FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0021436

Facility Name: Lewis Memorial Christian Vlg

Address: 3400 West Washington (Number) Springfield (City) 62711 (Zip Code)

County: Sangamon

Telephone Number: 217-787-9600 **Fax #** 217-787-9601

HFS ID Number:

Date of Initial License for Current Owners: 9/19/1977

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 (c)(3)

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314-587-7924
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/15 to 6/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Susan McGhee
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,586	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	171	TOTALS	171	62,586	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,980	23,890	10,116	51,986	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,980	23,890	10,116	51,986	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.06%

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, Lawn & Maintenance Care, Housekeeping, Laundry Services for IL Residents

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/19/1977

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 5,416

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	335,025	23,561	49,201	407,787		407,787		407,787			1
2	Food Purchase		315,785		315,785		315,785	(10,344)	305,441			2
3	Housekeeping	185,970	45,452		231,422		231,422		231,422			3
4	Laundry	65,625	131		65,756		65,756		65,756			4
5	Heat and Other Utilities			273,717	273,717		273,717	2,626	276,343			5
6	Maintenance	114,405	5,460	131,843	251,708		251,708	5,891	257,599			6
7	Other (specify):* Trash			13,470	13,470		13,470		13,470			7
8	TOTAL General Services	701,025	390,389	468,231	1,559,645		1,559,645	(1,827)	1,557,818			8
	B. Health Care and Programs											
9	Medical Director			24,120	24,120		24,120		24,120			9
10	Nursing and Medical Records	4,205,749	230,454	34,848	4,471,051		4,471,051	(10,722)	4,460,329			10
10a	Therapy			1,044,438	1,044,438		1,044,438		1,044,438			10a
11	Activities	89,207	15,613	4,299	109,119		109,119		109,119			11
12	Social Services	196,077	2,452	6,674	205,203		205,203		205,203			12
13	CNA Training											13
14	Program Transportation			15,719	15,719		15,719	(15,719)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,491,033	248,519	1,130,098	5,869,650		5,869,650	(26,441)	5,843,209			16
	C. General Administration											
17	Administrative	174,260		843,972	1,018,232	(41,530)	976,702	(644,798)	331,904			17
18	Directors Fees											18
19	Professional Services			78,879	78,879		78,879	162,349	241,228			19
20	Dues, Fees, Subscriptions & Promotions			39,410	39,410		39,410	(2,004)	37,406			20
21	Clerical & General Office Expenses	244,352	21,307	224,864	490,523	41,530	532,053	287,346	819,399			21
22	Employee Benefits & Payroll Taxes			1,114,649	1,114,649		1,114,649	81,805	1,196,454			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,712	16,712		16,712	66,663	83,375			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			135,020	135,020		135,020	43,871	178,891			26
27	Other (specify):* Marketing	177,173	35,444	3,804	216,421		216,421	(216,421)				27
28	TOTAL General Administration	595,785	56,751	2,457,310	3,109,846		3,109,846	(221,189)	2,888,657			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,787,843	695,659	4,055,639	10,539,141		10,539,141	(249,457)	10,289,684			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 Lewis Memorial Christian Vlg #0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			833,706	833,706		833,706	57,834	891,540			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			367,381	367,381		367,381	(258,011)	109,370			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,088	25,088		25,088		25,088			35
36	Other (specify):* Deferred Financing Costs			29,853	29,853		29,853		29,853			36
37	TOTAL Ownership			1,256,028	1,256,028		1,256,028	(200,177)	1,055,851			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			514,218	514,218		514,218	(18,015)	496,203			39
40	Barber and Beauty Shops	23,486	2,011		25,497		25,497		25,497			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			376,014	376,014		376,014		376,014			42
43	Other (specify):* Apt/Congregate	669,369		1,407,929	2,077,298		2,077,298	(2,077,298)				43
44	TOTAL Special Cost Centers	692,855	2,011	2,298,161	2,993,027		2,993,027	(2,095,313)	897,714			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,480,698	697,670	7,609,828	14,788,196		14,788,196	(2,544,947)	12,243,249			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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,344)	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	(258,011)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,722)	10		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	(93,275)	21		24
25	Fund Raising, Advertising and Promotional	(216,421)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg5A	(2,164,921)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,753,694)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	303,597	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 303,597		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,450,097)		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 Yes	2 No	3 Amount	4 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

