

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

<p>I. IDPH License ID Number: <u>0020610</u></p> <p>Facility Name: <u>Wabash Christian Retirement</u></p> <p>Address: <u>216 College Blvd Carmi 62821</u> <small>Number City Zip Code</small></p> <p>County: <u>White</u></p> <p>Telephone Number: <u>618-382-4644</u> Fax # <u>618-382-2350</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/1/1974</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kenna Hudson</u> Telephone Number: <u>314-587-7924</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/14</u> to <u>6/30/15</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Dr. Timothy Phillippe</u> (Title) <u>CEO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Amanda Tinney, CPA Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP 600 Washington Ave. Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4389</u> Fax # <u>314-925-4350</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Dr. Timothy Phillippe</u> (Title) <u>CEO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Amanda Tinney, CPA Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP 600 Washington Ave. Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4389</u> Fax # <u>314-925-4350</u>
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Facility Name & ID Number Wabash Christian Retirement

0020610 Report Period Beginning: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	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	23,428	15,962	9,820	49,210	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,428	15,962	9,820	49,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.42%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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 6/1/1974

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 156 and days of care provided 8,539

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: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number

Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	346,940	14,284	16,804	378,028		378,028		378,028		1
2	Food Purchase		297,572		297,572		297,572	(5,046)	292,526		2
3	Housekeeping	167,054	38,074		205,128		205,128		205,128		3
4	Laundry	67,211	3,575		70,786		70,786		70,786		4
5	Heat and Other Utilities			178,678	178,678		178,678	(1,618)	177,060		5
6	Maintenance	140,215	24,900	47,625	212,740		212,740	5,193	217,933		6
7	Other (specify):* Trash			3,959	3,959		3,959		3,959		7
8	TOTAL General Services	721,420	378,405	247,066	1,346,891		1,346,891	(1,471)	1,345,420		8
	B. Health Care and Programs										
9	Medical Director			8,200	8,200		8,200		8,200		9
10	Nursing and Medical Records	3,007,690	158,679	12,661	3,179,030		3,179,030		3,179,030		10
10a	Therapy		3,392	1,048,045	1,051,437		1,051,437		1,051,437		10a
11	Activities	121,281	2,399		123,680		123,680	(2,920)	120,760		11
12	Social Services	176,961	649	8,531	186,141		186,141		186,141		12
13	CNA Training										13
14	Program Transportation			6,912	6,912		6,912	(6,912)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,305,932	165,119	1,084,349	4,555,400		4,555,400	(9,832)	4,545,568		16
	C. General Administration										
17	Administrative	138,382	826	605,000	744,208		744,208	(454,205)	290,003		17
18	Directors Fees										18
19	Professional Services			30,663	30,663		30,663	45,171	75,834		19
20	Dues, Fees, Subscriptions & Promotions			33,279	33,279		33,279		33,279		20
21	Clerical & General Office Expenses	155,863	10,218	160,682	326,763		326,763	219,106	545,869		21
22	Employee Benefits & Payroll Taxes			1,010,401	1,010,401		1,010,401	50,800	1,061,201		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,085	15,085		15,085	26,901	41,986		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			127,490	127,490		127,490	(11,928)	115,562		26
27	Other (specify):* Marketing	101,017	475	32,989	134,481		134,481	(134,481)			27
28	TOTAL General Administration	395,262	11,519	2,015,589	2,422,370		2,422,370	(258,636)	2,163,734		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,422,614	555,043	3,347,004	8,324,661		8,324,661	(269,939)	8,054,722		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 Wabash Christian Retirement

#0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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			378,265	378,265	378,265	42,369	420,634				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,141	68,141	68,141	(59,330)	8,811				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,199	28,199	28,199		28,199				35
36	Other (specify):* FIN 47 Accretion			7,217	7,217	7,217		7,217				36
37	TOTAL Ownership			481,822	481,822	481,822	(16,961)	464,861				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			426,613	426,613	426,613	(11,214)	415,399				39
40	Barber and Beauty Shops			17,569	17,569	17,569		17,569				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,446	332,446	332,446		332,446				42
43	Other (specify):* Apt/Congregate			48,784	48,784	48,784	(48,784)					43
44	TOTAL Special Cost Centers			825,412	825,412	825,412	(59,998)	765,414				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,422,614	555,043	4,654,238	9,631,895	9,631,895	(346,898)	9,284,997				45

