

Facility Name & ID Number Washington Christian Village

0026955 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	16,892	10,096	9,175	36,163	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,892	10,096	9,175	36,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.21%

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 4/1/1982

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/1/1982 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 6,101

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2009 Fiscal Year: 6/30/2009

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

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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	254,673	32,282	14,477	301,432		301,432		301,432		1
2	Food Purchase		243,910		243,910		243,910	(6,322)	237,588		2
3	Housekeeping	183,710	22,693		206,403		206,403		206,403		3
4	Laundry		5,089		5,089		5,089		5,089		4
5	Heat and Other Utilities			137,598	137,598		137,598	(839)	136,759		5
6	Maintenance	80,448	11,056	33,911	125,415		125,415	2,441	127,856		6
7	Other (specify):* Trash			7,763	7,763		7,763		7,763		7
8	TOTAL General Services	518,831	315,030	193,749	1,027,610		1,027,610	(4,720)	1,022,890		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,410,644	421,194	8,498	2,840,336	(258,283)	2,582,053		2,582,053		10
10a	Therapy			805,445	805,445		805,445		805,445		10a
11	Activities	76,823			76,823		76,823		76,823		11
12	Social Services	104,184	2,153	7,076	113,413		113,413		113,413		12
13	CNA Training										13
14	Program Transportation			6,215	6,215		6,215		6,215		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,591,651	423,347	834,434	3,849,432	(258,283)	3,591,149		3,591,149		16
	C. General Administration										
17	Administrative	108,925	2,983	442,800	554,708		554,708	(378,916)	175,792		17
18	Directors Fees										18
19	Professional Services			3,010	3,010		3,010	29,553	32,563		19
20	Dues, Fees, Subscriptions & Promotions			27,789	27,789		27,789		27,789		20
21	Clerical & General Office Expenses	98,627	10,405	44,327	153,359		153,359	164,476	317,835		21
22	Employee Benefits & Payroll Taxes			550,043	550,043		550,043	27,355	577,398		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,580	10,580		10,580	12,573	23,153		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,649	108,649		108,649	1,471	110,120		26
27	Other (specify):* Marketing	64,166	2,075	16,083	82,324		82,324	(82,324)			27
28	TOTAL General Administration	271,718	15,463	1,203,281	1,490,462		1,490,462	(225,812)	1,264,650		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,382,200	753,840	2,231,464	6,367,504	(258,283)	6,109,221	(230,532)	5,878,689		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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Report Period Beginning: July 1, 2008 Ending: June 30, 2009

June 30, 2009

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			176,781	176,781		176,781	17,231	194,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			249,239	249,239		249,239	(159,004)	90,235			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,143	24,143		24,143		24,143			35
36	Other (specify):*											36
37	TOTAL Ownership			450,163	450,163		450,163	(141,773)	308,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			76,697	76,697	258,283	334,980		334,980			39
40	Barber and Beauty Shops	25,560	837		26,397		26,397		26,397			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			120,344	120,344		120,344	(120,344)				43
44	TOTAL Special Cost Centers	25,560	837	263,836	290,233	258,283	548,516	(120,344)	428,172			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,407,760	754,677	2,945,463	7,107,900		7,107,900	(492,649)	6,615,251			45

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

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (1,602)	2	1
2	Late Fees, Finance Charges	58	21	2
3	Miscellaneous	(132)	17	3
4	Apt/Congregate	(120,344)	43	4
5	Bank Fees	(2,947)	21	5
6	Financing Fee	(8,532)	21	6
7	Charity Care	(3,792)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(137,291)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village# 0026955