Lewis Memorial Christian Vlg

ID# 0021436

Report Period Beginning: 7/1/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (15,719)	14	1
2	Late Fees, Finance Charges	(422)	21	2
3	Apartment/Congregate	(2,188,728)	43	3
4	Vending Revenue	(760)	21	4
5	Fines & Penalties	(52,130)	21	5
6	Miscellaneous Revenue	(8)	21	6
7	Lobbying Expense	(2,004)	20	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**	(2,259,771)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,344)	0	0	0	0	0	0	0	0	0	0	(10,344)	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	0	2,626	0	0	0	0	0	0	0	0	0	2,626	5
6	Maintenance	0	5,891	0	0	0	0	0	0	0	0	0	5,891	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,344)	8,517	0	0	0	0	0	0	0	0	0	(1,827)	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	(10,722)	0	0	0	0	0	0	0	0	0	0	(10,722)	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	(15,719)	0	0	0	0	0	0	0	0	0	0	(15,719)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(26,441)	0	0	0	0	0	0	0	0	0	0	(26,441)	16
	C. General Administration													
17	Administrative	0	(644,798)	0	0	0	0	0	0	0	0	0	(644,798)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	162,349	0	0	0	0	0	0	0	0	0	162,349	19
20	Fees, Subscriptions & Promotions	(2,004)	0	0	0	0	0	0	0	0	0	0	(2,004)	20
21	Clerical & General Office Expenses	(146,595)	433,941	0	0	0	0	0	0	0	0	0	287,346	21
22	Employee Benefits & Payroll Taxes	0	81,805	0	0	0	0	0	0	0	0	0	81,805	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	66,663	0	0	0	0	0	0	0	0	0	66,663	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	43,871	0	0	0	0	0	0	0	0	0	43,871	26
27	Other (specify):*	(216,421)	0	0	0	0	0	0	0	0	0	0	(216,421)	27
28	**TOTAL General Administration**	(365,020)	143,831	0	0	0	0	0	0	0	0	0	(221,189)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(401,805)	152,348	0	0	0	0	0	0	0	0	0	(249,457)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	57,834	0	0	0	0	0	0	0	0	0	57,834	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(258,011)	0	0	0	0	0	0	0	0	0	0	(258,011)	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**	(258,011)	57,834	0	0	0	0	0	0	0	0	0	(200,177)	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	(18,015)	0	0	0	0	0	0	0	0	0	(18,015)	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):*	(2,188,728)	111,430	0	0	0	0	0	0	0	0	0	(2,077,298)	43
44	**TOTAL Special Cost Centers**	(2,188,728)	93,415	0	0	0	0	0	0	0	0	0	(2,095,313)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,848,544)	303,597	0	0	0	0	0	0	0	0	0	(2,544,947)	45

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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. [X] 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%	$ 2,626	$ 2,626	1
2	V	6	Maintenance				5,891	5,891	2
3	V	17	Administrative	843,972			199,174	(644,798)	3
4	V	19	Professional Services				162,349	162,349	4
5	V	21	Clerical				357,133	357,133	5
6	V	22	Employee Benefits				81,805	81,805	6
7	V	21	Dues & Subscriptions				9,554	9,554	7
8	V	24	Travel and Seminars				66,663	66,663	8
9	V	26	Insurance				43,871	43,871	9
10	V	30	Depreciation				57,834	57,834	10
11	V	21	Other Administrative Expense				67,254	67,254	11
12	V	43	Apt/Congregate/Wellness				111,430	111,430	12
13	V	39	Pharmacy Services	477,849	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	459,834	(18,015)	13
14	Total			$ 1,321,821			$ 1,625,418	$ * 303,597	14