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning: 7/1/14

Ending: 6/30/15

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	(5,021)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(59,330)	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	(65,512)	21		24
25	Fund Raising, Advertising and Promotional	(134,481)	27		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(67,284)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (331,628)		\$	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)	(15,270)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,270)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (346,898)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Wabash Christian Retirement

ID# 0020610

Report Period Beginning: 7/1/14

Ending: 6/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Revenue	\$ (2,445)	21	1
2	Late Charges	(41)	21	2
3	Fines & Penalties	(1,430)	21	3
4	Transportation	(6,912)	14	4
5	Charity Care	(912)	21	5
6	Activity Revenue	(2,920)	11	6
7	Vending Revenue	(25)	2	7
8	Cable TV Revenue	(3,780)	5	8
9	Telephone Revenue	(35)	21	9
10	Apt/Congregate Expenses	(48,784)	43	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		(67,284)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement# 0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	(5,046)	0	0	0	0	0	0	0	0	0	0	(5,046)	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	(3,780)	2,162	0	0	0	0	0	0	0	0	0	(1,618)	5
6	Maintenance	0	5,193	0	0	0	0	0	0	0	0	0	5,193	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,826)	7,355	0	(1,471)	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	(2,920)	0	0	0	0	0	0	0	0	0	0	(2,920)	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	(6,912)	0	0	0	0	0	0	0	0	0	0	(6,912)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,832)	0	0	0	0	0	0	0	0	0	0	(9,832)	16
	C. General Administration													
17	Administrative	0	(454,205)	0	0	0	0	0	0	0	0	0	(454,205)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	45,171	0	0	0	0	0	0	0	0	0	45,171	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(70,375)	289,481	0	0	0	0	0	0	0	0	0	219,106	21
22	Employee Benefits & Payroll Taxes	0	50,800	0	0	0	0	0	0	0	0	0	50,800	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	26,901	0	0	0	0	0	0	0	0	0	26,901	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	(11,928)	0	0	0	0	0	0	0	0	0	(11,928)	26
27	Other (specify):*	(134,481)	0	0	0	0	0	0	0	0	0	0	(134,481)	27
28	TOTAL General Administration	(204,856)	(53,780)	0	(258,636)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(223,514)	(46,425)	0	(269,939)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	42,369	0	0	0	0	0	0	0	0	0	42,369	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(59,330)	0	0	0	0	0	0	0	0	0	0	(59,330)	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	(59,330)	42,369	0	(16,961)	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	(11,214)	0	0	0	0	0	0	0	0	0	(11,214)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(48,784)	0	0	0	0	0	0	0	0	0	0	(48,784)	43
44	TOTAL Special Cost Centers	(48,784)	(11,214)	0	(59,998)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(331,628)	(15,270)	0	(346,898)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board of Directors Attachment						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 2,162	\$ 2,162	1
2	V	6 Maintenance				5,193	5,193	2
3	V	17 Administrative	605,000			150,795	(454,205)	3
4	V	19 Professional Services				45,171	45,171	4
5	V	21 Clerical				288,556	288,556	5
6	V	22 Employee Benefits				50,800	50,800	6
7	V	21 Dues & Subscriptions				203	203	7
8	V	24 Travel and Seminars				26,901	26,901	8
9	V	26 Insurance				(11,928)	(11,928)	9
10	V	30 Depreciation				42,369	42,369	10
11	V	21 Other Administrative Expense				722	722	11
12	V	39 Pharmacy Services	361,752	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	350,538	(11,214)	12
13	V							13
14	Total		\$ 966,752			\$ 951,482	\$ * (15,270)	14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	This workpaper is N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	This workpaper is N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

