2006

**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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<a href="#">This workpaper is not applicable.</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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

**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
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Inter-Company N/P	X		Cash Flow	\$8,500.00	3/1/2005	\$ 505,934	\$ 428,418	9/1/2011	0.0850	\$ 39,338	1
2	Tax Exempt Bonds Called But Not Cashd In By The Holder							14,250				2
3	Tax Exempt Bonds On Duplex Called But Not Cashd In By The Holder							750				3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$8,500.00		\$ 505,934	\$ 443,418			\$ 39,338	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 505,934	\$ 443,418			\$ 39,338	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line #           

\* 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.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 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.)		\$ N/A	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	
2001	8																						
2002	9																						
2003	10																						
2004	11																						
2005	12																						
<b>FOR BHF USE ONLY</b>																							
13	FROM R. E. TAX STATEMENT FOR 2005 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

**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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-5136 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>This workpaper is not applicable.</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
6. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
7. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
8. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
9. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocation:**

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   X   NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

**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.

**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?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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 ground (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 Bldgs.

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>60,480</u>	<u>1974</u>	<u>\$ 56,683</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>7,440</u>	<u>2</u>
3	<b>TOTALS</b>	<b>60,480</b>		<b>\$ 64,123</b>	<b>3</b>

Facility Name &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	1974	1958	\$ 1,040,410	\$ 26,010	40	\$ 26,010	\$	\$ 834,507	4
5	78	1976	1976	724,843	18,121	40	18,121		551,835	5
6										6
7										7
8	Home Office Allocation			64,115	7,778		7,778		19,457	8
	<b>Improvement Type**</b>									
9	Building		1978	13,972	399	35	399		11,414	9
10	Boiler Room		1981	3,648		15			3,648	10
11	Building Improvements		1982	19,950	798	25	798		18,631	11
12	Electrical Supplies		1982	234		20			234	12
13	Rewiring Westside		1982	3,000		20			3,000	13
14	Guttering		1982	9,567		15			9,567	14
15	Wallcovering		1982	1,750		10			1,750	15
16	Heating Control Systems		1982	34,046		20			34,046	16
17	Light Fixtures		1984	1,432		10			1,432	17
18	Floor Tile		1985	6,641		10			6,641	18
19	Vinyl & Labor		1985	397		10			397	19
20	Sewer Work		1985	20,976	699	30	699		14,737	20
21	Nurse Station		1985	7,623	98	20	98		7,623	21
22	Hot Water Heaters		1986	4,900		15			4,900	22
23	Boiler System		1986	6,061	304	20	304		6,061	23
24	Floor Tile		1987	977		10			977	24
25	Bathroom Remodel		1987	5,615	281	20	281		5,456	25
26	Wallpaper		1988	870		5			870	26
27	Carpeting		1989	1,086		5			1,086	27
28	Carpeting		1989	800		5			800	28
29	Painting & Papering		1989	856		5			856	29
30	Painting		1989	467		5			467	30
31	Light Fixtures (28)		1989	1,341		10			1,341	31
32	Rooftop A/C Unit (2)		1989	6,280		5			6,280	32
33										33
34										34
35										35
36										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 &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Roof	1989	\$ 81,902	\$ 4,095	20	\$ 4,095	\$	\$ 67,568	37
38	Tile	1990	1,231		5			1,231	38
39	Faucets	1990	1,716		10			1,716	39
40	Carpeting	1990	3,236		5			3,236	40
41	Carpeting	1990	2,392		5			2,392	41
42	Carpeting	1990	2,298		5			2,298	42
43	Carpeting	1990	2,799		5			2,799	43
44	Rooftop A/C Unit (2)	1991	4,080		8			4,080	44
45	Condensing Unit	1991	1,355		10			1,355	45
46	Steel Doors	1991	1,650	110	15	110		1,632	46
47	New Roof	1991	11,931	795	15	795		11,726	47
48	Light Fixtures	1991	2,189		10			2,189	48
49	Remodel 22 Bathrooms	1992	10,313	516	20	516		7,439	49
50	Steel Doors	1992	1,650	110	15	110		1,586	50
51	Wallpaper	1992	1,695		5			1,695	51
52	Remodel Bathrooms	1992	2,331	117	20	117		1,677	52
53	Carpeting	1992	2,480		5			2,480	53
54	Rooftop A/C Unit	1992	5,338	561	8	561		5,338	54
55	Carpeting	1992	3,166		5			3,166	55
56	A/C Units	1992	1,700		5			1,700	56
57	Remodeling	1992	11,704	585	20	585		8,246	57
58	Wallcoverings	1992	1,170		20			1,170	58
59	Water Heater	1992	1,862	124	15	124		1,705	59
60	Base Trim	1993	953		10			953	60
61	Garage Door	1993	848		10			848	61
62	New Roof Beauty Shop	1993	4,515	301	15	301		3,788	62
63	Rheem Water Heater	1994	2,270		10			2,270	63
64	Door	1994	1,365		10			1,365	64
65	Fire Alarm System	1994	26,850	1,343	20	1,343		16,228	65
66	Egress Locks	1994	2,298		10			2,298	66
67	Carpeting	1995	545		5			545	67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,181,689	\$ 63,145		\$ 63,145	\$	\$ 1,714,732	70