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority		X	Refinance Debt		6/30/07	$ 4,820,517	$ 4,455,463	5/15/2031	0.0567	$ 164,355	1
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	5,500,000	2,474,254	5/15/2027	0.0625	158,221	2
3	Illinois Finance Authority		X	Refinance Debt		3/1/16	5,646,005	6,163,881	5/15/2040	0.0500	36,838	3
4	GO Bonds	X		Refinance Debt	$1,490.00	Various*	Various*	268,049	6/30/2032	Various*	7,967	4
5	*This is an allocation of the total GO Bond debt, which includes several different series with several different rates of interest.											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,490.00		$ 15,966,522	$ 13,361,647			$ 367,381	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,966,522	$ 13,361,647			$ 367,381	15

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

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

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lewis Memorial Christian Vlg COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0021436

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attachment	See Attachment	$ 119,476.54	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 119,476.54	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,522 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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
Congregate
Wellness Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	Facility	79,522	Various	$ 308,762	1
2	Home Office Allocation			11,424	2
3	TOTALS	79,522		$ 320,186	3

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1977		$ 2,286,830	$ 59,752		$ 59,752	$	$ 2,210,797	4
5			1978		100,542						5
6			1979		420,937						6
7			2012		5,647,901	141,197		141,197		576,557	7
8	Home Office Allocation				113,018	4,530		4,530		86,670	8
	Improvement Type**										
9	1978 Fixed Assets			1978	85,870		VARIOUS			85,870	9
10	1979 Fixed Assets			1979	29,226		VARIOUS			29,226	10
11	1980 Fixed Assets			1980	827	6	VARIOUS	6		746	11
12	1984 Fixed Assets			1984	6,077		VARIOUS			6,077	12
13	1985 Fixed Assets			1985	1,852		VARIOUS			1,852	13
14	1986 Fixed Assets			1986	9,259		VARIOUS			9,259	14
15	1987 Fixed Assets			1987	2,850		VARIOUS			2,850	15
16	1989 Fixed Assets			1989	2,957		VARIOUS			2,957	16
17										-	17
18	1991 Fixed Assets			1991	34,141		VARIOUS			34,141	18
19										-	19
20	1993 Fixed Assets			1993	129,417		VARIOUS			129,417	20
21										-	21
22	1995 Fixed Assets			1995	42,240		VARIOUS			42,240	22
23	1997 Fixed Assets			1997	13,091		VARIOUS			13,091	23
24	1998 Fixed Assets			1998	34,569		VARIOUS			34,569	24
25	1999 Fixed Assets			1999	73,686	1,106	VARIOUS	1,106		48,798	25
26	2000 Fixed Assets			2000	8,022		VARIOUS			8,022	26
27	2001 Fixed Assets			2001	1,184		VARIOUS			1,184	27
28	2002 Fixed Assets			2002	36,777	1,985	VARIOUS	1,985		34,801	28
29	2003 Fixed Assets			2003	13,765	86	VARIOUS	86		13,366	29
30	2004 Fixed Assets			2004	117,302		VARIOUS			117,302	30
31	2005 Fixed Assets			2005	43,603	63	VARIOUS	63		43,588	31
32	2006 Fixed Assets			2006	532,586	34,434	VARIOUS	34,434		341,252	32
33	2007 Fixed Assets			2007	354,205	24,753	VARIOUS	24,753		226,458	33
34	2008 Fixed Assets			2008	2,352,063	123,838	VARIOUS	123,838		1,003,110	34
35	2009 Fixed Assets			2009	111,071	11,107		11,107		75,170	35
36	SNF Refurb project			2010	414,080	41,408		41,408		269,152	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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	
37	Dining Room Ceiling	2010	$ 30,100	$ 3,010		$ 3,010	$	$ 19,063	37
38	Back Service Doors	2010	4,182	418		418		2,614	38
39	Replace Laundry Roof Top Alc Unit	2010	37,820	3,782		3,782		23,638	39
40	Gutter Installation on Front Canopy	2010	1,960	196		196		1,225	40
41	Door Closure for LSC Survey	2010	2,671	267		267		1,558	41
42	Bistro - Architectural Services	2010	5,536	554		554		3,228	42
43									43
44									44
45									45
46	Half Wall Extension	2010	3,555	355		355		2,014	46
47	Bistro - Sprinklers	2010	1,503	150		150		839	47
48	Bistro - Duct Work	2010	1,288	129		129		719	48
49	Bistro - Construction	2010	63,570	3,179		3,179		17,747	49
50	Campus Beautification	2010	18,105	1,811		1,811		11,316	50
51	Landscaping	2010	400,013	40,001		40,001		246,675	51
52	FYIO Mine Subsidence	2010	305,566	30,557		30,557		185,886	52
53	Removal of stumps and sign	2010	8,126	813		813		4,875	53
54	Pour Walk - Grade site	2010	18,800	1,880		1,880		11,280	54
55		2010							55
56	Backflow Preventer	2010	5,980	598		598		3,439	56
57	Dumpster Pad	2010	15,342	1,534		1,534		8,821	57
58	Parking Lot Sealing &Striping	2010	9,925	993		993		5,624	58
59	Light poles next to sidewalk	2010	4,222	422		422		2,357	59
60	Bistro - Plumbing	2011	2,847	285		285		1,566	60
61	Bistro - Electrical Work	2011	10,252	1,025		1,025		5,639	61
62	Activity Room Ceiling	2011	5,900	590		590		3,196	62
63	Lounge Remodel	2011	20,386	2,039		2,039		11,042	63
64									64
65	HVAC Unit #8	2011	13,520	1,352		1,352		6,197	65
66									66
67	Water and Sewer lines	2010	37,395	3,740		3,740		20,256	67
68									68
69	Engineering - Sewer Line	2011	11,598	1,160		1,160		5,992	69
70	TOTAL (lines 4 thru 69)		$ 14,060,110	$ 545,105		$ 545,105	$	$ 6,055,327	70