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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	Name of Lender	2		3	4	5	6		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		Debt Relocation	\$1,381.00	3/1/2005	\$ 366,253	\$ 217,882	9/1/2011	0.0572	\$ 12,344						
2	Illinois Finance Authority		X	Renovation Projects	\$2,540.00	6/30/2007	586,567	1,020,009	5/15/2031	0.0567	54,228						
3	Illinois Finance Authority		X	Renovation Projects		7/29/2010	53,720		5/15/2027	0.0613	1,569						
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related				\$3,921.00		\$ 1,006,540	\$ 1,237,891			\$ 68,141						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 1,006,540	\$ 1,237,891			\$ 68,141						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT This Page is N/A

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
TOTALS			\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

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? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Wabash Christian Retirement

0020610 Report Period Beginning:

7/1/14 Ending:

6/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480 B. General Construction Type: Exterior Masonry Frame Wood & Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

DUPLEX BUILDING

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>60,480</u>	<u>1974</u>	<u>\$ 56,683</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>7,838</u>	<u>2</u>
3	TOTALS	60,480		\$ 64,521	3

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	1984	1958	\$ 1,040,410	\$	40	\$	\$	\$ 1,040,410	4
5	78	1976	1976	724,843	15,385	40	15,385		712,193	5
6										6
7										7
8	Home Office Allocation			76,011	8,173		8,173		56,356	8
	Improvement Type**									
9	1975 Fixed Assets		1975	10,000		VARIOUS			10,000	9
10	1978 Fixed Assets		1978	13,972		VARIOUS			13,972	10
11	1981 Fixed Assets		1981	6,683		VARIOUS			6,683	11
12	1982 Fixed Assets		1982	37,046		VARIOUS			37,046	12
13	1985 Fixed Assets		1985	35,240	583	VARIOUS	583		35,240	13
14	1987 Fixed Assets		1987	2,447		VARIOUS			2,447	14
15	1989 Fixed Assets		1989	1,341		VARIOUS			1,341	15
16	1990 Fixed Assets		1990	1,231		VARIOUS			1,231	16
17	1991 Fixed Assets		1991	2,189		VARIOUS			2,189	17
18	1992 Fixed Assets		1992	23,667		VARIOUS			23,667	18
19	1993 Fixed Assets		1993	2,395		VARIOUS			2,395	19
20	1994 Fixed Assets		1994	33,141		VARIOUS			33,141	20
21	1995 Fixed Assets		1995	86,447	2,750	VARIOUS	2,750		56,879	21
22	1997 Fixed Assets		1997	14,771		VARIOUS			14,771	22
23	1998 Fixed Assets		1998	7,303		VARIOUS			7,303	23
24	1999 Fixed Assets		1999	10,980		VARIOUS			10,980	24
25	2000 Fixed Assets		2000	252,644	6,533	VARIOUS	6,533		104,752	25
26	2001 Fixed Assets		2001	20,594	1,243	VARIOUS	1,243		19,087	26
27	2002 Fixed Assets		2002	19,056	986	VARIOUS	986		17,155	27
28	2003 Fixed Assets		2003	149,425	6,584	VARIOUS	6,584		121,270	28
29	2004 Fixed Assets		2004	248,664	14,405	VARIOUS	14,405		192,289	29
30	2005 Fixed Assets		2005	155,231	8,093	VARIOUS	8,093		108,459	30
31	2006 Fixed Assets		2006	286,458	20,742	VARIOUS	20,742		190,382	31
32	2007 Fixed Assets		2007	147,422	12,728	VARIOUS	12,728		124,328	32
33	2008 Fixed Assets		2008	334,432	33,383	VARIOUS	33,383		230,281	33
34	Chapel remodel-artwork&table		2009	807	81	10	81		518	34
35	Regress lighting		2009	1,238	124	10	124		774	35
36	Light Fixtures		2009	553	55	10	55		346	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 Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Door coding locks	2009	\$ 6,745	\$ 675	10	\$ 675	\$	\$ 4,103	37
38	Roof	2009	144,092	14,409	10	14,409		80,451	38
39	Chapel Roof	2009	1,505	151	10	151		853	39
40	New Windows Wing 7	2009	10,397	1,040	10	1,040		6,152	40
41									41
42	Sprinkler System	2009	22,000	2,200	10	2,200		12,650	42
43	Seal coat & Striping for Parking Lot	2009	4,714	471	10	471		2,750	43
44	New screens for gutters	2010	2,700	270	10	270		1,485	44
45	Sprinkler System	2010	112,380	11,238	10	11,238		61,809	45
46	New Roof - SNF	2010	163,717	8,186	20	8,186		42,294	46
47									47
48	Beauty Shop Exit Door	2010	7,859	786	10	786		3,733	48
49	Convert Activity Room	2010	4,382	438	10	438		2,081	49
50	Wing 1 - Bathroom	2010	67,815	6,782	10	6,782		33,908	50
51	LSC Corrections	2010	22,567	2,257	10	2,257		11,284	51
52									52
53	Wing 3 - Lighting	2010	375	38	10	38		172	53
54	Dining Room - Fire Doors	2010	4,900	490	10	490		2,287	54
55	Parking Lot	2010	34,607	3,461	10	3,461		16,439	55
56	Medical Records Storage Shed	2010	7,860	786	10	786		3,668	56
57	Bathroom Flooring	2011	739	74	10	74		320	57
58	PTAC Units	2011	7,046	705	10	705		3,112	58
59	Public Bathrooms - Wallpaper	2011	159	16	10	16		68	59
60	Delta Lavatory Faucets - Wide	2011	4,084	408	10	408		1,804	60
61	Delta Lavatory Faucets - Regular	2011	1,227	123	10	123		542	61
62	Room 301 - Bathroom remodel	2011	5,858	586	10	586		2,636	62
63	Room 302 - Bathroom Remodel	2011	8,598	860	10	860		3,869	63
64	Room 303 - Bathroom Remodel	2011	8,648	865	10	865		3,892	64
65	Wing 3 - Asbestos Removal	2011	12,348	1,235	10	1,235		5,454	65
66	Wing 3 - Refurb	2011	1,751	175	10	175		788	66
67	Wing 3 - Fixtures	2011	426	43	10	43		189	67
68	Wing 3 - Flooring	2011	14,485	1,448	10	1,448		6,276	68
69	Wing 2 - HVACs	2011	5,062	506	10	506		2,067	69
70	TOTAL (lines 4 thru 69)		\$ 4,435,687	\$ 192,570		\$ 192,570	\$	\$ 3,495,021	70