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,322)	0	0	0	0	0	0	0	0	0	0	(6,322)	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	(10,730)	9,891	0	0	0	0	0	0	0	0	0	(839)	5
6	Maintenance	0	2,441	0	0	0	0	0	0	0	0	0	2,441	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,052)	12,332	0	(4,720)	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	(132)	(378,784)	0	0	0	0	0	0	0	0	0	(378,916)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	29,553	0	0	0	0	0	0	0	0	0	29,553	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(14,226)	178,702	0	0	0	0	0	0	0	0	0	164,476	21
22	Employee Benefits & Payroll Taxes	0	27,355	0	0	0	0	0	0	0	0	0	27,355	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,573	0	0	0	0	0	0	0	0	0	12,573	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	1,471	0	0	0	0	0	0	0	0	0	1,471	26
27	Other (specify):*	(82,324)	0	0	0	0	0	0	0	0	0	0	(82,324)	27
28	TOTAL General Administration	(96,682)	(129,130)	0	(225,812)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(113,734)	(116,798)	0	(230,532)	29								

STATE OF ILLINOIS

Facility Name & ID Number Washington Christian Village# 0026955

Report Period Beginning:

July 1, 2008 Ending:

Summary B

June 30, 2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	17,231	0	0	0	0	0	0	0	0	0	17,231	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(160,864)	1,860	0	0	0	0	0	0	0	0	0	(159,004)	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	(160,864)	19,091	0	(141,773)	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):*	(120,344)	0	0	0	0	0	0	0	0	0	0	(120,344)	43
44	TOTAL Special Cost Centers	(120,344)	0	0	0	0	0	0	0	0	0	0	(120,344)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(394,942)	(97,707)	0	(492,649)	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%	\$ 9,891	\$ 9,891	1
2	V	6 Maintenance				2,441	2,441	2
3	V	17 Administration	442,800			64,016	(378,784)	3
4	V	19 Professional Services				29,553	29,553	4
5	V	21 Clerical				178,702	178,702	5
6	V	22 Employee Benefits				27,355	27,355	6
7	V	24 Travel & Seminar				12,573	12,573	7
8	V	26 Insurance				1,471	1,471	8
9	V	30 Depreciation				17,231	17,231	9
10	V	32 Interest				1,860	1,860	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 442,800			\$ 345,093	\$ * (97,707)	14

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

Facility Name & ID Number

Washington Christian Village

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Report Period Beginning: July 1, 2008

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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	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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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	This workpaper is not applicable				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

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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										
										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	\$11,104.00	Various	\$ 4,316,302	\$ 4,161,158	6/30/2032	0.0587	\$ 249,239	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$11,104.00		\$ 4,316,302	\$ 4,161,158			\$ 249,239	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	\$ 4,161,158			\$ 249,239	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.)

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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 Use	2 Square Feet	3 Year Acquired	4 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>5,297</u>	<u>2</u>
3	TOTALS	38,484		\$ 55,297	3

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	122	1982		\$ 1,203,052	\$ 34,373	35	\$ 34,373	\$	\$ 936,662	4
5										5
6										6
7										7
8	Home Office Allocation			50,317	3,685		3,685		94,773	8
	Improvement Type**									
9	Office Door	1982		299	9	35	9		232	9
10	A/C Compressor	1982		1,200		5			1,200	10
11	Improvements	1982		13,562	387	35	387		10,462	11
12	Improvements	1983		34,486	985	35	985		26,111	12
13	Sprinkler System	1983		1,806		25			1,806	13
14	A/C Condensers	1983		4,775		20			4,775	14
15	Door	1984		231	7	20	7		167	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		13,044	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		239,826	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		2,250	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	Chaplain's Office A/C Unit	2000		875	88	10	88		868	31
32	Smoke Detectors (3)	2000		544	54	10	54		517	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, 2008 Ending: June 30, 2009