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 12A, Carried Forward		$ 14,060,110	$ 545,105		$ 545,105	$	$ 6,055,327	1
2									2
3									3
4									4
5									5
6	Geotechnical Services	2011	2,750	275		275		1,375	6
7									7
8									8
9	SNF Storage Building	2011	5,014	501		501		2,632	9
10									10
11	HVAC Unit B	2012	26,590	2,659		2,659		11,966	11
12	Chapel - Replace Wals and Ceiling	2012	8,587	859		859		3,220	12
13	Walk in Cooler	2012	22,500	1,500		1,500		5,500	13
14									14
15	Landscaping	2012	35,519	3,552		3,552		15,984	15
16									16
17	Maintenance Building Garage	2012	25,908	1,037		1,037		4,664	17
18									18
19	ROOF - KITCHEN AREA AND WEST AND SOUTH	2013	44,680	4,468		4,468		13,776	19
20	FENCE - DUMPSTER ENCLOSURE	2013	7,927	793		793		2,444	20
21	LANDSCAPING- SHRUB BEDS	2013	3,900	780		780		2,405	21
22	ROOF KITCHEN MAIN AREA	2014	100,000	8,340		8,340		19,042	22
23	DUCTLESS SPLIT SYSTEM IN SERVER ROOM	2014	7,375	738		738		1,598	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Concrete replace driveway	2014	3,174	212		212		388	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,354,033	$ 570,818		$ 570,818	$	$ 6,140,321	34