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

Facility Name &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,181,689	\$ 63,145		\$ 63,145	\$	\$ 1,714,732		1
2	Kitchen	1995 85,264	2,750	31	2,750		30,846		2
3	Conc. Trought-Laundry	1995 1,183		10			1,183		3
4	Remodel Wing	1995 9,535		5			9,535		4
5	Rooftop A/C Unit Eastside	1995 1,800	30	10	30		1,800		5
6	Remodel Wing 8	1996 8,494		5			8,494		6
7	Tile Kitchen	1997 2,304		5			2,304		7
8	Double Doors	1997 736		5			736		8
9	Remodel Wing	1998 5,534		5			5,534		9
10	Activity Bathroom	1998 6,101		5			6,101		10
11	Security Door	1999 984		5			984		11
12	Congoleum Flooring	2000 3,540		5			3,540		12
13	Paint (Wing 4)	2000 3,153		5			3,153		13
14	Vinyl Floor Covering	2000 1,770		5			1,770		14
15	Vinyl Floor	2000 720		5			720		15
16	Border & Wallpaper	2000 736		5			736		16
17	Kitchen Vinyl	2000 725		5			725		17
18	Handrails (58)	2000 1,283	85	15	85		523		18
19	3 1/2 ton A/C (Wing 3)	2000 1,900		5			1,900		19
20	Trane Furnance and A/C System (Wing 2)	2000 8,164	544	15	544		3,309		20
21	Lamenate Flooring (Bath and Kitchen)	2000 2,091	209	10	209		1,271		21
22	Carpet	2000 1,822		5			1,822		22
23	Carpet ( East Wing)	2000 629		5			629		23
24	Building	2000 236,608	5,915	40	5,915		35,983		24
25	Wing & Bathroom Remodel	2000 23,246	2,325	10	2,325		12,981		25
26	Administrative Wing Remodel	2000 610	15	40	15		93		26
27	Energy Management System	2001 10,000	667	15	667		3,557		27
28	Vinyl Wall Covering	2001 517	96	5	96		517		28
29	Heat/AC Control System	2001 4,100	273	15	273		1,479		29
30	Vinyl for the Walls of Wing #4	10/18/2001 1,437	287	5	287		1,363		30
31	Heating/AC Unit & Install Fire Damper	12/3/2001 9,902	660	15	660		3,025		31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,616,577	\$ 77,001		\$ 77,001	\$	\$ 1,861,345		34

