

Facility Name & ID Number Washington Christian Village# 0026955 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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>44,652</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>44,652</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>19,170</u>	<u>9,276</u>	<u>9,424</u>	<u>37,870</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>19,170</u>	<u>9,276</u>	<u>9,424</u>	<u>37,870</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.81%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

NoneF. 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 6,284Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	220,229	20,294	12,582	253,105		253,105		253,105		1
2	Food Purchase		212,147		212,147		212,147	(5,805)	206,342		2
3	Housekeeping	168,824	20,115		188,939		188,939		188,939		3
4	Laundry		5,539		5,539		5,539		5,539		4
5	Heat and Other Utilities			166,047	166,047		166,047	(4,279)	161,768		5
6	Maintenance	71,747	24,111	53,045	148,903		148,903	3,205	152,108		6
7	Other (specify):* Trash			8,940	8,940		8,940		8,940		7
8	TOTAL General Services	460,800	282,206	240,614	983,620		983,620	(6,879)	976,741		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,276,267	422,869	44,769	2,743,905	(250,461)	2,493,444		2,493,444		10
10a	Therapy			638,265	638,265		638,265		638,265		10a
11	Activities	38,485			38,485		38,485		38,485		11
12	Social Services	138,560	2,336	6,522	147,418		147,418		147,418		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			4,157	4,157		4,157		4,157		15
16	TOTAL Health Care and Programs	2,453,312	425,205	700,913	3,579,430	(250,461)	3,328,969		3,328,969		16
	C. General Administration										
17	Administrative	111,521	737	378,004	490,262		490,262	(387,692)	102,570		17
18	Directors Fees										18
19	Professional Services			23,308	23,308		23,308	41,599	64,907		19
20	Dues, Fees, Subscriptions & Promotions			42,052	42,052		42,052	(6,703)	35,349		20
21	Clerical & General Office Expenses	147,817	6,877	62,917	217,611		217,611	80,672	298,283		21
22	Employee Benefits & Payroll Taxes			499,399	499,399		499,399	15,624	515,023		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,576	19,576		19,576	16,053	35,629		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			98,611	98,611		98,611	1,129	99,740		26
27	Other (specify):*										27
28	TOTAL General Administration	259,338	7,614	1,123,867	1,390,819		1,390,819	(239,318)	1,151,501		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,173,450	715,025	2,065,394	5,953,869	(250,461)	5,703,408	(246,197)	5,457,211		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

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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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			171,091	171,091		171,091	14,699	185,790		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			277,135	277,135		277,135	(240,447)	36,688		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			26,207	26,207		26,207		26,207		35
36	Other (specify):*										36
37	TOTAL Ownership			474,433	474,433		474,433	(225,748)	248,685		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			84,201	84,201	250,461	334,662		334,662		39
40	Barber and Beauty Shops	25,476	774		26,250		26,250		26,250		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			66,978	66,978		66,978		66,978		42
43	Other (specify):* Apt & Congregate				124,002		124,002	(124,002)			43
44	TOTAL Special Cost Centers	25,476	774	151,179	301,431	250,461	551,892	(124,002)	427,890		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,198,926	715,799	2,691,006	6,729,733		6,729,733	(595,947)	6,133,786		45

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

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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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,100)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,651)	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	(240,447)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,063)	21		24
25	Fund Raising, Advertising and Promotional	(6,703)	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	(274,082)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (554,046)		\$	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)	(41,901)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,901)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (595,947)		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	X		250,461	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 250,461		47

BHF USE ONLY					
48		49		50	51
					52

Washington Christian Village

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ (705)	2	1
2	Late Fees, Finance Charges	(152)	21	2
3	Miscellaneous	(77,646)	17	3
4	Apt/Congregate	(124,002)	43	4
5	Fines & Penalties	(4,412)	21	5
6	Bank Fees	(4,210)	21	6
7	Marketing Salary	(56,898)	21	7
8	Financing Fee	(4,812)	21	8
9	Marketing General Supplies	(1,241)	21	9
10	Marketing Printing	(4)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(274,082)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2007