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 12B, Carried Forward		$ 14,354,033	$ 570,818		$ 570,818	$	$ 6,140,321	1
2									2
3									3
4	Landscape at Main Entrance west side	2014	5,656	566		566		990	4
5									5
6									6
7	West Courtyard Landscaping	2015	8,112	811		811		879	7
8	AC unit Care Plan office	2015	6,455	1,291		1,291		1,506	8
9	Water Heater - Skilled Facility	2015	7,890	789		789		789	9
10	Skilled Water Heater	2015	7,980	665		665		665	10
11	Variou Onsie Improvements	2015	2,481	145		145		145	11
12	Install Flooring in Main Dining & Chapel	2016	47,162	1,965		1,965		1,965	12
13	Duplex 3436 Install Flooring	2016	5,627	188		188		188	13
14	Skilled Dining Room Walls Replace	2016	16,275	407		407		407	14
15	Replace Flooring in Unit 201 Oak	2016	920	15		15		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	TOTAL (lines 1 thru 33)		$ 14,462,591	$ 577,660		$ 577,660	$	$ 6,147,870	34

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 1,562,210	$ 215,253	$ 215,253	$		$ 847,205	71
72	Current Year Purchases	165,323	20,667	20,667			20,667	72
73	Fully Depreciated Assets	527,760	1,907	1,907			527,760	73
74	Home Office Allocation	415,885	49,727	49,727			307,005	74
75	TOTALS	$ 2,671,178	$ 287,554	$ 287,554	$		$ 1,702,637	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			$ 184,432	$ 22,749	$ 22,749	$		$ 140,274	76
77										77
78										78
79	Home Office Allocation			16,411	3,577	3,577			12,102	79
80	TOTALS			$ 200,843	$ 26,326	$ 26,326	$		$ 152,376	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)	$ 17,654,798	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 891,540	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 891,540	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)	$ 8,002,883	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	Shared Home	$ 1,628,914	$ 68,647	$ 409,646	86
87	Wellness Center Building and Equipment	1,049,818	56,012	501,172	87
88	Duplex Building and Equipment	5,548,065	244,177	3,170,530	88
89					89
90					90
91	TOTALS	$ 8,226,797	$ 368,836	$ 4,081,348	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 3,343,027	92
93	Home Office Allocation	7,272	93
94			94
95		$ 3,350,299	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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 25,088 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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   LMCV Only Hires Certified CNAs

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	14,792	$ 452,418	$	14,792	$ 452,418	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,611	131,730		2,611	131,730	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		11,229	460,290		11,229	460,290	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	28,632	$ 1,044,438	$	28,632	$ 1,044,438	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.

STATE OF ILLINOIS

Facility Name & ID Number Lewis Memorial Christian Vlg **#** 0021436 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,449,325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 242,233)	2,031,161		3
4	Supply Inventory (priced at)	13,554		4
5	Short-Term Investments	9,454,269		5
6	Prepaid Insurance	20,937		6
7	Other Prepaid Expenses	16,743		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/Entrance Fees	34,834		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 22,020,823	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	18,736,015		14
15	Leasehold Improvements, at Historical Cost	3,944,376		15
16	Equipment, at Historical Cost	2,335,704		16
17	Accumulated Depreciation (book methods)	(11,678,454)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,247,191		21
22	Other Long-Term Assets (spe CIP/Deferred Financi	3,526,201		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,419,795	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 41,440,618	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 695,442	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	518,014		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,738		32
33	Accrued Interest Payable	90,450		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	190,722		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,554,366	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	13,361,647		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	2,439,911		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,801,558	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,355,924	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 24,084,694	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 41,440,618	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 23,882,308	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 23,882,308	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	209,893	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) **Restricted Contributions**	5,362	15
16	Other (describe) **Net Assets Released from Restriction**	(12,864)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 202,391	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22	**Rounding**	(5)	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (5)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 24,084,694	24 *