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		2,185	39
40	Gutter & Soffit	1992	9,161		15			9,161	40
41	Water Heater	1993	1,134		10			1,134	41
42	Fire System-Horn/Strobe	1994	1,560		10			1,560	42
43	Water Heater	1994	890		10			890	43
44	Main/Store Room Doors	1994	1,730		10			1,730	44
45	Electrical Outlets	1994	813		10			813	45
46	Doors	1995	3,368		10			3,368	46
47	Hot H2O Lines/Rerout	1995	7,345		5			7,345	47
48	Rubber Adhered Roof	1996	62,678	3,134	20	3,134		42,046	48
49	BTC 200 Water Heater	1996	2,384		10			2,384	49
50	Kitchen Door	1996	622		10			622	50
51	Exhaust Fan/Light	1996	918		10			918	51
52	Add 4 baseboard heaters	1996	1,100		10			1,100	52
53	Remodel foyer area	1996	17,101		10			17,101	53
54	Roof Work - North Wing	1997	32,480	2,165	15	2,165		25,262	54
55	IDPH Construction Project fee	1997	910		10			910	55
56	Replace cove base	1999	2,009	17	10	17		2,009	56
57	100 gal. Gas water heater	1999	2,358	39	10	39		2,358	57
58	Kitchen fire suppression system	1999	1,307	54	10	54		1,307	58
59	Wallpaper office conference room	1999	2,148		5			2,148	59
60	Condensing unit	1999	875	80	10	80		875	60
61	Wallpaper office alcove	1999	1,894		5			1,894	61
62	Carpeting offices	1999	3,510		5			3,510	62
63	Automatic Opener Front Doors	2000	5,204	520	10	520		4,510	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,870,623	\$ 56,154		\$ 56,154	\$	\$ 1,498,144	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, 2008 Ending: June 30, 2009

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		\$ 1,870,623	\$ 56,154		\$ 56,154	\$	\$ 1,498,144	1
2	Airphone Emergency Phone System	2001	2,005	201	10	201		1,688	2
3	Remodeling South Wing	2001	47,029	3,135	15	3,135		25,866	3
4	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419		5			2,419	4
5	Remodeling South Wing	9/1/2001	1,755	117	15	117		917	5
6	(3) Steel Doors	12/24/2001	1,371	137	10	137		1,040	6
7	Modular Nurses Station	5/24/2002	4,744	474	10	474		3,400	7
8	Opto 22 - Heating/AC Control System	1/8/2002	15,227	761	20	761		5,710	8
9	Architects Fees/Remodeling of Building	6/1/2002	11,383	759	15	759		5,375	9
10	Remodeling	4/30/2002	93,076	6,205	15	6,205		44,987	10
11	Remodel Front Entrance	4/24/2002	840	56	15	56		406	11
12	Remodel North Corridor/Wall Coverings	5/1/2002	66,545		5			66,545	12
13	Remodel North Corridor/Carpet	4/30/2002	27,270		5			27,270	13
14	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	1,367	15	1,367		9,912	14
15	Replace A/C in Lobby	4/25/2002	2,276	228	10	228		1,650	15
16	Carpet/New Offices Near Lunch Room	5/1/2002	560		5			560	16
17	Corridor Door	4/30/2002	743	74	10	74		539	17
18	Remodel New Offices Near Lunch Room	5/1/2002	1,319	132	10	132		945	18
19	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262		5			6,262	19
20	100 Gallon AO Smith Water Heater	7/17/2002	3,600	360	10	360		2,520	20
21	Remodeling - Offices	3/1/2003	8,522	852	10	852		5,397	21
22	Remodel Employee Break Room	3/1/2003	2,118		5			2,118	22
23	Architects Fees/Building Front	3/1/2003	319	21	15	21		135	23
24	Remodel Front Entrance	8/8/2003	34,300	2,287	15	2,287		13,529	24
25	Tile Floors-Rms 154 & 174 Central Hall etc	9/13/2003	882	29	5	29		882	25
26	Repipe Boiler System	10/8/2003	2,581	258	10	258		1,484	26
27	Roof Repairs	11/13/2003	2,758	184	5	184		2,758	27
28	Fabricate/Install Piping - O2 Room	1/22/2004	580	58	5	58		580	28
29	(2) Auto Door Closers	1/29/2004	527	53	5	53		527	29
30	Move/Add Smoke Detectors	2/17/2004	3,503	350	10	350		1,897	30
31	Remodel SW Alcove	5/17/2004	909	91	10	91		470	31
32	A/C Compressor - Activity Dept	6/11/2004	1,462		3			1,462	32
33	Commercial Disposal	7/19/2004	1,105	221	5	221		1,105	33
34	TOTAL (lines 1 thru 33)		\$ 2,239,120	\$ 74,564		\$ 74,564	\$	\$ 1,738,499	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, 2008 Ending: June 30, 2009

