FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 7/1/16 to 6/30/17 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) Chuck Schmitz
(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: 7/1/16 Ending: 6/30/17

III. STATISTICAL DATA

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

	1 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	62,415	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	62,415	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	21,393	19,773	14,359	55,525	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,393	19,773	14,359	55,525	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.96%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 7,724

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: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	373,381	23,382	59,217	455,980		455,980		455,980			1
2	Food Purchase		343,265		343,265		343,265	(7,787)	335,478			2
3	Housekeeping	236,266	50,565		286,831		286,831		286,831			3
4	Laundry	69,344	138		69,482		69,482		69,482			4
5	Heat and Other Utilities			294,886	294,886		294,886	2,929	297,815			5
6	Maintenance	125,874	7,967	149,297	283,138		283,138	5,209	288,347			6
7	Other (specify):* Trash			12,317	12,317		12,317		12,317			7
8	TOTAL General Services	804,865	425,317	515,717	1,745,899		1,745,899	351	1,746,250			8
	B. Health Care and Programs											
9	Medical Director			76,920	76,920		76,920		76,920			9
10	Nursing and Medical Records	4,592,027	101,949	111,954	4,805,930		4,805,930	(4,877)	4,801,053			10
10a	Therapy			1,418,907	1,418,907		1,418,907		1,418,907			10a
11	Activities	93,393	8,306	3,747	105,446		105,446		105,446			11
12	Social Services	201,152	2,402	3,696	207,250		207,250		207,250			12
13	CNA Training											13
14	Program Transportation			14,728	14,728		14,728	(14,728)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,886,572	112,657	1,629,952	6,629,181		6,629,181	(19,605)	6,609,576			16
	C. General Administration											
17	Administrative	175,868		880,257	1,056,125		1,056,125	(682,126)	373,999			17
18	Directors Fees											18
19	Professional Services			46,238	46,238		46,238	108,944	155,182			19
20	Dues, Fees, Subscriptions & Promotions			47,052	47,052		47,052	(2,280)	44,772			20
21	Clerical & General Office Expenses	289,237	18,596	454,017	761,850		761,850	231,825	993,675			21
22	Employee Benefits & Payroll Taxes			1,075,796	1,075,796		1,075,796	102,988	1,178,784			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,243	10,243		10,243	60,732	70,975			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			169,546	169,546		169,546	62,294	231,840			26
27	Other (specify):* Marketing	202,196	14,885	32,847	249,928		249,928	(249,928)				27
28	TOTAL General Administration	667,301	33,481	2,715,996	3,416,778		3,416,778	(367,551)	3,049,227			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,358,738	571,455	4,861,665	11,791,858		11,791,858	(386,805)	11,405,053			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: 7/1/16 Ending: 6/30/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			981,649	981,649		981,649	53,688	1,035,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			676,623	676,623		676,623	(250,683)	425,940			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,338	32,338		32,338		32,338			35
36	Other (specify):* **Deferred Financing Costs**			7,123	7,123		7,123		7,123			36
37	**TOTAL Ownership**			1,697,733	1,697,733		1,697,733	(196,995)	1,500,738			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			914,754	914,754		914,754	(36,767)	877,987			39
40	Barber and Beauty Shops	23,352	1,908		25,260		25,260		25,260			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			383,861	383,861		383,861		383,861			42
43	Other (specify):* **Apt/Congregate**	592,401		1,052,184	1,644,585		1,644,585	(1,644,585)				43
44	**TOTAL Special Cost Centers**	615,753	1,908	2,350,799	2,968,460		2,968,460	(1,681,352)	1,287,108			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,974,491	573,363	8,910,197	16,458,051		16,458,051	(2,265,152)	14,192,899			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: 7/1/16 Ending: 6/30/17

