

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0026955

Facility Name: Washington Christian Village

Address: 1110 Newcastle Road Washington 61571
 Number City Zip Code

County: Tazewell

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

HFS ID Number: 37-0841562006

Date of Initial License for Current Owners: 04/01/1982

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Brenda S. Lavin **Telephone Number:** 217-732-5136

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2005 to June 30, 2006 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) <u>Tim Phillippe</u>	
	(Title) <u>Chief Executive Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Deborah Elsey</u> <u>Principal</u>	
	(Firm Name & Address) <u>Larson, Allen, Weishair & Co.</u> <u>220 South 6th Street, #300, Minneapolis, MN 55402</u>	
	(Telephone) <u>612-376-4642</u> Fax # <u>612-376-4850</u>	

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: 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	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	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	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,519</u>	<u>6,219</u>	<u>5,800</u>	<u>38,538</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,519</u>	<u>6,219</u>	<u>5,800</u>	<u>38,538</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.54%

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)

None

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 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 04/01/1982

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/1982 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 122 and days of care provided 4,202

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number Washington Christian Village # 0026955 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				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	
	A. General Services											
1	Dietary	201,890	25,091	10,483	237,464		237,464		237,464			1
2	Food Purchase		219,975		219,975		219,975	(4,952)	215,023			2
3	Housekeeping	85,400	26,339		111,739		111,739		111,739			3
4	Laundry	74,104			74,104		74,104		74,104			4
5	Heat and Other Utilities			129,228	129,228		129,228	3,182	132,410			5
6	Maintenance	83,970	21,659	33,295	138,924		138,924	10,225	149,149			6
7	Other (specify):* Trash			9,091	9,091		9,091		9,091			7
8	TOTAL General Services	445,364	293,064	182,097	920,525		920,525	8,455	928,980			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,137,462	250,733	59,615	2,447,810		2,447,810	(118,758)	2,329,052			10
10a	Therapy			274,389	274,389		274,389		274,389			10a
11	Activities	23,824			23,824		23,824	(491)	23,333			11
12	Social Services	140,459	2,168	6,754	149,381		149,381		149,381			12
13	CNA Training											13
14	Program Transportation			5,391	5,391		5,391		5,391			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,301,745	252,901	353,349	2,907,995		2,907,995	(119,249)	2,788,746			16
	C. General Administration											
17	Administrative	135,649	873	320,101	456,623		456,623	(237,121)	219,502			17
18	Directors Fees											18
19	Professional Services			10,190	10,190		10,190	17,050	27,240			19
20	Dues, Fees, Subscriptions & Promotions			54,532	54,532		54,532	(16,937)	37,595			20
21	Clerical & General Office Expenses	126,953	5,626	70,831	203,410		203,410	58,878	262,288			21
22	Employee Benefits & Payroll Taxes			570,550	570,550		570,550	22,000	592,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,545	18,545		18,545	7,054	25,599			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,121	98,121		98,121	2,691	100,812			26
27	Other (specify):*											27
28	TOTAL General Administration	262,602	6,499	1,142,870	1,411,971		1,411,971	(146,385)	1,265,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,009,711	552,464	1,678,316	5,240,491		5,240,491	(257,179)	4,983,312			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: July 1, 2005 Ending: June 30, 2006

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
	D. Ownership										
30	Depreciation			171,171	171,171	171,171	23,431	194,602			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			323,628	323,628	323,628	(5,097)	318,531			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Deferred Bond Costs			1,167	1,167	1,167		1,167			36
37	TOTAL Ownership			495,966	495,966	495,966	18,334	514,300			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			16,993	16,993	16,993		16,993			39
40	Barber and Beauty Shops	21,950	1,038		22,988	22,988		22,988			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			66,795	66,795	66,795		66,795			42
43	Other (specify):* Apt/Congregate			131,733	131,733	131,733	(131,733)				43
44	TOTAL Special Cost Centers	21,950	1,038	215,521	238,509	238,509	(131,733)	106,776			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,031,661	553,502	2,389,803	5,974,966	5,974,966	(370,578)	5,604,388			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: July 1, 2005