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		\$ 2,239,120	\$ 74,564		\$ 74,564	\$	\$ 1,738,499	1
2	Engineering Costs - Sprinkler System	8/12/2004	11,556	1,156	10	1,156		5,682	2
3	Convert Activity Space to PT	12/31/2004	11,042	1,104	10	1,104		5,061	3
4	Installation of New Sprinkler System	2/1/2005	115,822	11,582	10	11,582		51,155	4
5	Redo South Desk Area (State Regs)	4/1/2005	2,231	223	10	223		948	5
6	Fire Doors in Center Hall	3/22/2005	2,054	205	10	205		890	6
7	Install Fire Doors/Central Hall & Linen Closet	3/26/2005	3,600	360	10	360		1,560	7
8	West Wing Closet Door w/installation	5/24/2005	1,655	331	5	331		1,379	8
9	Outside shelter	2/20/1996	5,349		10			5,349	9
10	16 x 18 shed	11/7/1997	2,520		10			2,520	10
11	Fully depreciated land improvements	4/1/1982	43,675		15			43,675	11
12	Sewer	2/26/1988	987		20			987	12
13	Blacktop	8/25/1988	7,275		15			7,275	13
14	Resurface parking	6/30/1993	10,785		10			10,785	14
15	Sidewalk, west	10/22/1996	950		10			950	15
16	Landscaping front	5/6/2002	11,053	1,105	10	1,105		7,921	16
17	Wall Covering and Supplies	8/19/2005	7,894	1,579	5	1,579		6,184	17
18	Vinyl Floor Covering, SW Hall	7/18/2005	545	55	10	55		218	18
19	Southeast Shower Room	6/30/2006	3,079	616	5	616		2,720	19
20	Remodel SW Hall/Lobby	6/30/2006	91,120	4,556	20	4,556		13,668	20
21	Sprinkler System	7/1/2006	16,996	680	25	680		2,040	21
22	Reclaim/Rehab remodel room signs, smoke detectors, closets	7/1/2006	4,485	897	5	897		2,691	22
23	SW Hall & Lobby-lighting, fire door, baseboard heat/window	7/1/2006	67,534	3,377	20	3,377		10,130	23
24	Door alarm system/patient wandering	7/1/2006	12,756	1,276	10	1,276		3,827	24
25	S.E. shower room	7/1/2006	11,316	1,132	10	1,132		3,395	25
26	Center Hall & SE Hall lighting project, sprinkler relocate	7/1/2006	36,102	1,805	20	1,805		5,415	26
27	Closet Shelving	7/1/2006	3,730	373	10	373		1,119	27
28	NE & NW Nurses Station Ceiling & Light, smoke detector, AC	8/1/2006	61,238	3,062	20	3,062		8,931	28
29	Air conditioning for Kitchen	8/31/2006	17,634	1,763	10	1,763		5,143	29
30	Electric restoration - new cable in main service	9/25/2006	4,000	200	20	200		567	30
31	Steelcraft doors rm 171LH & 173 RH and hinges	11/29/2006	642	43	15	43		114	31
32	Window glass replacement in rm 165 center panel and slides	12/4/2006	511	51	10	51		132	32
33	window for beauty shop	4/1/2007	575	58	10	58		153	33
34	TOTAL (lines 1 thru 33)		\$ 2,809,831	\$ 112,153		\$ 112,153	\$	\$ 1,951,083	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, 2008 Ending: June 30, 2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,809,831	\$ 112,153		\$ 112,153	\$	\$ 1,951,083	1
2	Install relay and buzzer for generator batteries	6/11/2007	730	73	10	73		152	2
3	Nurse Call & door alarm	6/1/2007	3,198	320	10	320		666	3
4	Install attic rooftop vents	6/26/2007	6,440	644	10	644		1,342	4
5	Parking Lot resurface and reseal	7/1/2006	5,628	1,126	5	1,126		3,377	5
6	sidewalk for NW fire exit	7/1/2006	3,632	363	10	363		1,090	6
7	Vestibule remodel	8/1/2007	5,915	591	10	591		1,134	7
8	Air conditioner unit for Activities	8/1/2007	1,843	184	10	184		353	8
9	Generator and Boiler replacement project	11/1/2007	165,063	8,253	20	8,253		13,755	9
10	Miniblinds fro main dining room	12/17/2007	598	120	5	120		189	10
11	Generator and Boiler replacement	12/1/2007	12,635	1,264	10	1,264		2,001	11
12	SW/Reclaim unit dining area	2/1/2008	922	92	10	92		131	12
13	Supplies for SW/Nurse station	4/1/2008	5,690	569	10	569		711	13
14	SW cooridor AC replacement	6/1/2008	33,860	3,386	10	3,386		3,668	14
15	NW cooridor AC replacement	6/1/2008	36,325	3,633	10	3,633		3,935	15
16	Rehab to home remodeling	9/1/2007	985	197	5	197		361	16
17	Courtyard	8/1/2007	689	69	10	69		132	17
18	Kitchen floor & remodel	1/1/2009	37,874	1,894	10	1,894		1,894	18
19	100 gallon water heater - natural gas	1/1/2009	6,298	315	10	315		315	19
20	Replacement windows - NW wing	1/1/2009	12,025	601	10	601		601	20
21	Chapel remodeling	6/1/2009	39,238	327	10	327		327	21
22	Carrier roof top AC units - dining room	2/1/2009	27,975	1,166	10	1,166		1,166	22
23	Southeast corridor cooling system	2/1/2009	35,600	1,483	10	1,483		1,483	23
24	2 cabinet unit heaters - north wing	2/1/2009	7,000	292	10	292		292	24
25	Upgrade to door alarms	2/1/2009	2,465	103	10	103		103	25
26	North room renovation	6/30/2009	65,912	549	10	549		549	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,328,371	\$ 139,766		\$ 139,766	\$	\$ 1,990,809	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 276,355	\$ 36,148	\$ 36,148	\$	Various	\$ 144,403	71
72	Current Year Purchases	44,709	4,226	4,226		Various	4,226	72
73	Fully Depreciated Assets	219,417					219,417	73
74	Home Office Allocation	165,788	12,140	12,140			24,574	74
75	TOTALS	\$ 706,269	\$ 52,514	\$ 52,514	\$		\$ 392,620	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	325	325		3	11,714	77
78	Home Office Allocation			19,202	1,406	1,406			8,556	78
79										79
80	TOTALS			\$ 75,297	\$ 1,731	\$ 1,731	\$		\$ 64,651	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,165,234	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,012	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,012	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)	\$ 2,448,080	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	8,605	87
88	Buildings & Equipment	691,617	26,230	524,464	88
89					89
90					90
91	TOTALS	\$ 821,176	\$ 26,555	\$ 533,069	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 4,903	92
93			93
94			94
95		\$ 4,903	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