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,435,687	\$ 192,570		\$ 192,570	\$	\$ 3,495,021	1
2	Wing 9 - HVAC	2011	2,247	225	10	225		917	2
3	Boiler section module, piping valves,	2011	9,790	1,632	6	1,632		5,847	3
4	Duct Booster AXC150B 6", ventilation m	2011	1,073	215	5	215		823	4
5	Wall Cabinets -ADON office concord whi	2011	978	65	15	65		239	5
6	Wall Cabinets - Nurses station wing 6	2011	489	33	15	33		120	6
7	Door - Steel & Frame - Haven House wat	2011	1,112	56	20	56		199	7
8	Haven Water Damage-restore floors, wal	2011	47,843	4,784	10	4,784		17,542	8
9	Garden Homes Landscaping	2011	2,129	213	10	213		869	9
10	Garden Homes Sidewalk	2011	1,049	105	10	105		428	10
11	Garden Home sidewalk concrete	2011	870	87	10	87		348	11
12	Sealcoat Parking Lot and stripe	2011	5,007	278	3	278		5,007	12
13	Medical Building Fire Suppression	2011	6,752	620	10	620		3,265	13
14	WEIL MCCAIN 550 ULTRA BOILERS	2012	84,800	4,240	20	4,240		11,660	14
15	Landscape - Wall Block	2012	832	83	10	83		277	15
16	LANDSCAPING PAVERS AND PLANTS	2012	2,672	267	10	267		735	16
17	Walkway Pavilion Cover - Therapy Gym	2013	17,876	1,192	15	1,192		2,781	17
18	Flooring - Therapy Tub	2013	1,914	191	10	191		463	18
19	Therapy Gym - Foundation	2013	88,366	3,535	25	3,535		8,837	19
20	Therapy Gym - Roof	2013	9,403	940	10	940		2,351	20
21	Therapy Gym - Siding	2013	5,400	540	10	540		1,350	21
22	Therapy Gym - Doors and Casework	2013	23,870	1,591	15	1,591		3,978	22
23	Therapy Gym - Windows	2013	3,000	150	20	150		375	23
24	Therapy Gym - Flooring	2013	8,000	800	10	800		2,000	24
25	Therapy Gym - Handrails	2013	2,770	185	15	185		462	25
26	Therapy Gym - HVAC	2013	12,646	1,265	10	1,265		3,162	26
27	Therapy Gym - Masonry	2013	23,500	940	25	940		2,350	27
28	Therapy Gym - Painting	2013	12,500	2,500	5	2,500		6,250	28
29	Therapy Gym - Sprinklers and Smoke Ala	2013	8,936	894	10	894		2,234	29
30	Therapy Gym - Plumbing & Electric	2013	105,457	5,273	20	5,273		13,182	30
31	Therapy Gym - Signage	2013	256	51	5	51		128	31
32	Therapy Gym - Architectural Drawings	2013	39,722	3,972	10	3,972		9,931	32
33	Therapy Gym - Walls/Trusses/Drywall	2013	52,477	2,099	25	2,099		5,248	33
34	TOTAL (lines 1 thru 33)		\$ 5,019,423	\$ 231,590		\$ 231,590	\$	\$ 3,608,377	34