Ending: June 30, 2006

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	(3,552)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,962)	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				9
10	Interest and Other Investment Income	(5,412)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,104)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(12,189)	43		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	(18,329)	21		24
25	Fund Raising, Advertising and Promotional	(16,937)	20		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 attached	(296,270)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (358,755)		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (358,755)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (1,400)	2	1
2	Activity	(491)	11	2
3	Miscellaneous	(250)	17	3
4	Marketing Seminars	(202)	24	4
5	Marketing Meals	(2,901)	24	5
6	Marketing Transportation	(3,782)	24	6
7	Marketing Salary	(39,561)	21	7
8	Marketing Minor Equipment	(32)	21	8
9	Marketing General Supplies	(1,450)	21	9
10	Marketing Printing	(30)	21	10
11	Marketing Rental and Leasing	(400)	21	11
12	Marketing Finance Charges	(49)	21	12
13	Apt/Cong Supplies	(4,339)	43	13
14	Apt/Cong Management Fee	(10,488)	43	14
15	Apt/Cong Purchased Services	(72)	43	15
16	Apt/Cong Contracted Services	(205)	43	16
17	Apt/Cong Repair and Maintenance	(2,449)	43	17
18	Apt/Cong Electricity	(14,376)	43	18
19	Apt/Cong Gas	(11,197)	43	19
20	Apt/Cong Water	(1,869)	43	20
21	Apt/Cong Sewer	(3,380)	43	21
22	Apt/Cong Depreciation	(25,832)	43	22
23	Apt/Cong Insurance	(22,204)	43	23
24	Apt/Cong Real Estate Tax	(23,133)	43	24
25	Pharmacy Chargeable	(4,920)	10	25
26	Pharmacy Chargeable	(84,097)	10	26
27	Pharmacy - Non - Chargeable	(29,741)	10	27
28	Late Fees, Finance Charges	(1,055)	21	28
29	Bank Fees	(1,649)	21	29
30	Financing Fee	(4,716)	21	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(296,270)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village

0026955

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,952)	0	0	0	0	0	0	0	0	0	0	(4,952)	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	(4,962)	8,144	0	0	0	0	0	0	0	0	0	3,182	5
6	Maintenance	0	10,225	0	0	0	0	0	0	0	0	0	10,225	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,914)	18,369	0	8,455	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	(118,758)	0	0	0	0	0	0	0	0	0	0	(118,758)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(491)	0	0	0	0	0	0	0	0	0	0	(491)	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	(119,249)	0	0	0	0	0	0	0	0	0	0	(119,249)	16
	C. General Administration													
17	Administrative	(250)	(236,871)	0	0	0	0	0	0	0	0	0	(237,121)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,050	0	0	0	0	0	0	0	0	0	17,050	19
20	Fees, Subscriptions & Promotions	(16,937)	0	0	0	0	0	0	0	0	0	0	(16,937)	20
21	Clerical & General Office Expenses	(68,375)	127,253	0	0	0	0	0	0	0	0	0	58,878	21
22	Employee Benefits & Payroll Taxes	0	22,000	0	0	0	0	0	0	0	0	0	22,000	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,885)	13,939	0	0	0	0	0	0	0	0	0	7,054	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	2,691	0	0	0	0	0	0	0	0	0	2,691	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(92,447)	(53,938)	0	(146,385)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(221,610)	(35,569)	0	(257,179)	29								

STATE OF ILLINOIS

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2005 Ending:

Summary B
June 30, 2006

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	23,431	0	0	0	0	0	0	0	0	0	23,431	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,412)	315	0	0	0	0	0	0	0	0	0	(5,097)	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	(5,412)	23,746	0	18,334	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	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):*	(131,733)	0	0	0	0	0	0	0	0	0	0	(131,733)	43
44	TOTAL Special Cost Centers	(131,733)	0	0	0	0	0	0	0	0	0	0	(131,733)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(358,755)	(11,823)	0	(370,578)	45								

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
<u>See attached schedule.</u>						