Ending:

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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	(5,805)	0	0	0	0	0	0	0	0	0	0	(5,805)	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	(14,651)	10,372	0	0	0	0	0	0	0	0	0	(4,279)	5
6	Maintenance	0	3,205	0	0	0	0	0	0	0	0	0	3,205	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,456)	13,577	0	(6,879)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(77,646)	(310,046)	0	0	0	0	0	0	0	0	0	(387,692)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	41,599	0	0	0	0	0	0	0	0	0	41,599	19
20	Fees, Subscriptions & Promotions	(6,703)	0	0	0	0	0	0	0	0	0	0	(6,703)	20
21	Clerical & General Office Expenses	(84,792)	165,464	0	0	0	0	0	0	0	0	0	80,672	21
22	Employee Benefits & Payroll Taxes	0	15,624	0	0	0	0	0	0	0	0	0	15,624	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	16,053	0	0	0	0	0	0	0	0	0	16,053	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	1,129	0	0	0	0	0	0	0	0	0	1,129	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(169,141)	(70,177)	0	(239,318)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(189,597)	(56,600)	0	(246,197)	29								

STATE OF ILLINOIS

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Summary B
June 30, 2008

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	14,699	0	0	0	0	0	0	0	0	0	14,699	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(240,447)	0	0	0	0	0	0	0	0	0	0	(240,447)	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	(240,447)	14,699	0	(225,748)	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):*	(124,002)	0	0	0	0	0	0	0	0	0	0	(124,002)	43
44	TOTAL Special Cost Centers	(124,002)	0	0	0	0	0	0	0	0	0	0	(124,002)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(554,046)	(41,901)	0	(595,947)	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
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	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%	\$ 10,372	\$ 10,372
2	V	6 Maintenance				3,205	3,205
3	V	17 Administration	376,092			66,046	(310,046)
4	V	19 Professional Services				41,599	41,599
5	V	21 Clerical				165,464	165,464
6	V	22 Employee Benefits				15,624	15,624
7	V	24 Travel & Seminar				16,053	16,053
8	V	26 Insurance				1,129	1,129
9	V	30 Depreciation				14,699	14,699
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 376,092			\$ 334,191	\$ * (41,901)

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

Facility Name & ID Number

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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.

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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 _____
 Street Address _____
 City / State / Zip Code _____
 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	Bond Fund	X		Refinancing debt	\$10,324.00	various	\$ 4,316,302	\$ 4,316,302	6/30/2032	varies	\$ 277,135	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$10,324.00		\$ 4,316,302	\$ 4,316,302			\$ 277,135	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,316,302	\$ 4,316,302			\$ 277,135	15								

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-723-5175 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>6,409.00</u>	\$ _____
2. <u>02-02-14-300-021</u>	<u>Devonshire Estates 5th Addn</u>	\$ <u>15,091.00</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>21,500.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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, 2007 Ending:

June 30, 2008

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>	1
2	<u>Home Office Allocation</u>			<u>5,293</u>	2
3	TOTALS	38,484		\$ 55,293	3

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	\$	\$ 902,289	4
5											5
6											6
7											7
8	Home Office Allocations				49,278	3,451		3,451		81,924	8
	Improvement Type**										
9	Office Door			1982	299	9	35	9		223	9
10	A/C Compressor			1982	1,200		5			1,200	10
11	Improvements			1982	13,562	387	35	387		10,075	11
12	Improvements			1983	34,486	985	35	985		25,125	12
13	Sprinkler System			1983	1,806	48	25	48		1,806	13
14	A/C Condensers			1983	4,775		20			4,775	14
15	Door			1984	231	7	20	7		161	15
16	Nurse Call System			1984	2,930		15			2,930	16
17	Alarm System			1984	786		20			786	17
18	Remodeling			1985	18,956	542	35	542		12,502	18
19	Tub Room			1985	1,230		15			1,230	19
20	Insulation			1985	4,890		20			4,890	20
21	Light Fixtures			1985	425		10			425	21
22	Roof repairs			1985	342,609	9,789	35	9,789		230,038	22
23	Fire door			1986	400		20			400	23
24	Insulation			1986	4,203		20			4,203	24
25	Decorations			1988	342		5			342	25
26	Wall coverings			1988	356		5			356	26
27	Improvements			1988	3,706	106	35	106		2,144	27
28	Duct Work			1988	313		10			313	28
29	Nurse Call System			1989	8,534		15			8,534	29
30	22 Overbed lights			1989	1,579		10			1,579	30
31											31
32											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 & ID Number Washington Christian Village