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

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 5,019,423	\$ 231,590		\$ 231,590	\$	\$ 3,608,377	1
2	FLOOD LIGHTS	2013	2,349	235	10	235		548	2
3									3
4	WING 6 - 2.5 TON HVAC	2013	2,216	443	5	443		997	4
5	WING 7 - PUMP FURNACE	2013	1,394	93	15	93		232	5
6	Electric - Sewer Grinder	2013	5,354	357	15	357		833	6
7	10 Ton A/C Roof Unit for Dining Room	2013	6,471	647	10	647		1,294	7
8	Chapel Door Keypad Locks	2013	1,873	187	10	187		359	8
9	Kitchen - (20) 4ft LED Ceiling Lights	2013	5,480	365	15	365		700	9
10	Kitchen - Overhead Lights	2013	548	37	15	37		61	10
11	Patient Hand Rails	2013	670	45	15	45		89	11
12	1.5 HP Garbage Disposal	2013	2,100	420	5	420		840	12
13	Carpet - Front Office & Conference Roo	2013	3,496	699	5	699		1,224	13
14	Front Entrance - Remodel Railings	2013	2,678	268	10	268		491	14
15	Hot Water Heater & Storage Tank	2013	39,447	3,945	10	3,945		7,232	15
16	Front Office Inpro Wall Covering	2013	4,730	946	5	946		1,656	16
17	Install of Walk-in Cooler/Freezer Comb	2013	36,623	2,442	15	2,442		3,866	17
18	Replace 6in Sewer Main sidewalk	2013	5,594	224	25	224		429	18
19	Replace kitchen drain	2014	5,400	540	10	540		585	19
20	Bearing assembly for Water Softner	2014	2,365	237	10	237		355	20
21	IS3200 Door Kit Accutech	2014	4,286	429	10	429		500	21
22	Install vinyl family room	2014	2,000	150	10	150		150	22
23	Install vinyl flooring	2014	2,450	184	10	184		184	23
24	Wainscot replace in office	2014	2,359	236	10	236		315	24
25	Landscape wing 7 entrance	2014	2,261	226	10	226		245	25
26	Sealcoat parking lot	2014	6,715	879	7	879		879	26
27	Window treatment designs	2015	2,108	70	10	70		70	27
28	Install Generator Steel door	2015	1,345	34	10	34		34	28
29	TheraPure Tub w/Lift	2015	13,185	330	10	330		330	29
30	MC Wing Bathroom doors 305, 306 &307	2015	1,476	25	10	25		25	30
31	Install 5' Shower	2015	3,511	59	10	59		59	31
32	Wallpaper in main lobby & back hall	2015	1,325	33	10	33		33	32
33	Remove asbestos	2015	13,650	114	10	114		114	33
34	TOTAL (lines 1 thru 33)		\$ 5,204,882	\$ 246,485		\$ 246,485	\$	\$ 3,633,104	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,204,882	\$ 246,485		\$ 246,485	\$	\$ 3,633,104	1
2	Wing 6 new flooring	2015	19,840	165	10	165		165	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	Tie to FS		2,265	(74)		(74)		1,655	33
34	TOTAL (lines 1 thru 33)		\$ 5,226,986	\$ 246,577		\$ 246,577	\$	\$ 3,634,924	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 702,280	\$ 98,601	\$ 98,601	\$		\$ 372,062	71
72	Current Year Purchases	125,826	11,179	11,179			11,179	72
73	Fully Depreciated Assets	507,906	14,945	14,945			507,906	73
74	Home Office Allocation	305,188	32,815	32,815			208,274	74
75	TOTALS	\$ 1,641,200	\$ 157,540	\$ 157,540	\$		\$ 1,099,421	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attachment		Various	\$ 92,220	\$ 13,652	\$ 13,652	\$		\$ 82,845	76
77										77
78										78
79	Home Office Allocation			12,847	1,381	1,381			8,884	79
80	TOTALS			\$ 105,067	\$ 15,033	\$ 15,033	\$		\$ 91,729	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)	\$ 7,037,774	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 419,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 419,150	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)	\$ 4,826,074	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	Duplex	\$ 554,751	\$ 20,117	\$ 411,289	86
87	Land	9,227			87
88					88
89					89
90					90
91	TOTALS	\$ 563,978	\$ 20,117	\$ 411,289	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 16,862	92
93	Home Office Allocation	116	93
94			94
95		\$ 16,978	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wabash Christian Retirement