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: \$ 24,143 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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	4,946	\$ 319,933	\$	4,946	\$ 319,933	1
2	Licensed Speech and Language Development Therapist		hrs		2,049	144,824		2,049	144,824	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,995	340,688		4,995	340,688	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			\$	11,991	\$ 805,445	\$	11,991	\$ 805,445	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, 2008Ending: June 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2009 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (122,714)	\$	1
2	Cash-Patient Deposits	18,544		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (80,006))	1,035,917		3
4	Supply Inventory (priced at)	18,436		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,575		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/Other A/R</u>	367,290		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,329,048	\$	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	3,870,553		14
15	Leasehold Improvements, at Historical Cost	93,577		15
16	Equipment, at Historical Cost	611,020		16
17	Accumulated Depreciation (book methods)	(2,853,246)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	70,991		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Note Receivable</u>	1,842,199		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,805,750	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,134,798	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 200,780	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,544		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,884		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,315		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>	55,367		36
37	<u>Current Portion Refundable Ent Fees</u>	4,300		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 547,190	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,161,158		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees/Other Liab</u>	53,461		43
44	<u>Apt & Congregate</u>	52,798		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,267,417	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,814,607	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 320,191	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,134,798	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (860,270)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (860,270)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,180,461	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)	\$ 1,180,461	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)	\$ 320,191	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Washington Christian Village