0026955

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		2,066	39
40									40
41	Gutter & Soffit	1992	9,161		15			9,161	41
42	Water Heater	1993	1,134		10			1,134	42
43									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									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		38,913	52
53	BTC 200 Water Heater	1996	2,384		10			2,384	53
54	Kitchen Door	1996	622		10			622	54
55	Exhaust Fan/Light	1996	918		10			918	55
56	Add 4 baseboard heaters	1996	1,100		10			1,100	56
57									57
58	Remodel foyer area	1996	17,101		10			17,101	58
59									59
60	Roof Work - North Wing	1997	32,480	2,165	15	2,165		23,097	60
61	IDPH Construction Project fee	1997	910	38	10	38		910	61
62									62
63	Replace cove base	1999	2,009	201	10	201		1,993	63
64	100 gal. Gas water heater	1999	2,358	236	10	236		2,319	64
65	Kitchen fire suppression system	1999	1,307	131	10	131		1,255	65
66	Wallpaper office conference room	1999	2,148		5			2,148	66
67	Condensing unit	1999	875	88	10	88		795	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)		\$ 1,862,961	\$ 55,810		\$ 55,810	\$	\$ 1,427,599	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, 2007 Ending: June 30, 2008

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	Totals from Page 12A, Carried Forward		\$ 1,862,961	\$ 55,810		\$ 55,810	\$	\$ 1,427,599	37
38	Chaplain's Office A/C Unit	2000	875	88	10	88		780	38
39	Smoke Detectors (3)	2000	544	54	10	54		462	39
40									40
41	Automatic Opener Front Doors	2000	5,204	520	10	520		3,990	41
42	Airphone Emergency Phone System	2001	2,005	201	10	201		1,487	42
43	Remodeling South Wing	2001	47,029	3,135	15	3,135		22,731	43
44	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419		5			2,419	44
45	Remodeling South Wing	9/1/2001	1,755	117	15	117		800	45
46									46
47	(3) Steel Doors	12/24/2001	1,371	137	10	137		903	47
48	Modular Nurses Station	5/24/2002	4,744	474	10	474		2,925	48
49	Opto 22 - Heating/AC Control System	1/8/2002	15,227	761	20	761		4,949	49
50	Architects Fees/Remodeling of Building	6/1/2002	11,383	759	15	759		4,617	50
51	Remodeling	4/30/2002	93,076	6,205	15	6,205		37,877	51
52	Remodel Front Entrance	4/24/2002	840	56	15	56		350	52
53	Remodel North Corridor/Wall Coverings	5/1/2002	66,545		5			66,545	53
54	Remodel North Corridor/Carpet	4/30/2002	27,270		5			27,270	54
55	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	1,367	15	1,367		8,545	55
56	Replace A/C in Lobby	4/25/2002	2,276	228	10	228		1,423	56
57	Carpet/New Offices Near Lunch Room	5/1/2002	560		5			560	57
58	Corridor Door	4/30/2002	743	74	10	74		464	58
59	Remodel New Offices Near Lunch Room	5/1/2002	1,319	132	10	132		813	59
60	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262		5			6,262	60
61	100 Gallon AO Smith Water Heater	7/17/2002	3,600	360	10	360		2,160	61
62	Remodeling - Offices	3/1/2003	8,522	852	10	852		4,545	62
63	Remodel Employee Break Room	3/1/2003	2,118	282	5	282		2,118	63
64	Architects Fees/Building Front	3/1/2003	319	21	15	21		113	64
65	Remodel Front Entrance	8/8/2003	34,300	2,287	15	2,287		11,243	65
66	Tile Floors-Rms 154 & 174 Central Hall etc	9/13/2003	882	176	5	176		853	66
67	Repipe Boiler System	10/8/2003	2,581	258	10	258		1,226	67
68									68
69	Roof Repairs	11/13/2003	2,758	552	5	552		2,574	69
70	TOTAL (lines 4 thru 69)		\$ 2,229,995	\$ 74,906		\$ 74,906	\$	\$ 1,648,603	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, 2007 Ending: June 30, 2008