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 8,144	\$ 8,144 1
2	V	6 Maintenance		Christian Homes, Inc.	100.00%	10,225	10,225 2
3	V	17 Administration	312,360	Christian Homes, Inc.	100.00%	75,489	(236,871) 3
4	V	19 Professional Services		Christian Homes, Inc.	100.00%	17,050	17,050 4
5	V	21 Clerical		Christian Homes, Inc.	100.00%	127,253	127,253 5
6	V	22 Employee Benefits		Christian Homes, Inc.	100.00%	22,000	22,000 6
7	V	24 Travel & Seminar		Christian Homes, Inc.	100.00%	13,939	13,939 7
8	V	26 Insurance		Christian Homes, Inc.	100.00%	2,691	2,691 8
9	V	30 Depreciation		Christian Homes, Inc.	100.00%	23,431	23,431 9
10	V	32 Interest		Christian Homes, Inc.	100.00%	315	315 10
11	V						
12	V						
13	V						
14	Total		\$ 312,360			\$ 300,537	\$ * (11,823) 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:

July 1, 2005

Ending:

June 30, 2006

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	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: 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

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

Name of Related Organization Christian Homes, Inc.
 Street Address 200 N. Postville Dr.
 City / State / Zip Code Lincoln, IL 62656
 Phone Number ()
 Fax Number ()

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					\$	\$		\$	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

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	Tax Exempt		x	Building & Equipment	\$8,033.00	9/1/1991	\$ 1,000,000	\$ 440,000	9/1/2011	0.0600	\$ 27,900	1								
2	1996-A		x	Redeem Debt	\$3,541.00	7/1/1996	500,000	407,000	7/1/2021	0.0700	28,837	2								
3	1999-A		x	Redeem Debt	\$6,745.00	1/1/1999	1,000,000	851,400	1/1/2024	0.0650	55,955	3								
4	2001-Y (92%)		x	Refinance Debt	\$13,921.00	10/1/2001	2,300,000	2,247,484	10/1/2031	0.0600	141,345	4								
5	Revolving Loan		x	Roof Work - Building	\$552.00	12/1/1997	79,346	32,213	8/1/2011	0.0200	709	5								
Working Capital																				
6	CHI Bond		x	Operations	\$6,000.00	5/1/2003	817,485	808,660	1/1/2043	0.0850	68,882	6								
7												7								
8												8								
9	TOTAL Facility Related				\$38,792.00		\$ 5,696,832	\$ 4,786,757			\$ 323,628	9								
B. Non-Facility Related*																				
10	2001-Y (8%)		x	Refinance Debt	\$1,210.00	10/1/2001	200,000	195,433	10/1/2031	0.0600	12,189	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$1,210.00		\$ 200,000	\$ 195,433			\$ 12,189	14								
15	TOTALS (line 9+line14)						\$ 5,896,832	\$ 4,982,190			\$ 335,817	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.)

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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Brenda S. Lavin

TELEPHONE 217-732-5136 FAX #: ()

A. Summary of Real Estate Tax Cost

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>02-02-14-308-001</u>	<u>Devonshire Estates 5th Add Sec 11</u>	\$ <u>6,357.14</u>	\$ <u> </u>
2. <u>02-02-14-300-023</u>	<u>PT Lot 30 SW 1/4</u>	\$ <u>1,777.54</u>	\$ <u> </u>
3. <u>02-02-14-300-021</u>	<u>Devonshire Estates 5th Addn</u>	\$ <u>14,482.14</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>
TOTALS		\$ <u>22,616.82</u>	\$ <u> </u>

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 & 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.

Facility Name & ID Number Washington Christian Village

0026955 Report Period Beginning:

July 1, 2005 Ending:

June 30, 2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,956 B. General Construction Type: Exterior Brick Frame 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 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).

Apartments

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>38,484</u>	<u>1982</u>	<u>\$ 50,000</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>6,828</u>	<u>2</u>
3	TOTALS	38,484		\$ 50,000	3