0020610

Report Period Beginning: 7/1/14

Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 28,199 Description: See Attachment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: 7/1/14 Ending: 6/30/15
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><u>WCRU</u> only hires certified CNAs</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	V10A-3	hrs	\$	9,784	\$	416,454	\$	9,784	\$	416,454	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,274		185,901		3,274		185,901	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	V10A-3	hrs		14,508		445,690		14,508		445,690	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			\$	27,566	\$	1,048,045	\$	27,566	\$	1,048,045	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 Wabash Christian Retirement

0020610

Report Period Beginning: 7/1/14

Ending:

6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15

(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	\$ 6,011,928	\$	1
2	Cash-Patient Deposits	17,083		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>173,612</u>)	1,070,949		3
4	Supply Inventory (priced at)	24,480		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,073		6
7	Other Prepaid Expenses	18,055		7
8	Accounts Receivable (owners or related parties)	243,113		8
9	Other(specify): <u>Accrued Interest Receivable//AR</u>	4,802		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,407,483	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	651,870		11
12	Long-Term Investments	574,347		12
13	Land	65,910		13
14	Buildings, at Historical Cost	5,444,455		14
15	Leasehold Improvements, at Historical Cost	234,930		15
16	Equipment, at Historical Cost	1,461,139		16
17	Accumulated Depreciation (book methods)	(4,969,181)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	978,535		21
22	Other Long-Term Assets (spec <u>CIP</u>)	16,862		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,458,867	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,866,350	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 96,226	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,483		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	424,000		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,217		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Other Accrued Expenses</u>	450,436		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 996,362	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,237,891		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees</u>	44,270		43
44	<u>Apt & Congregate</u>	28,117		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,310,278	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,306,640	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,559,710	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,866,350	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,866,348	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,866,348	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	693,365	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 693,362	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)	\$ 9,559,710	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,601,740	1
2	Discounts and Allowances for all Levels	(1,792,960)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,808,780	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,379,131	6
7	Oxygen	23,442	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,402,573	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	22,000	13
14	Non-Patient Meals	5,021	14
15	Telephone, Television and Radio	3,780	15
16	Rental of Facility Space		16
17	Sale of Drugs	556,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,486	19
20	Radiology and X-Ray	30,275	20
21	Other Medical Services	74,246	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 731,734	23
D. Non-Operating Revenue			
24	Contributions	204,745	24
25	Interest and Other Investment Income***	59,330	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 264,075	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center (Apt/Duplex)</u>	84,312	28
28a	<u>Miscellaneous</u>	33,786	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 118,098	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,325,260	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,346,891	31
32	Health Care	4,555,400	32
33	General Administration	2,422,370	33
B. Capital Expense			
34	Ownership	481,822	34
C. Ancillary Expense			
35	Special Cost Centers	492,966	35
36	Provider Participation Fee	332,446	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,631,895	40
41	Income before Income Taxes (line 30 minus line 40)**	693,365	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 693,365	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,981,687	44
45	Private Pay - Net Inpatient Revenue	2,131,357	45
46	Medicare - Net Inpatient Revenue	(203,814)	46
47	Other-(specify) <u>HMO/Medicare Advantage/Outpatient Part B</u>	(167,565)	47
48	Other-(specify) <u>Nursing</u>	67,115	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,808,780	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Wabash Christian Retirement