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	Totals from Page 12B, Carried Forward		\$ 2,229,995	\$ 74,906		\$ 74,906	\$	\$ 1,648,603	37
38	Fabricate/Install Piping - O2 Room	1/22/2004	580	116	5	116		522	38
39	(2) Auto Door Closers	1/29/2004	527	105	5	105		474	39
40	Move/Add Smoke Detectors	2/17/2004	3,503	350	10	350		1,547	40
41									41
42	Remodel SW Alcove	5/17/2004	909	91	10	91		379	42
43	A/C Compressor - Activity Dept	6/11/2004	1,462		3			1,462	43
44	Commercial Disposal	7/19/2004	1,105	221	5	221		884	44
45	Engineering Costs - Sprinkler System	8/12/2004	11,556	1,156	10	1,156		4,526	45
46	Convert Activity Space to PT	12/31/2004	11,042	1,104	10	1,104		3,957	46
47	Installation of New Sprinkler System	2/1/2005	115,822	11,582	10	11,582		39,572	47
48	Redo South Desk Area (State Regs)	4/1/2005	2,231	223	10	223		725	48
49									49
50	Fire Doors in Center Hall	3/22/2005	2,054	205	10	205		685	50
51	Install Fire Doors/Central Hall & Linen Closet	3/26/2005	3,600	360	10	360		1,200	51
52	West Wing Closet Door w/installation	5/24/2005	1,655	331	5	331		1,048	52
53									53
54	Outside shelter	2/20/1996	5,349		10			5,349	54
55	16 x 18 shed	11/7/1997	2,520	84	10	84		2,520	55
56	Fully depreciated land improvements	4/1/1982	43,675		15			43,675	56
57	Sewer	2/26/1988	987	29	20	29		987	57
58	Blacktop	8/25/1988	7,275		15			7,275	58
59	Resurface parking	6/30/1993	10,785		10			10,785	59
60	Sidewalk, west	10/22/1996	950		10			950	60
61	Landscaping front	5/6/2002	11,053	1,105	10	1,105		7,715	61
62	Wall Covering and Supplies	8/19/2005	7,894	1,579	5	1,579		4,605	62
63	Vinyl Floor Covering, SW Hall	7/18/2005	545	55	10	55		164	63
64	Southeast Shower Room	6/30/2006	3,079	616	5	616		2,104	64
65	Remodel SW Hall/Lobby	6/30/2006	91,120	4,556	20	4,556		9,112	65
66	Sprinkler System	7/1/2006	16,996	680	25	680		1,360	66
67	Reclaim/Rehab remodel room signs, smoke detectors, closets	7/1/2006	4,485	897	5	897		1,794	67
68	SW Hall & Lobby-lighting, fire door, baseboard heat/window	7/1/2006	67,534	3,376	20	3,376		6,753	68
69	Door alarm system/patient wandering	7/1/2006	12,756	1,276	10	1,276		2,552	69
70	TOTAL (lines 4 thru 69)		\$ 2,673,044	\$ 105,003		\$ 105,003	\$	\$ 1,813,284	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, 2007 Ending: June 30, 2008