Facility Name & ID Number Washington Christian Village

0026955

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 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	\$ 34,373	35	\$ 34,373		\$ 834,408	4
5											5
6											6
7											7
8		Home Office Allocation			57,005	7,139		7,139		17,856	8
		Improvement Type**									
9		Office Door		1982	299	9	35	9		217	9
10		A/C Compressor		1982	1,200		5			1,200	10
11		Improvements		1982	13,562	387	35	387		9,095	11
12		Improvements		1983	34,486	985	35	985		22,901	12
13		Sprinkler System		1983	1,806	72	25	72		1,680	13
14		A/C Condensers		1983	4,775		20			4,775	14
15		Boiler		1983	8,332		20			8,332	15
16		Water Heater		1983	321		15			321	16
17		Sign		1984	2,800		12			2,800	17
18		Door		1984	231	7	20	7		156	18
19		Nurse Call System		1984	2,930		15			2,930	19
20		Alarm System		1984	786		20			786	20
21		Remodeling		1985	18,956	542	35	542		11,653	21
22		Tub Room		1985	1,230		15			1,230	22
23		Insulation		1985	4,890	10	20	10		4,890	23
24		Light Fixtures		1985	425		10			425	24
25		Ceiling Tile		1985	323	3	20	3		323	25
26		Roof repairs		1985	342,609	9,789	35	9,789		210,464	26
27		Fire door		1986	400	12	20	12		400	27
28		Insulation		1986	4,203	210	20	210		4,130	28
29		Decorations		1988	342		5			342	29
30		Wall coverings		1988	356		5			356	30
31		Improvements		1988	3,706	106	35	106		1,935	31
32		Duct Work		1988	313		10			313	32
33											33
34											34
35		Nurse Call System		1989	8,534		15			8,534	35
36		22 Overbed lights		1989	1,579		10			1,579	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:

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	Bath station	1989	\$ 558	\$	15	\$	\$	\$ 558	37
38	Floor coverings	1990	1,765		5			1,765	38
39	Relay Stone and Tuckwork	1991	2,395	120	20	120		1,830	39
40	Water Heater	1991	1,223		10			1,223	40
41	Gutter & Soffit	1992	9,161	611	15	611		8,554	41
42	Water Heater	1993	1,134		10			1,134	42
43	Boiler	1993	11,405	760	15	760		9,563	43
44	Fire System-Horn/Strobe	1994	1,560		10			1,560	44
45	Water Heater	1994	890		10			890	45
46	Main/Store Room Doors	1994	1,730		10			1,730	46
47	Electrical Outlets	1994	813		10			813	47
48									48
49	Doors	1995	3,368		10			3,368	49
50	Cabinets SFF Dining	1995	2,189	146	15	146		1,630	50
51	Hot H2O Lines/Rerout	1995	7,345		5			7,345	51
52	Rubber Adhered Roof	1996	62,678	3,134	20	3,134		32,646	52
53	BTC 200 Water Heater	1996	2,384	143	10	143		2,384	53
54	Kitchen Door	1996	622	43	10	43		622	54
55	Exhaust Fan/Light	1996	918	82	10	82		918	55
56	Add 4 baseboard heaters	1996	1,100	110	10	110		1,073	56
57	Wallpaper	1996	2,417		5			2,417	57
58	Remodel foyer area	1996	17,101	1,710	10	1,710		16,387	58
59	Carpeting - Front Entry	1997	974		5			974	59
60	Roof Work - North Wing	1997	32,480	2,165	15	2,165		18,763	60
61	IDPH Construction Project fee	1997	910	91	10	91		637	61
62									62
63	Replace cove base	1999	2,009	201	10	201		1,591	63
64	100 gal. Gas water heater	1999	2,358	236	10	236		1,849	64
65	Kitchen fire suppression system	1999	1,307	131	10	131		993	65
66	Wallpaper office conference room	1999	2,148		5			2,148	66
67	Condensing unit	1999	875	88	10	88		623	67
68	Wallpaper office alcove	1999	1,894		5			1,894	68
69	Carpeting offices	1999	3,510		5			3,510	69
70	TOTAL (lines 4 thru 69)		\$ 1,900,672	\$ 63,415		\$ 63,415	\$	\$ 1,285,423	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:

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		\$ 1,900,672	\$ 63,415		\$ 63,415	\$	\$ 1,285,423	1
2	Chaplain's Office A/C Unit	2000	875	88	10	88		572	2
3	Smoke Detectors (3)	2000	544	54	10	54		374	3
4	Boiler	2000	5,250	263	20	263		1,600	4
5	Automatic Opener Front Doors	2000	5,204	520	10	520		2,947	5
6	Airphone Emergency Phone System	2001	2,005	201	10	201		1,089	6
7	Remodeling South Wing	2001	47,029	3,135	15	3,135		16,459	7
8	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419	484	5	484		2,299	8
9	Remodeling South Wing	9/1/2001	1,755	117	15	117		566	9
10	Upgrades to Boiler System	11/1/2001	19,857	1,986	10	1,986		9,268	10
11	(3) Steel Doors	12/24/2001	1,371	137	10	137		628	11
12	Modular Nurses Station	5/24/2002	4,744	474	10	474		1,975	12
13	Opto 22 - Heating/AC Control System	1/8/2002	15,227	761	20	761		3,425	13
14	Architects Fees/Remodeling of Building	6/1/2002	11,383	759	15	759		3,099	14
15	Remodeling	4/30/2002	93,076	6,205	15	6,205		26,371	15
16	Remodel Front Entrance	4/24/2002	840	56	15	56		238	16
17	Remodel North Corridor/Wall Coverings	5/1/2002	66,545	13,309	5	13,309		55,454	17
18	Remodel North Corridor/Carpet	4/30/2002	27,270	5,454	5	5,454		23,180	18
19	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	1,367	15	1,367		5,810	19
20	Replace A/C in Lobby	4/25/2002	2,276	228	10	228		969	20
21	Carpet/New Offices Near Lunch Room	5/1/2002	560	112	5	112		467	21
22	Corridor Door	4/30/2002	743	74	10	74		315	22
23	Remodel New Offices Near Lunch Room	5/1/2002	1,319	132	10	132		550	23
24	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262	1,252	5	1,252		5,112	24
25	100 Gallon AO Smith Water Heater	7/17/2002	3,600	360	10	360		1,440	25
26	Remodeling - Offices	3/1/2003	8,522	852	10	852		2,840	26
27	Remodel Employee Break Room	3/1/2003	2,118	424	5	424		1,400	27
28	Architects Fees/Building Front	3/1/2003	319	21	15	21		70	28
29	Remodel Front Entrance	8/8/2003	34,300	2,287	15	2,287		6,670	29
30	Tile Floors-Rms 154 & 174 Central Hall etc	9/13/2003	882	176	5	176		499	30
31	Repipe Boiler System	10/8/2003	2,581	258	10	258		710	31
32	Replace Tubes & Tube Sheets/Boiler	11/6/2003	6,950	1,390	5	1,390		3,707	32
33	Roof Repairs	11/13/2003	2,758	552	5	552		1,472	33
34	TOTAL (lines 1 thru 33)		\$ 2,299,763	\$ 106,903		\$ 106,903	\$	\$ 1,466,998	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:

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		\$ 2,299,763	\$ 106,903		\$ 106,903	\$	\$ 1,466,998	1
2	Fabricate/Install Piping - O2 Room	1/22/2004	580	116	5	116		290	2
3	(2) Auto Door Closers	1/29/2004	527	105	5	105		263	3
4	Move/Add Smoke Detectors	2/17/2004	3,503	350	10	350		846	4
5	Project Review Fee	2/29/2004	2,400						5
6	Remodel SW Alcove	5/17/2004	909	91	10	91		197	6
7	A/C Compressor - Activity Dept	6/11/2004	1,462	487	3	487		1,015	7
8	Commercial Disposal	7/19/2004	1,105	221	5	221		442	8
9	Engineering Costs - Sprinkler System	8/12/2004	11,556	1,156	10	1,156		2,216	9
10	Convert Activity Space to PT	12/31/2004	11,042	1,104	10	1,104		1,748	10
11	Installation of New Sprinkler System	2/1/2005	115,822	11,582	10	11,582		16,408	11
12	Redo South Desk Area (State Regs)	4/1/2005	2,231	223	10	223		279	12
13									13
14	Fire Doors in Center Hall	3/22/2005	2,054	205	10	205		290	14
15	Install Fire Doors/Central Hall & Linen Closet	3/26/2005	3,600	360	10	360		480	15
16	West Wing Closet Door w/installation	5/24/2005	1,655	331	5	331		386	16
17									17
18	Outside shelter	2/20/1996	5,349	311	10	311		5,349	18
19	16 x 18 shed	11/7/1997	2,520	252	10	252		2,184	19
20	Fully depreciated land improvements	4/1/1982	43,675		15			43,675	20
21	Sewer	2/26/1988	987	49	20	49		902	21
22	Blacktop	8/25/1988	7,275		15			7,275	22
23	Resurface parking	6/30/1993	10,785		10			10,785	23
24	Sidewalk, west	10/22/1996	950	95	10	95		926	24
25	Landscaping front	5/6/2002	11,053	1,105	10	1,105		5,505	25
26	Wall Covering and Supplies	8/19/2005	7,894	1,447	5	1,447		1,447	26
27	Vinyl Floor Covering, SW Hall	7/18/2005	545	55	10	55		55	27
28	Southeast Shower Room	6/30/2006	3,081						28
29	Remodel SW Hall/Lobby	6/30/2006	91,120						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,643,443	\$ 126,548		\$ 126,548	\$	\$ 1,569,961	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: July 1, 2005 Ending: June 30, 2006