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	(7,787)	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	(250,683)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,877)	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	(362,834)	21		24
25	Fund Raising, Advertising and Promotional	(249,928)	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	(1,744,955)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,621,064)		$	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	355,912	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 355,912		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,265,152)		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: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (14,728)	14	1
2	Late Fees, Finance Charges	(1,087)	21	2
3	Apartment/Congregate	(1,788,545)	43	3
4	Vending Revenue	(667)	21	4
5	Fines & Penalties	64,238	21	5
6	Miscellaneous Revenue	(1,886)	21	6
7	Lobbying Expense	(2,280)	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**	(1,744,955)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	(7,787)	0	0	0	0	0	0	0	0	0	0	(7,787)	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	2,929	0	0	0	0	0	0	0	0	0	2,929	5
6	Maintenance	0	5,209	0	0	0	0	0	0	0	0	0	5,209	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,787)	8,138	0	0	0	0	0	0	0	0	0	351	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	(4,877)	0	0	0	0	0	0	0	0	0	0	(4,877)	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	(14,728)	0	0	0	0	0	0	0	0	0	0	(14,728)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,605)	0	0	0	0	0	0	0	0	0	0	(19,605)	16
	C. General Administration													
17	Administrative	0	(682,126)	0	0	0	0	0	0	0	0	0	(682,126)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	108,944	0	0	0	0	0	0	0	0	0	108,944	19
20	Fees, Subscriptions & Promotions	(2,280)	0	0	0	0	0	0	0	0	0	0	(2,280)	20
21	Clerical & General Office Expenses	(302,236)	534,061	0	0	0	0	0	0	0	0	0	231,825	21
22	Employee Benefits & Payroll Taxes	0	102,988	0	0	0	0	0	0	0	0	0	102,988	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	60,732	0	0	0	0	0	0	0	0	0	60,732	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	62,294	0	0	0	0	0	0	0	0	0	62,294	26
27	Other (specify):*	(249,928)	0	0	0	0	0	0	0	0	0	0	(249,928)	27
28	**TOTAL General Administration**	(554,444)	186,893	0	0	0	0	0	0	0	0	0	(367,551)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(581,836)	195,031	0	0	0	0	0	0	0	0	0	(386,805)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	53,688	0	0	0	0	0	0	0	0	0	53,688	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(250,683)	0	0	0	0	0	0	0	0	0	0	(250,683)	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**	(250,683)	53,688	0	0	0	0	0	0	0	0	0	(196,995)	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	(36,767)	0	0	0	0	0	0	0	0	0	(36,767)	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):*	(1,788,545)	143,960	0	0	0	0	0	0	0	0	0	(1,644,585)	43
44	**TOTAL Special Cost Centers**	(1,788,545)	107,193	0	0	0	0	0	0	0	0	0	(1,681,352)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,621,064)	355,912	0	0	0	0	0	0	0	0	0	(2,265,152)	45

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Horizons	100.00%	$ 2,929	$ 2,929	1
2	V	6	Maintenance				5,209	5,209	2
3	V	17	Administrative	880,257			198,131	(682,126)	3
4	V	19	Professional Services				108,944	108,944	4
5	V	21	Clerical				472,279	472,279	5
6	V	22	Employee Benefits				102,988	102,988	6
7	V	21	Dues & Subscriptions				13,221	13,221	7
8	V	24	Travel and Seminars				60,732	60,732	8
9	V	26	Insurance				62,294	62,294	9
10	V	30	Depreciation				53,688	53,688	10
11	V	21	Other Administrative Expense				48,561	48,561	11
12	V	43	Apt/Congregate/Wellness				143,960	143,960	12
13	V	39	Pharmacy Services	692,951	Midwest Senior Ministries d/b/a Senior Care Pharmacy		656,184	(36,767)	13
14	Total			$ 1,573,208			$ 1,929,120	$ * 355,912	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: 7/1/16 Ending: 6/30/17

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: 7/1/16 Ending: 6/30/17

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: 7/1/16 Ending: 6/30/17

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			6/30/07	$ 4,820,517	$ 4,455,462	5/15/2031	0.0567	$ 245,038	1
2	Illinois Finance Authority		X			7/1/10	5,500,000	2,474,254	5/15/2027	0.0625	121,394	2
3	Illinois Finance Authority		X			3/1/16	5,646,005	6,975,978	5/15/2040	0.0500	298,566	3
4	GO Bonds	X			Various	Various*	Various*	123,081	6/30/2032	Various*	11,625	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	Interest Offset										(250,683)	6
7												7
8												8
9	TOTAL Facility Related						$ 15,966,522	$ 14,028,775			$ 425,940	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	$ 14,028,775			$ 425,940	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:** 7/1/16 **Ending:** 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attachment	See Attachment	$ 124,917.42	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 124,917.42	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 7/1/16 Ending: 6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,787 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	105,787	Various	$ 308,762	1
2	Home Office Allocation			12,061	2
3	TOTALS	105,787		$ 320,823	3