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

Facility Name &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,616,577	\$ 77,001		\$ 77,001		\$ 1,861,345		1
2	Wallpaper Room 107 Bathroom Ceiling	537	107	5	107		490		2
3	Remodel Administrators Office	12,702	847	15	847		3,247		3
4	Vinyl Remnant & Borders/Education Room	1,314	263	5	263		1,096		4
5	Installation New Hand Rails/Wings 2 & 5	2,412	241	10	241		723		5
6	Remodel Administrators Office	2,084	139	15	139		533		6
7	Replace dry valve on fire alarm/sprinkler	3,230	323	10	323		1,292		7
8	Ceiling mount pendant light fixtures	1,040	104	10	104		381		8
9	Remodel West Lobby	51,323	5,132	10	5,132		17,962		9
10	Roof flash & seal new HVAC	3,365	337	10	337		1,151		10
11	Steel doors for service entry	1,900	95	20	95		325		11
12	(2) Rooftop AC units	6,620	662	10	662		2,152		12
13	Move kitchen rooftop AC & ductwork	6,990	350	20	350		1,167		13
14	(2)390DEL-LOCKNETICS door for Wing 7	1,950	130	15	130		401		14
15	Repair ductless AC in dish room	1,079	216	5	216		666		15
16	Tub Wing 1 Shower room	641	64	10	64		197		16
17	Nurse call system	25,795	2,580	10	2,580		7,955		17
18	5 ton Trane 3 phase condensor Wing 1 & 4	3,450	230	15	230		709		18
19	Repair fire alarm svstem	5,692	285	20	285		879		19
20	(2) Del Locks/Power Supply - Wing 7	2,708	271	10	271		790		20
21	Compressor Wall A/C Unit	580	116	5	116		338		21
22	Kitchen Fire Suppression System	2,085	208	10	208		610		22
23	Addition to Nurse Call System	1,868	187	10	187		561		23
24	Carrier Compressor	711	237	3	237		711		24
25	Generator & Accessories	56,551	3,770	15	3,770		10,682		25
26	6 Wall Cabinets	965	64	15	64		171		26
27	80 Gallon Hot Water Heater	4,612	461	10	461		1,191		27
28	Set Commercial Double Doors - East Lobby	1,236	82	15	82		198		28
29	Carpet/Base - DON Office	660	132	5	132		275		29
30	Trane 5 Ton Roof Top A/C East Lobby	6,650	665	10	665		1,275		30
31	Alzheimer's Wing	196,102	13,073	15	13,073		22,878		31
32	Trane 2.5 Ton Roof Top A/C Wing 5 Hallway	3,500	350	10	350		613		32
33	Network Cabling	37,829	3,783	10	3,783		6,620		33
34	TOTAL (lines 1 thru 33)	\$ 3,064,758	\$ 112,505		\$ 112,505		\$ 1,949,584		34

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

Facility Name &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,064,758	\$ 112,505		\$ 112,505	\$	\$ 1,949,584	1
2	Trane 1.5 Ton A/C Computer Server Room	11/15/2004	5,675	568	10	568		947	2
3	Remodeling Wing 3	2/15/2005	7,580	1,516	5	1,516		2,148	3
4	Carpet/Cove Base - Therapy Room	2/7/2005	1,252	250	5	250		354	4
5	Floor Tile/Grout Alzheimer Wing	2/7/2005	530	106	5	106		150	5
6	Roof - West Side of Bldg	4/29/2005	49,880	3,325	15	3,325		4,156	6
7	Handrails/Vinyl - Wings 3 & 9 Hallways	3/2/2005	2,462	492	5	492		656	7
8	Carpet/Base - Room 203	4/30/2005	663	133	5	133		166	8
9	Remodeling Dishwasher Room	5/6/2005	9,365	1,873	5	1,873		2,185	9
10	Replace Sprinkler System Piping	7/1/2006	70,172		10				10
11	Trane Roof Top A/C - Wing 7	5/16/2005	3,050	305	10	305		356	11
12	Land Improvements	6/30/1975	10,000		20			10,000	12
13	Landscaping	5/31/1981	6,683		14			6,683	13
14	Grading	7/6/1987	1,470	74	20	74		1,405	14
15	Sidewalk	5/27/1993	2,395	160	15	160		2,107	15
16	Circular Driveway	10/5/1994	2,628	175	15	175		2,056	16
17	Resurface Parking Lot	7/7/1997	14,035		3			14,035	17
18	Waterfall	3/12/1998	908		5			908	18
19	Landscaping - Courtyard	5/29/1998	1,202		5			1,202	19
20	Asphalt - Parking Lot	8/31/1999	7,440		5			7,440	20
21	Rock for Water Garden	6/17/2000	604	60	10	60		365	21
22	Aquarium - Sere Garden	3/1/2000	1,704	170	10	170		1,077	22
23	Tree	7/12/2000	500	25	20	25		150	23
24	230' Colonial Style Poly Vinyl Fence	11/16/2001	4,638	309	15	309		1,442	24
25	In-ground Transformer	7/31/2003	18,810	940	20	940		2,822	25
26	Sidewalk repair	8/15/2003	10,060	1,006	10	1,006		2,934	26
27	Concrete Work - Gen Bldg Transformer Pads	8/13/2003	5,312	353	15	353		1,033	27
28	Trees for Alzheimers Garden	5/22/2004	1,172	59	20	59		123	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,304,948	\$ 124,404		\$ 124,404	\$	\$ 2,016,484	34