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	\$ 311,899	\$ 37,737	\$ 37,737	\$	Various	\$ 168,402	71
72	Current Year Purchases	42,140	3,571	3,571		Various	3,571	72
73	Fully Depreciated Assets	259,320	6,875	6,875		Various	259,320	73
74	Home Office Allocation	116,063	14,535	14,535			87,657	74
75	TOTALS	\$ 729,422	\$ 62,718	\$ 62,718	\$		\$ 518,950	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	1995 Ford Bus	1995	\$ 44,381	\$	\$	\$	8	\$ 44,381	76
77	Repairs & Restor. Of 1995	1995 Ford Bus	2005	11,714	3,579	3,579		3	3,579	77
78										78
79	Home Office Allocation			14,033	1,757	1,757			1,759	79
80	TOTALS			\$ 70,128	\$ 5,336	\$ 5,336	\$		\$ 49,719	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)	\$ 3,492,993	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,602	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,602	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)	\$ 2,138,630	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	Land Improvements	8,903	390	7,611	87
88	Buildings & Equipment	664,639	25,442	449,661	88
89					89
90					90
91	TOTALS	\$ 794,198	\$ 25,832	\$ 457,272	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 221,377	92
93	CIP - Assisted Living	323,428	93
94	Home Office Allocation	3,114	94
95		\$ 547,919	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: 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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Washington Christian Village# 0026955 Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							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.

Facility Name & ID Number Washington Christian Village# 0026955Report Period Beginning: July 1, 2005

Ending:

June 30, 2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of June 30, 2006 (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	\$ 36,934	\$	1
2	Cash-Patient Deposits	15,139		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>31,015</u>)	978,596		3
4	Supply Inventory (priced at)	22,871		4
5	Short-Term Investments	2,845		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,532		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc. Int. Rec., A/R - Other, Pledg</u>	31,514		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,094,431	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	3,157,939		14
15	Leasehold Improvements, at Historical Cost	83,628		15
16	Equipment, at Historical Cost	687,867		16
17	Accumulated Depreciation (book methods)	(2,488,630)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	260,810		21
22	Other Long-Term Assets (spe CIP)	544,805		22
23	Other(specify): <u>Deferred Bond Costs</u>	6,028		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,423,103	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,517,534	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 154,965	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,139		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,003		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,925		32
33	Accrued Interest Payable	2,200		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Liabilities</u>	31,704		36
37	<u>Due to Auxiliary</u>	3,398		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 415,334	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	147,213		39
40	Mortgage Payable			40
41	Bonds Payable	4,949,977		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees</u>	64,368		43
44	<u>Security Dep Pay./Due Life Right Resident</u>	72,500		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,234,058	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,649,392	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,131,858)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,517,534	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,089,392)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,089,392)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(618,941)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (618,941)	17
	B. Transfers (Itemize):		
18	Transfers from Affiliates	1,576,475	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,576,475	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,131,858)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village# 0026955Report Period Beginning: July 1, 2005Ending: June 30, 2006**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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,556,233	1
2	Discounts and Allowances for all Levels	(2,168,622)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,387,611	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	521,014	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 521,014	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	23,903	13
14	Non-Patient Meals	3,552	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,568	19
20	Radiology and X-Ray	12,774	20
21	Other Medical Services	5,547	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,151	23
D. Non-Operating Revenue			
24	Contributions	160,368	24
25	Interest and Other Investment Income***	8,280	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,648	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apartment/Duplex</u>	204,963	28
28a	<u>Other Revenue</u>	(362)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 204,601	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,356,025	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	920,525	31
32	Health Care	2,907,995	32
33	General Administration	1,411,971	33
B. Capital Expense			
34	Ownership	495,966	34
C. Ancillary Expense			
35	Special Cost Centers	171,714	35
36	Provider Participation Fee	66,795	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,974,966	40
41	Income before Income Taxes (line 30 minus line 40)**	(618,941)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (618,941)	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 & ID Number Washington Christian Village