0020610

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	1,876	2,079	\$ 88,897	\$ 42.76	1
2	Assistant Director of Nursing	1,880	2,100	56,015	26.67	2
3	Registered Nurses	30,604	32,810	710,500	21.65	3
4	Licensed Practical Nurses	24,727	27,136	493,321	18.18	4
5	CNAs & Orderlies	118,863	129,655	1,457,918	11.24	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,920	2,145	26,046	12.14	9
10	Activity Assistants	8,741	9,674	90,106	9.31	10
11	Social Service Workers	14,396	15,712	348,367	22.17	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	3,596	4,153	52,886	12.73	13
14	Head Cook	8,387	9,045	84,844	9.38	14
15	Cook Helpers/Assistants	19,877	22,389	212,927	9.51	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	6,361	6,892	140,215	20.34	17
18	Housekeepers	15,117	16,177	157,712	9.75	18
19	Laundry	7,289	8,380	75,983	9.07	19
20	Administrator	-	-	-		20
21	Assistant Administrator	1,940	2,080	54,525	26.21	21
22	Other Administrative	2,219	2,395	56,831	23.73	22
23	Office Manager	3,984	4,340	47,833	11.02	23
24	Clerical	5,663	6,360	57,393	9.02	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	1,925	2,076	21,853	10.53	31
32	Other Health Care(specify)	6,388	7,172	155,007	21.61	32
33	Other(specify)	1,848	2,080	33,435	16.07	33
34	TOTAL (lines 1 - 33)	287,601	314,850	\$ 4,422,614 *	\$ 14.05	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	344	\$ 16,429	V01-3	35
36	Medical Director	72	8,200	V09-3	36
37	Medical Records Consultant	105	2,208	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	180	4,108	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	85	5,230	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	786	\$ 36,175		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sandra Bryant	Administrator	0	\$ 138,382	Workers' Compensation Insurance	\$ 130,643	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(132)	Advertising: Employee Recruitment	2,676	
				FICA Taxes	311,797	Health Care Worker Background Check	2,070	
				Employee Health Insurance	536,900	(Indicate # of checks performed <u>46</u>)		
				Employee Meals		Patient Background Checks	2,760	
				Illinois Municipal Retirement Fund (IMRF)*				
				New Hire Expense	6,183	LICENSE	5,320	
				Employee Uniforms	871	DUES	15,645	
				Employee Expense	14,639	SUBSCRIPTIONS	4,808	
				457 Plan Expense	9,500			
						Less: Public Relations Expense	()	
				Home Office Allocation	50,800	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,382	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,061,201	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 33,279	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 605,000				Out-of-State Travel	\$ 3,514
							In-State Travel	9,833
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 605,000				Seminar Expense	1,738
C. Professional Services								
Vendor/Payee	Type		Amount					
Davis & Campbell	Legal		\$ 28,773					
Receivable Management Services	Legal		261					
National Research	Professional Services		1,628					
Home Office Allocation			45,171				Home Office Allocation	
							26,901	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 75,834	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 41,986

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Wabash Christian Retirement# 0020610Report Period Beginning: 7/1/14Ending: 6/30/15**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. LSN 9,145.42
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,507 Line 10
- (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. \$ 332,446
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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 5,021
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? NONE
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTONLARSONALLEN, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.