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

Facility Name &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,304,948	\$ 124,404		\$ 124,404		\$ 2,016,484	1
2	Replace/Extend Sidewalks	6/22/2005	15,057	1,004	15	1,004		1,093	2
3	12x18 Barn	11/22/1999	3,000	300	10	300		2,000	3
4	Bus Port	11/11/2003	3,630	242	15	242		625	4
5	Wallpanels 4X8 Chamois Sheet	10/28/2005	1,064	53	15	53		53	5
6	Hand Rails W Brackets & Mis	9/30/2005	3,781	315	10	315		315	6
7	Replacement Windows W/Grid	10/27/2005	23,610	1,181	15	1,181		1,181	7
8	Carpeting Wing 7 Hallway	12/20/2005	4,776	557	5	557		557	8
9	Wallpaper Wing 7	11/21/2005	736	98	5	98		98	9
10	Gutters for Activity	1/24/2006	1,395	70	10	70		70	10
11	(5) Fire Proof Attic Hatch Door	1/31/2006	4,000	100	20	100		100	11
12	(40) Sets Custom Made Cubicles	7/1/2005	1,828	366	5	366		366	12
13	(7) Lighting Fixtures Chandel	7/31/2005	685	68	10	68		68	13
14	ReWork Existing Dry System	8/18/2005	3,840	141	25	141		141	14
15	Carpeting Conference Room	9/30/2005	580	97	5	97		97	15
16	Ceiling Repairs Remodeling	2/1/2006	13,868	289	20	289		289	16
17	Mosaic Tile Wing 4 Shower	3/27/2006	960	16	20	16		16	17
18	(5) Window AC Units For Repla	5/18/2006	2,625	87	5	87		88	18
19	Sprinkler System Improvements	6/13/2006	1,349	11	10	11		11	19
20	(8) Replacement Windows S	6/28/2006	4,800	40	10	40		40	20
21	Install new Culver @ College Blvd	9/27/2005	3,072	142	18	142		142	21
22	Addtl Parking East Side	7/20/2005	9,095	455	20	455		455	22
23	Redo Visitor Parking Lot and Mai	9/12/2005	17,869	745	20	745		745	23
24	Sprinkler Piping Replacement	6/30/2006	30,318		10				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)		\$ 3,456,886	\$ 130,781		\$ 130,781		\$ 2,025,034	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 434,889	\$ 47,997	\$ 47,997	\$	Various	\$ 237,688	71
72	Current Year Purchases	56,046	3,861	3,861		Various	3,861	72
73	Fully Depreciated Assets	302,382				Various	302,382	73
74	Home Office Allocation	126,467	15,838	15,838			95,514	74
75	TOTALS	\$ 919,784	\$ 67,696	\$ 67,696	\$		\$ 639,445	75

D. Vehicle Depreciation (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	Ford Bus	1993	\$ 39,450	\$	\$	\$	5	\$ 39,450	76
77	Patient Transportation	2001 Chrysler Voyager	2004	6,700	1,675	1,675		4	3,210	77
78	Patient Transportation	Tie Down for Chrysler	2006	1,248	78	78			78	78
79	Home Office Allocation			15,291	1,915	1,915			1,916	79
80	TOTALS			\$ 62,689	\$ 3,668	\$ 3,668	\$		\$ 44,654	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)	\$	4,503,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	202,145	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	202,145	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)	\$	2,709,133	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	Apartment	\$ 463,747	\$ 14,852	\$ 264,623	86
87	Land	9,227			87
88	Duplex	40,027	2,427	18,902	88
89					89
90					90
91	TOTALS	\$ 513,001	\$ 17,279	\$ 283,525	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 178,023	92
93	CIP Assisted Living	314,919	93
94	Home Office Allocation	3,393	94
95		\$ 496,335	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: This workpaper is not applicable.  
 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	<b>TOTAL</b>				\$			7

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.	<u>      </u> /2007	\$ <u>      </u>
13.	<u>      </u> /2008	\$ <u>      </u>
14.	<u>      </u> /2009	\$ <u>      </u>

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: \_\_\_\_\_ \*

**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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (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	<b>TOTAL</b>		\$	\$	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.