0026955

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	1,568	1,732	\$ 123,570	\$ 71.35	1
2	Assistant Director of Nursing	1,868	1,981	49,305	24.89	2
3	Registered Nurses	11,144	13,862	296,149	21.36	3
4	Licensed Practical Nurses	19,613	23,101	442,893	19.17	4
5	CNAs & Orderlies	82,539	93,183	1,091,146	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,819	2,046	24,449	11.95	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	10,284	11,452	143,224	12.51	11
12	Dietician					12
13	Food Service Supervisor	1,416	1,481	27,495	18.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,938	21,369	174,395	8.16	15
16	Dishwashers					16
17	Maintenance Workers	6,119	6,629	83,970	12.67	17
18	Housekeepers	8,577	9,214	85,400	9.27	18
19	Laundry	8,129	8,736	74,104	8.48	19
20	Administrator	1,427	1,600	135,649	84.78	20
21	Assistant Administrator	389	439	11,956	27.23	21
22	Other Administrative					22
23	Office Manager	1,882	1,971	37,201	18.87	23
24	Clerical	3,472	3,640	38,235	10.50	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 Ward Clerk	2,490	2,704	32,114	11.88	32
33	Other(specify) <u>Community Liaison</u>	8,598	9,349	160,406	17.16	33
34	TOTAL (lines 1 - 33)	190,272	214,489	\$ 3,031,661 *	\$ 14.13	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	249	\$ 10,483	1.3	35
36	Medical Director	12	7,200	9.3	36
37	Medical Records Consultant	24	3,960	10.3	37
38	Nurse Consultant	388	32,136	10.3	38
39	Pharmacist Consultant	180	3,207	10.3	39
40	Physical Therapy Consultant	2,559	133,455	10A.3	40
41	Occupational Therapy Consultant	2,079	108,360	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	410	32,574	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	89	5,430	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,990	\$ 336,805		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 Washington Christian Village

0026955

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sherry Gutermuth	Administrator		\$ 135,649	Workers' Compensation Insurance	\$ 122,652	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,938	Advertising: Employee Recruitment	18,116	
				FICA Taxes	223,101	Health Care Worker Background Check		
				Employee Health Insurance	198,360	(Indicate # of checks performed <u>77</u>)	770	
				Employee Meals		License, Dues, Subscriptions	18,709	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Promotion	16,937	
				Workers' Comp Medical Expense	39			
				Employee Physicals	4,126			
				Employee Uniforms	2,089			
				Employee Expense	11,245	Less: Public Relations Expense	()	
				Home Office Allocations	22,000	Non-allowable advertising	(16,937)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 135,649	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)					\$ 592,550		\$ 37,595	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee			\$ 312,360				Out-of-State Travel	\$
Other Expense			7,741					
							In-State Travel	10,455
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 320,101	TOTAL			Seminar Expense	1,205
(Attach a copy of any management service agreement)							Home Office Allocations	13,939
C. Professional Services								
Vendor/Payee	Type		Amount					
F R & R	Consulting		\$ 2,250				Entertainment Expense	()
Shank Public Relations	Phone Calls		56				(agree to Sch. V, line 24, col. 8)	
Davis & Campbell	Legal		3,717				TOTAL	\$ 25,599
Krieg Devault	Legal		4,167					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 10,190					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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 Services Network, \$3,261.02
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,807 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. _____
- (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. \$ 66,795
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. \$ No Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,552
- (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. \$ 15,199
- c. What percent of all travel expense relates to transportation of nurses and patients? 28%
- 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.