0026955

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

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	\$ 7,583,126	1
2	Discounts and Allowances for all Levels	(1,764,014)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,819,112	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,816,856	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,816,856	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	24,854	13
14	Non-Patient Meals	4,720	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	143,291	17
18	Sale of Supplies to Non-Patients	5,895	18
19	Laboratory	17,377	19
20	Radiology and X-Ray	11,234	20
21	Other Medical Services	13,375	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 220,746	23
D. Non-Operating Revenue			
24	Contributions	83,138	24
25	Interest and Other Investment Income***	160,864	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 244,002	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	191,416	28
28a	<u>Miscellaneous</u>	(3,771)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 187,645	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,288,361	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,027,610	31
32	Health Care	3,849,432	32
33	General Administration	1,490,462	33
B. Capital Expense			
34	Ownership	450,163	34
C. Ancillary Expense			
35	Special Cost Centers	223,438	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)*	\$ 7,107,900	40
41	Income before Income Taxes (line 30 minus line 40)**	1,180,461	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,180,461	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, 2008

Ending:

June 30, 2009

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	1,659	1,848	\$ 81,624	\$ 44.17	1
2	Assistant Director of Nursing	1,713	1,888	53,587	28.38	2
3	Registered Nurses	13,969	15,922	438,764	27.56	3
4	Licensed Practical Nurses	21,709	24,217	499,779	20.64	4
5	CNAs & Orderlies	84,260	94,387	1,154,121	12.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,749	1,932	27,455	14.21	8
9	Activity Director	1,502	1,552	20,527	13.23	9
10	Activity Assistants	5,641	5,909	52,104	8.82	10
11	Social Service Workers	3,381	4,214	60,129	14.27	11
12	Dietician					12
13	Food Service Supervisor	1,754	1,959	34,944	17.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,889	23,897	219,729	9.19	15
16	Dishwashers					16
17	Maintenance Workers	5,684	6,128	80,448	13.13	17
18	Housekeepers	17,284	18,659	183,710	9.85	18
19	Laundry					19
20	Administrator	1,727	1,927	108,925	56.53	20
21	Assistant Administrator					21
22	Other Administrative	836	886	10,495	11.85	22
23	Office Manager	2,425	2,629	32,782	12.47	23
24	Clerical	3,127	4,387	65,845	15.01	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 C: Ward Clerk, Dir o	4,109	4,537	50,765	11.19	32
33	Other(specify) <u>Comm Liason, MI</u>	9,056	9,970	232,027	23.27	33
34	TOTAL (lines 1 - 33)	203,474	226,848	\$ 3,407,760 *	\$ 15.02	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	270	\$ 13,567	3.1.3	35
36	Medical Director	36	7,200	3.9.3	36
37	Medical Records Consultant	12	300	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,515	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	100	3.10A.3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	93	5,612	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	606	\$ 30,294		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# 0026955Report Period Beginning: July 1, 2008 Ending: June 30, 2008**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 - \$6,257.40
- (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. \$ 31,020 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. \$ 66,795
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,720
- (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. \$ 14,003
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
- (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.