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$	$ 2,270,549	4
5			1978		521,479						5
6			2012		5,647,901	141,197		141,197		717,754	6
7			2016		3,172,339	126,894		126,894		126,894	7
8	Home Office Allocation				119,656	4,554		4,554		96,056	8
	Improvement Type**										
9				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		752	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		49,904	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	1,579	VARIOUS	1,579		36,380	28
29	2003 Fixed Assets			2003	12,411	58	VARIOUS	58		12,070	29
30	2004 Fixed Assets			2004	117,302		VARIOUS			117,302	30
31	2005 Fixed Assets			2005	43,603		VARIOUS			43,588	31
32	2006 Fixed Assets			2006	532,586	19,189	VARIOUS	19,189		360,441	32
33	2007 Fixed Assets			2007	354,203	23,054	VARIOUS	23,054		249,512	33
34	2008 Fixed Assets			2008	2,352,064	123,842	VARIOUS	123,842		1,126,959	34
35	2009 Fixed Assets			2009	111,071	11,107		11,107		86,277	35
36	2010 Fixed Assets			2010	1,352,344	132,057	VARIOUS	132,057		954,127	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: 7/1/16 Ending: 6/30/17

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	Bistro - Plumbing	2011	$ 2,847	$ 285	10	$ 285	$	$ 1,851	37
38	Bistro - Electrical Work	2011	10,252	1,025	10	1,025		6,664	38
39	Activity Room Ceiling	2011	5,900	590	10	590		3,786	39
40	Lounge Remodel	2011	20,385	2,038	10	2,038		13,078	40
41	HVAC Unit #8	2011	13,520	1,352	10	1,352		7,549	41
42	Water and Sewer lines	2010	37,395	3,740	10	3,740		23,996	42
43	Engineering - Sewer Line	2011	11,598	1,160	10	1,160		7,152	43
44	Geotechnical Services	2011	2,750	275	10	275		1,650	44
45	SNF Storage Building	2011	5,014	501	10	501		3,134	45
46	HVAC Unit B	2012	26,590	2,659	10	2,659		14,625	46
47	Chapel - Replace Wals and Ceiling	2012	8,587	859	10	859		4,079	47
48	Walk in Cooler	2012	22,500	1,500	10	1,500		7,000	48
49	Landscaping	2012	35,518	3,551	10	3,551		19,534	49
50	Maintenance Building Garage	2012	25,908	1,036	10	1,036		5,700	50
51	ROOF - KITCHEN AREA AND WEST AND SOUTH	2013	44,680	4,467	10	4,467		18,244	51
52	FENCE - DUMPSTER ENCLOSURE	2013	7,927	793	10	793		3,237	52
53	LANDSCAPING- SHRUB BEDS	2013	3,900	780	5	780		3,185	53
54	ROOF KITCHEN MAIN AREA	2014	100,000	8,340		8,340		27,382	54
55	DUCTLESS SPLIT SYSTEM IN SERVER ROOM	2014	7,375	738	10	738		2,335	55
56	Concrete replace driveway	2014	3,176	203	15	203		601	56
57	Landscape at Main Entrance west side	2014	5,657	565	10	565		1,554	57
58	West Courtyard Landscaping	2015	8,112	811	10	811		1,690	58
59	AC unit Care Plan office	2015	6,455	1,291	5	1,291		2,797	59
60	Water Heater - Skilled Facility	2015	7,890	798	10	798		1,578	60
61	Skilled Water Heater	2015	7,980	798	10	798		1,463	61
62	Variou Onsie Improvements	2015	2,481	248	10	248		393	62
63	Install Flooring in Main Dining & Chapel	2016	47,162	4,716	10	4,716		6,681	63
64	Duplex 3436 Install Flooring	2016	5,627	563	10	563		750	64
65	Skilled Dining Room Walls Replace	2016	16,275	1,628	10	1,628		2,034	65
66	Replace Flooring in Unit 201 Oak	2016	920	92	10	92		107	66
67									67
68	Landscape 22 Bed Add'l Courtyard	2016	31,285	3,128	10	3,128		3,128	68
69	Install Exhaust Fan in Warming Kitchen	2016	1,530	255	16	255		255	69
70	TOTAL (lines 4 thru 69)		$ 17,673,030	$ 695,180		$ 695,180	$	$ 6,846,532	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: 7/1/16 Ending: 6/30/17