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Totals from Page 12C, Carried Forward		\$ 2,673,044	\$ 105,003		\$ 105,003	\$	\$ 1,813,284	37
38	S.E. shower room	7/1/2006	11,316	1,132	10	1,132		2,263	38
39	Center Hall & SE Hall lighting project, sprinkler relocate	7/1/2006	36,102	1,805	20	1,805		3,610	39
40	Closet Shelving	7/1/2006	3,730	373	10	373		746	40
41	Buffet/Chapel remodel, paint, wallpaper, cabinet, countertop	7/1/2006	5,770	1,154	5	1,154		2,308	41
42	NE & NW Nurses Station Ceiling & Light, smoke detector, AC	8/1/2006	61,238	3,062	20	3,062		5,869	42
43	Air conditioning for Kitchen	8/31/2006	17,634	1,763	10	1,763		3,380	43
44	Electric restoration - new cable in main service	9/25/2006	4,000	200	20	200		367	44
45	Steelcraft doors rm 171LH & 173 RH and hinges	11/29/2006	642	43	15	43		71	45
46	Window glass replacement in rm 165 center panel and slides	12/4/2006	511	51	10	51		81	46
47	window for beauty shop	4/1/2007	575	58	10	58		96	47
48	Install relay and buzzer for generator batteries	6/11/2007	730	73	10	73		79	48
49	Nurse Call & door alarm	6/1/2007	3,198	320	10	320		346	49
50	Install attic rooftop vents	6/26/2007	6,440	644	10	644		698	50
51	Parking Lot resurface and reseal	7/1/2006	5,628	1,126	5	1,126		2,251	51
52	sidewalk for NW fire exit	7/1/2006	3,632	363	10	363		726	52
53	Vestibule remodel	8/1/2007	5,915	542	10	542		542	53
54	Air conditioner unit for Activities	8/1/2007	1,843	169	10	169		169	54
55	Generator and Boiler replacement project	11/1/2007	165,063	5,502	20	5,502		5,502	55
56	Miniblinds fro main dining room	12/17/2007	598	70	5	70		70	56
57	Generator and Boiler replacement	12/1/2007	12,635	737	10	737		737	57
58	SW/Reclaim unit dining area	2/1/2008	922	39	10	39		39	58
59	Supplies for SW/Nurse station	4/1/2008	5,690	142	10	142		142	59
60	SW cooridor AC replacement	6/1/2008	33,860	282	10	282		282	60
61	NW cooridor AC replacement	6/1/2008	36,325	303	10	303		303	61
62	Rehab to home remodeling	9/1/2007	985	164	5	164		164	62
63	Courtyard	8/1/2007	689	63	10	63		63	63
64	Boiler (Retirement)	6/30/2000		154	20	154			64
65	Boiler (Retirement)	12/28/1993		447	15	447			65
66	Replace Tube and tube sheets in boiler (Retirement)	11/6/2003		817	5	817			66
67	Upgrades to boiler system (retirement)	11/1/2001		1,166	10	1,166			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,098,715	\$ 127,767		\$ 127,767	\$	\$ 1,844,188	70

**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	\$ 300,850	\$ 40,822	\$ 40,822	\$		\$ 154,191	71
72	Current Year Purchases	22,682	2,048	2,048			2,048	72
73	Fully Depreciated Assets	202,132					202,132	73
74	Home office allocation	144,652	10,129	10,129			22,739	74
75	TOTALS	\$ 670,316	\$ 52,999	\$ 52,999	\$		\$ 381,110	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	2002	11,714	3,904	3,904		3	11,389	77
78	Home Office Allocation			15,990	1,120	1,120			6,081	78
79										79
80	TOTALS			\$ 72,085	\$ 5,024	\$ 5,024	\$		\$ 61,851	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)		\$ 3,896,409	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 185,790	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 185,790	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ #REF!	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,287,149	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	325	8,280	87
88	Buildings & Equipment	682,500	26,727	498,235	88
89					89
90					90
91	TOTALS	\$ 812,059	\$ 27,052	\$ 506,515	91

G. Construction-in-Progress

	Description	Cost	
92	Home office allocation	\$ 5,590	92
93			93
94			94
95		\$ 5,590	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: _____

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 26,207 Description: See attached schedule

(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? <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. <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, 2007 Ending: June 30, 2008