**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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist	This	hrs											2
3	Licensed Recreational Therapist	workpaper	hrs											3
4	Licensed Physical Therapist	is not	hrs											4
5	Physician Care	applicable.	visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	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.



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,917,423</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,917,423</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>476,167</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>476,167</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>	<b>Affiliate transfers</b>	<b>141,473</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>141,473</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,535,063</b>	<b>24</b> *

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

**VII. 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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,195,112	1
2	Discounts and Allowances for all Levels	(393,049)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,802,063	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	842,005	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 842,005	8
<b>C. Other Operating Revenue</b>			
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	7,925	13
14	Non-Patient Meals	2,465	14
15	Telephone, Television and Radio	4,377	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,714	19
20	Radiology and X-Ray	9,710	20
21	Other Medical Services	15,262	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 60,453	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	107,685	24
25	Interest and Other Investment Income***	41,307	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 148,992	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Residential/Congregate</b>	60,121	28
28a	<b>Management Fees/Gains &amp; Losses on Investments</b>	(5,765)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 54,356	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,907,869	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,168,753	31
32	Health Care	3,302,883	32
33	General Administration	1,581,709	33
<b>B. Capital Expense</b>			
34	Ownership	217,789	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	74,063	35
36	Provider Participation Fee	86,505	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,431,702	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	476,167	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 476,167	43

\* 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 &amp; ID Number Wabash Christian Retirement

# 0020610

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,379	1,543	\$ 108,441	\$ 70.28	1
2	Assistant Director of Nursing	1,791	1,973	41,374	20.97	2
3	Registered Nurses	14,462	15,973	319,567	20.01	3
4	Licensed Practical Nurses	32,069	35,059	527,118	15.04	4
5	CNAs & Orderlies	103,157	113,988	1,037,494	9.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,527	4,755	43,809	9.21	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	14,390	15,836	189,419	11.96	11
12	Dietician					12
13	Food Service Supervisor	1,821	1,986	34,526	17.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,100	27,660	224,389	8.11	15
16	Dishwashers					16
17	Maintenance Workers	3,942	4,483	72,683	16.21	17
18	Housekeepers	13,478	14,996	126,982	8.47	18
19	Laundry	9,395	10,833	98,514	9.09	19
20	Administrator	1,794	1,988	106,766	53.71	20
21	Assistant Administrator	244	268	2,029	7.57	21
22	Other Administrative					22
23	Office Manager	1,696	1,968	36,192	18.39	23
24	Clerical	3,683	4,019	38,239	9.51	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					31
32	Other Health Care Dir of Admissions,	5,681	6,197	69,704	11.25	32
33	Other(specify) Marketing, Comm	5,094	5,697	108,060	18.97	33
34	TOTAL (lines 1 - 33)	243,703	269,222	\$ 3,185,306 *	\$ 11.83	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	246	\$ 10,312	3.1.3	35
36	Medical Director	24	7,200	3.9.3	36
37	Medical Records Consultant	100	2,890	3.10.3	37
38	Nurse Consultant	590	49,854	3.10.3	38
39	Pharmacist Consultant	192	4,248	3.10.3	39
40	Physical Therapy Consultant	3,365	199,303	3.10a.3	40
41	Occupational Therapy Consultant	3,559	228,050	3.10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,121	69,690	3.10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	82	5,079	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9,279	\$ 576,626		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53





Facility Name & ID Number Wabash Christian Retirement# 0020610Report Period Beginning: July 1, 2005 Ending: June 30, 200**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. Life Svc Network \$6,947 & INHAA \$100
- (3) Did the nursing home make political contributions or payments to a political 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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,381 Line 3.10.2
- (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. \$ 86,505  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,465
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
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. \$ 7,136  
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: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.