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,035,361	1
2	Discounts and Allowances for all Levels	(7,134,428)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,900,933	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,778,660	6
7	Oxygen	8,449	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,787,109	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	25,385	13
14	Non-Patient Meals	10,344	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	730,636	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,359	19
20	Radiology and X-Ray	32,351	20
21	Other Medical Services	87,354	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 933,429	23
	D. Non-Operating Revenue		
24	Contributions	250,314	24
25	Interest and Other Investment Income***	258,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 508,325	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Retirement Center (Apt/Duplex)**	1,753,131	28
28a	**Miscellaneous**	115,162	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,868,293	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,998,089	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,559,645	31
32	Health Care	5,869,650	32
33	General Administration	3,109,846	33
	B. Capital Expense		
34	Ownership	1,256,028	34
	C. Ancillary Expense		
35	Special Cost Centers	2,617,013	35
36	Provider Participation Fee	376,014	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,788,196	40
41	**Income before Income Taxes (line 30 minus line 40)****	209,893	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 209,893	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,035,192	44
45	Private Pay - Net Inpatient Revenue	4,709,073	45
46	Medicare - Net Inpatient Revenue	(1,624,786)	46
47	Other-(specify) **HMO/HMO Ancillary/Medicare Advantage**	(1,043,057)	47
48	Other-(specify) **Nursing/Outpatient Part B**	(175,489)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,900,933	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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,078	$ 87,907	$ 42.30	1
2	Assistant Director of Nursing	2,024	2,104	73,765	35.06	2
3	Registered Nurses	27,491	30,353	794,785	26.18	3
4	Licensed Practical Nurses	62,270	67,444	1,438,962	21.34	4
5	CNAs & Orderlies	137,189	142,558	1,777,836	12.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,851	2,037	35,500	17.43	9
10	Activity Assistants	5,070	5,519	53,707	9.73	10
11	Social Service Workers	13,738	14,832	196,077	13.22	11
12	Dietician					12
13	Food Service Supervisor	1,343	1,886	36,597	19.40	13
14	Head Cook	10,656	11,738	128,047	10.91	14
15	Cook Helpers/Assistants	16,787	18,112	170,381	9.41	15
16	Dishwashers					16
17	Maintenance Workers	6,216	6,827	114,405	16.76	17
18	Housekeepers	15,392	16,797	185,970	11.07	18
19	Laundry	6,456	7,134	65,625	9.20	19
20	Administrator	1,895	2,091	132,730	63.48	20
21	Assistant Administrator	1,994	2,165	60,228	27.82	21
22	Other Administrative					22
23	Office Manager	676	932	23,062	24.74	23
24	Clerical	12,586	13,764	202,592	14.72	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	1,798	1,992	32,494	16.31	31
32	Other Health C: Barber and Beauty	1,868	2,030	23,486	11.57	32
33	Other(specify) Apt/Congregate/M	50,440	54,442	846,542	15.55	33
34	TOTAL (lines 1 - 33)	379,668	406,835	$ 6,480,698 *	$ 15.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	962	$ 45,305	V01-3	35
36	Medical Director	456	24,120	V09-3	36
37	Medical Records Consultant	60	3,300	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	3,583	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	8	311	V11-3	44
45	Social Service Consultant	9	338	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,615	$ 76,957		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Schaaf	Executive Director	0	$ 132,730
Jacqueline Clark	HR Director		41,530
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 174,260

B. Administrative - Other

Description	Amount
Management Fees	$ 843,972
TOTAL (agree to Schedule V, line 17, col. 3)	$ 843,972
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 2,182
Davis & Campbell	Legal	40,311
Polsinelli Shugart	Legal	36,206
Maher Law Offices	Legal	180
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 78,879

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 201,253
Unemployment Compensation Insurance	22,650
FICA Taxes	408,441
Employee Health Insurance	447,761
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	16,602
Employee Uniforms	3,026
Employee Expense	10,081
457 Plan Expense	4,835
Home office allocation	81,805
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,196,454

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 325)	
Patient Background Checks	3,250
License	4,896
Dues	17,329
Subscriptions	11,931
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,406

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,294
In-State Travel	6,221
Seminar Expense	7,197
Home Office Allocation	66,663
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 83,375

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/15 Ending: 6/30/16

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. **Leading Age - $13,612**

(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. $ **34,458** 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. $ **376,014**
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. $ **10,344**

(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? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
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: **Plante Moran PLLC**

(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. **YES**
Attach invoices and a summary of services for all architect and appraisal fees