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units	5 Cost				
1	Licensed Occupational Therapist		hrs	\$	4,545	\$ 274,860	\$	4,545	\$ 274,860	1
2	Licensed Speech and Language Development Therapist		hrs		1,257	89,915		1,257	89,915	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,509	273,489		4,509	273,489	4
5	Physician Care		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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,311	\$ 638,264	\$	10,311	\$ 638,264	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, 2007

Ending:

June 30, 2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of June 30, 2008 (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	\$ (1,064,420)	\$	1
2	Cash-Patient Deposits	12,911		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (113,784))	1,106,997		3
4	Supply Inventory (priced at)	20,390		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,676		6
7	Other Prepaid Expenses	7,754		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interst/Other A/R</u>	216,131		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 302,439	\$	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	3,632,819		14
15	Leasehold Improvements, at Historical Cost	93,577		15
16	Equipment, at Historical Cost	596,203		16
17	Accumulated Depreciation (book methods)	(2,682,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	76,291		21
22	Other Long-Term Assets (spe CIP)	824		22
23	Other(specify): <u>Note Receivable</u>	1,842,199		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,729,649	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,032,088	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 133,106	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,911		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,774		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	38,220		36
37	<u>FIN 47 Liability</u>	19,260		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 475,771	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,316,302		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	43,241		43
44	<u>Apt & Congregate</u>	57,044		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,416,587	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,892,358	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (860,270)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,032,088	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,873,337)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,873,337)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,013,067	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)	\$ 1,013,067	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (860,270)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

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	\$ 7,380,845	1
2	Discounts and Allowances for all Levels	(1,406,208)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,974,637	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	964,146	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 964,146	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	26,884	13
14	Non-Patient Meals	5,100	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	119,759	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,436	19
20	Radiology and X-Ray	15,640	20
21	Other Medical Services	26,707	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 216,526	23
D. Non-Operating Revenue			
24	Contributions	87,687	24
25	Interest and Other Investment Income***	243,721	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 331,408	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	196,858	28
28a	<u>Miscellaneous</u>	59,225	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 256,083	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,742,800	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	983,620	31
32	Health Care	3,579,430	32
33	General Administration	1,390,819	33
B. Capital Expense			
34	Ownership	474,433	34
C. Ancillary Expense			
35	Special Cost Centers	234,453	35
36	Provider Participation Fee	66,978	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,729,733	40
41	Income before Income Taxes (line 30 minus line 40)**	1,013,067	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,013,067	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, 2007

Ending:

June 30, 2008

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	1,364	1,502	\$ 63,906	\$ 42.55	1
2	Assistant Director of Nursing	1,663	1,761	50,877	28.89	2
3	Registered Nurses	13,030	14,975	384,352	25.67	3
4	Licensed Practical Nurses	20,366	22,792	477,878	20.97	4
5	CNAs & Orderlies	81,880	88,595	1,128,742	12.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,231	2,231	17,803	7.98	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	11,520	12,808	140,142	10.94	11
12	Dietician					12
13	Food Service Supervisor	1,867	2,010	33,172	16.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,304	21,063	187,057	8.88	15
16	Dishwashers					16
17	Maintenance Workers	5,046	5,916	71,747	12.13	17
18	Housekeepers	16,688	17,832	168,825	9.47	18
19	Laundry					19
20	Administrator	1,860	1,927	111,521	57.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,159	2,237	38,625	17.27	23
24	Clerical	3,284	3,857	48,086	12.47	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(specify)	3,940	4,034	48,430	12.01	32
33	Other(specify)	8,591	9,621	227,763	23.67	33
34	TOTAL (lines 1 - 33)	194,793	213,161	\$ 3,198,926 *	\$ 15.01	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	277	\$ 12,582	3.1.3	35
36	Medical Director	60	7,200	3.9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	180	3,566	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	80	4,912	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	597	\$ 28,260		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	436	\$ 32,681	3.10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	436	\$ 32,681		53

Facility Name & ID Number Washington Christian Village

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 - \$6,122
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,421 Line 10-3
- (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. \$ 66,978
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,100
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 12,671
- c. What percent of all travel expense relates to transportation of nurses and patients? _____
- 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: LarsonAllen 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 \$5,000, 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.