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		$ 17,673,030	$ 695,180		$ 695,180	$	$ 6,846,532	1
2	Duct pressure VVT & Bypass Controller	2016	2,134	213	10	213		213	2
3	500N & 500S Smoke Detectors w/Exit Light	2016	2,930	244	10	244		244	3
4	Fire Caulking per IDHP	2016	28,070	2,105	10	2,105		2,105	4
5	Culligan Water Softener	2016	5,091	339	10	339		339	5
6	GP Conference Room Door	2016	6,035	402	10	402		402	6
7	Walk-thru bath tub @ 3420 Unit 2	2017	750	31	10	31		31	7
8	Dining Storage room doors	2017	9,090	227	10	227		227	8
9	Walk-thru bath tub @3420 unit 5	2017	750	13	10	13		13	9
10	400 Hall 12 rooms Flooring	2017	21,320	355	5	355		355	10
11	APR Valves on Carrier AC Units GP	2017	4,840	40	10	40		40	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	TOTAL (lines 1 thru 33)		$ 17,754,040	$ 699,151		$ 699,151	$	$ 6,850,503	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: 7/1/16 Ending: 6/30/17

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	$ 1,727,533	$ 201,331	$ 201,331	$		$ 1,069,199	71
72	Current Year Purchases	330,182	62,269	62,269			62,269	72
73	Fully Depreciated Assets	527,760					527,760	73
74	Home Office Allocation	391,928	47,161	47,161			298,847	74
75	TOTALS	$ 2,977,403	$ 310,761	$ 310,761	$		$ 1,958,075	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			$ 201,305	$ 23,452	$ 23,452	$		$ 163,725	76
77										77
78										78
79	Home Office Allocation			17,326	1,971	1,971			14,748	79
80	TOTALS			$ 218,631	$ 25,423	$ 25,423	$		$ 178,473	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)	$ 21,270,897	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,035,335	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,035,335	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)	$ 8,987,051	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 Building and Equipment	$ 1,665,185	$ 64,006	$ 468,659	86
87	Wellness Center Building and Equipment	1,072,956	57,895	559,067	87
88	Duplex Building and Equipment	5,656,047	251,534	3,417,328	88
89					89
90					90
91	TOTALS	$ 8,394,188	$ 373,435	$ 4,445,054	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 4,422	92
93	Home Office Allocation	27,901	93
94			94
95		$ 32,323	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: 7/1/16 Ending: 6/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 32,338 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: 7/1/16 Ending: 6/30/17

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: 7/1/16 Ending: 6/30/17

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	$	13,007	$ 671,520	$	13,007	$ 671,520	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		4,060	154,122		4,060	154,122	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		14,465	593,265		14,465	593,265	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				792,636		792,636	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						60,680		60,680	12
13	Other (specify): Radiology						24,671		24,671	13
14	TOTAL			$	31,532	$ 1,418,907	$ 877,987	31,532	$ 2,296,894	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 Lewis Memorial Christian Vlg **#** 0021436 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/17 **(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	$ 12,111	$	1
2	Cash-Patient Deposits	38,898		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 484,136)	2,756,978		3
4	Supply Inventory (priced at)	13,576		4
5	Short-Term Investments	11,405,717		5
6	Prepaid Insurance	28,472		6
7	Other Prepaid Expenses	12,565		7
8	Accounts Receivable (owners or related parties)	10,598,119		8
9	Other(specify):	146,709		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 25,013,145	$	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	22,118,433		14
15	Leasehold Improvements, at Historical Cost	4,004,196		15
16	Equipment, at Historical Cost	2,692,724		16
17	Accumulated Depreciation (book methods)	(13,022,455)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	858,783		21
22	Other Long-Term Assets (spe CIP	4,422		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,964,865	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 41,978,010	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,898		28
29	Short-Term Notes Payable	116,813		29
30	Accrued Salaries Payable	310,910		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	91,401		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 558,022	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	14,028,775		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		1,248,433		43
44		1,035,633		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,312,841	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 16,870,863	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 25,107,147	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 41,978,010	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 24,084,694	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 24,084,694	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,022,448	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,022,448	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)**	$ 25,107,147	24 *

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 14,205,986	1
2	Discounts and Allowances for all Levels	(9,972,893)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,233,093	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,156,394	6
7	Oxygen	23,647	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,180,041	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	38,329	13
14	Non-Patient Meals	7,787	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,046,357	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	105,765	19
20	Radiology and X-Ray	57,961	20
21	Other Medical Services	253,757	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,509,956	23
	D. Non-Operating Revenue		
24	Contributions	93,848	24
25	Interest and Other Investment Income***	250,683	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 344,531	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Retirement Center (Apt/Duplex)**	1,810,577	28
28a	**Miscellaneous**	402,301	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,212,878	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,480,499	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,745,899	31
32	Health Care	6,629,181	32
33	General Administration	3,416,778	33
	B. Capital Expense		
34	Ownership	1,697,733	34
	C. Ancillary Expense		
35	Special Cost Centers	2,584,599	35
36	Provider Participation Fee	383,861	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,458,051	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,022,448	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,022,448	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,698,913	44
45	Private Pay - Net Inpatient Revenue	3,991,558	45
46	Medicare - Net Inpatient Revenue	(1,936,702)	46
47	Other-(specify) **HMO/HMO Ancillary/Med Advantage**	(1,441,949)	47
48	Other-(specify) **Nursing/Outpatient Part B**	(78,727)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,233,093	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: 7/1/16 Ending: 6/30/17

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	1,576	1,803	$ 76,456	$ 42.40	1
2	Assistant Director of Nursing	3,372	3,669	129,597	35.32	2
3	Registered Nurses	27,411	36,754	945,226	25.72	3
4	Licensed Practical Nurses	60,234	65,283	1,555,134	23.82	4
5	CNAs & Orderlies	154,258	159,427	1,853,101	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,137	2,288	37,175	16.25	9
10	Activity Assistants	4,706	5,092	56,218	11.04	10
11	Social Service Workers	13,339	12,309	201,152	16.34	11
12	Dietician					12
13	Food Service Supervisor	1,785	1,813	39,493	21.78	13
14	Head Cook	8,546	9,081	98,341	10.83	14
15	Cook Helpers/Assistants	22,424	23,936	235,547	9.84	15
16	Dishwashers					16
17	Maintenance Workers	6,648	7,167	125,874	17.56	17
18	Housekeepers	20,708	22,789	236,266	10.37	18
19	Laundry	5,941	6,432	69,344	10.78	19
20	Administrator	2,714	2,805	175,868	62.70	20
21	Assistant Administrator	1,320	1,360	57,813	42.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,562	15,631	231,424	14.81	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	1,829	2,074	32,513	15.68	31
32	Other Health C: Barber and Beauty	1,676	1,798	23,352	12.99	32
33	Other(specify) Apt/Congregate/M	57,421	67,159	794,597	11.83	33
34	TOTAL (lines 1 - 33)	412,607	448,670	$ 6,974,491 *	$ 15.54	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	1,245	$ 54,863	V01-3	35
36	Medical Director	650	76,920	V09-3	36
37	Medical Records Consultant	60	3,300	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	4,228	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	4	215	V11-3	44
45	Social Service Consultant	4	215	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,083	$ 139,741		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: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Schaaf	Executive Director		$ 127,937
Brandy Black	Administrator		47,931
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,868

B. Administrative - Other

Description	Amount
Management Fees	$ 880,257
TOTAL (agree to Schedule V, line 17, col. 3)	$ 880,257
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 2,312
Davis & Campbell	Legal	30,680
Receivable Mgmt Services	Legal	266
Polsinelli Shugart	Legal	12,980
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 46,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,584
Unemployment Compensation Insurance	(4,830)
FICA Taxes	454,738
Employee Health Insurance	436,132
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	23,269
Employee Uniforms	(2,136)
Employee Expense	22,110
457 Plan Expense	9,489
Seminars	440
Home Office Allocation	102,988
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,178,784

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Sponsor Health Week	1,750
License	10,774
Dues	18,610
Subscriptions	13,516
Fees and Pool Inspection	122
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,772

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,088
In-State Travel	4,259
Seminar Expense	1,896
Home Office Allocation	60,732
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 70,975

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 - $14,253**

(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. $ **30,444** 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. $ **383,861**
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. $ **7,787**

(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