		FOR BHF USE					

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0021436

Facility Name: Lewis Memorial Christian Village

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
IRS Exemption Code 501 (c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

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 _____ to _____ 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 Village # 0021436 Report Period Beginning: Ending:

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	22,943	19,493	13,456	55,892	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,943	19,493	13,456	55,892	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.55%

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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 9/19/1977

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 8,161

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 Village # 0021436 Report Period Beginning: Ending:

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	351,902	27,945	70,953	450,800		450,800		450,800			1
2	Food Purchase		345,955		345,955		345,955		345,955			2
3	Housekeeping	245,658		47,682	293,340		293,340		293,340			3
4	Laundry	69,701		289	69,990		69,990		69,990			4
5	Heat and Other Utilities			296,367	296,367		296,367	2,730	299,097			5
6	Maintenance	103,466	138,460		241,926		241,926	5,650	247,576			6
7	Other (specify):* Trash			12,376	12,376		12,376		12,376			7
8	TOTAL General Services	770,727	512,360	427,667	1,710,754		1,710,754	8,380	1,719,134			8
	B. Health Care and Programs											
9	Medical Director			86,520	86,520		86,520		86,520			9
10	Nursing and Medical Records	4,729,977	118,930	37,340	4,886,247		4,886,247		4,886,247			10
10a	Therapy			1,438,388	1,438,388		1,438,388		1,438,388			10a
11	Activities	95,339	13,671	724	109,734		109,734		109,734			11
12	Social Services	204,530		12,657	217,187		217,187		217,187			12
13	CNA Training											13
14	Program Transportation			48,396	48,396		48,396		48,396			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,029,846	132,601	1,624,025	6,786,472		6,786,472		6,786,472			16
	C. General Administration											
17	Administrative	173,516		890,985	1,064,501		1,064,501	(830,812)	233,689			17
18	Directors Fees											18
19	Professional Services			56,045	56,045		56,045	99,731	155,776			19
20	Dues, Fees, Subscriptions & Promotions			39,395	39,395		39,395	(2,404)	36,991			20
21	Clerical & General Office Expenses	312,079	101,106	400,844	814,029		814,029	282,933	1,096,962			21
22	Employee Benefits & Payroll Taxes			1,230,468	1,230,468		1,230,468	138,289	1,368,757			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,351	16,351		16,351	62,533	78,884			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			191,071	191,071		191,071	1,602	192,673			26
27	Other (specify):* Marketing	197,880		41,308	239,188		239,188	(239,188)				27
28	TOTAL General Administration	683,475	101,106	2,866,467	3,651,048		3,651,048	(487,316)	3,163,732			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,484,048	746,067	4,918,159	12,148,274		12,148,274	(478,936)	11,669,338			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 Village #0021436 Report Period Beginning: Ending:

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			1,008,506	1,008,506		1,008,506	58,457	1,066,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			368,468	368,468		368,468		368,468			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,532	6,532		6,532		6,532			35
36	Other (specify):* Deferred Financing Costs			4,978	4,978		4,978		4,978			36
37	**TOTAL Ownership**			1,388,484	1,388,484		1,388,484	58,457	1,446,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,397	845,058	994,455		994,455	144,859	1,139,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			384,153	384,153		384,153		384,153			42
43	Other (specify):* Apt/Congregate	594,098		1,094,287	1,688,385		1,688,385	(1,557,915)	130,470			43
44	**TOTAL Special Cost Centers**	594,098	149,397	2,323,498	3,066,993		3,066,993	(1,413,056)	1,653,937			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,078,146	895,464	8,630,141	16,603,751		16,603,751	(1,833,535)	14,770,216			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 Village # 0021436 Report Period Beginning: Ending:

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				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,194)	21		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	(298,470)	21		24
25	Fund Raising, Advertising and Promotional	(239,188)	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	(1,693,668)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,232,520)		$	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)	398,985	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 398,985		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,833,535)		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 Village

ID# 0021436

Report Period Beginning:

Ending:

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ (1,688,385)	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Lobbying Expense	(2,403)	20	3
4	Travel and Seminar	(2,880)	24	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(1,693,668)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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	0	0	0	0	0	0	0	0	0	0	0	0	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	2,730	0	0	0	0	0	0	0	0	0	2,730	5
6	Maintenance	0	5,650	0	0	0	0	0	0	0	0	0	5,650	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	8,381	0	0	0	0	0	0	0	0	0	8,381	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(830,812)	0	0	0	0	0	0	0	0	0	(830,812)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	99,731	0	0	0	0	0	0	0	0	0	99,731	19
20	Fees, Subscriptions & Promotions	(2,403)	0	0	0	0	0	0	0	0	0	0	(2,403)	20
21	Clerical & General Office Expenses	(299,664)	582,597	0	0	0	0	0	0	0	0	0	282,933	21
22	Employee Benefits & Payroll Taxes	0	138,289	0	0	0	0	0	0	0	0	0	138,289	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,880)	65,413	0	0	0	0	0	0	0	0	0	62,533	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,602	0	0	0	0	0	0	0	0	0	1,602	26
27	Other (specify):*	(239,188)	0	0	0	0	0	0	0	0	0	0	(239,188)	27
28	**TOTAL General Administration**	(544,135)	56,819	0	0	0	0	0	0	0	0	0	(487,316)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(544,135)	65,199	0	0	0	0	0	0	0	0	0	(478,936)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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	58,457	0	0	0	0	0	0	0	0	0	58,457	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	58,457	0	0	0	0	0	0	0	0	0	58,457	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	144,859	0	0	0	0	0	0	0	0	0	144,859	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):*	(1,688,385)	130,470	0	0	0	0	0	0	0	0	0	(1,557,915)	43
44	**TOTAL Special Cost Centers**	(1,688,385)	275,329	0	0	0	0	0	0	0	0	0	(1,413,056)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,232,520)	398,985	0	0	0	0	0	0	0	0	0	(1,833,535)	45

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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%	$ 2,730	$ 2,730	1
2	V	6	Maintenance				5,650	5,650	2
3	V	17	Administrative	993,652			162,840	(830,812)	3
4	V	19	Professional Services				99,731	99,731	4
5	V	21	Clerical				510,888	510,888	5
6	V	22	Employee Benefits				138,289	138,289	6
7	V	21	Dues & Subscriptions				16,261	16,261	7
8	V	24	Travel and Seminars				65,413	65,413	8
9	V	26	Insurance				1,602	1,602	9
10	V	30	Depreciation				58,457	58,457	10
11	V	21	Other Administrative Expense				55,448	55,448	11
12	V	43	Apt/Congregate/Wellness				130,470	130,470	12
13	V	39	Pharmacy Services	572,799	Midwest Senior Ministries d/b/a Senior Care Pharmacy		717,658	144,859	13
14	Total			$ 1,566,451			$ 1,965,436	$ * 398,985	14

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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 workaper 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 Village # 0021436 Report Period Beginning: Ending:

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 Village # 0021436 Report Period Beginning: Ending:

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	$ 256,189	1
2	Illinois Finance Authority		X			7/1/10	5,500,000	2,474,254	5/15/2027	0.0625	88,531	2
3	Illinois Finance Authority		X			3/1/16	5,646,005	6,940,907	5/15/2040	0.0500	302,594	3
4	GO Bonds	X			Various	Various*	Various*	215,176	6/30/2032	Various*	6,451	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										(285,297)	6
7												7
8												8
9	TOTAL Facility Related						$ 15,966,522	$ 14,085,800			$ 368,468	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	$ 14,085,800			$ 368,468	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 Village # 0021436 Report Period Beginning: Ending:

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lewis Memorial Christian Village 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attachment	See Attachment	$ 128,727.57	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 128,727.57	$

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Village # 0021436 Report Period Beginning: Ending:

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			12,372	2
3	TOTALS	105,787		$ 321,134	3

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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	$	$ 2,330,299	4
5			1978		521,479						5
6			2012		5,647,901	141,197		141,197		858,951	6
7			2016		3,172,339	126,894		126,894		253,787	7
8	Home Office Allocation				110,982	3,871		3,871		90,981	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		759	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	1991 Fixed Assets			1991	34,141		VARIOUS			34,141	17
18	1993 Fixed Assets			1993	129,417		VARIOUS			129,417	18
19	1995 Fixed Assets			1995	42,240		VARIOUS			42,240	19
20	1997 Fixed Assets			1997	13,091		VARIOUS			13,091	20
21	1998 Fixed Assets			1998	34,569		VARIOUS			34,569	21
22	1999 Fixed Assets			1999	73,686	1,106	VARIOUS	1,106		51,010	22
23	2000 Fixed Assets			2000	8,022		VARIOUS			8,022	23
24	2001 Fixed Assets			2001	1,184		VARIOUS			1,184	24
25	2002 Fixed Assets			2002	36,777	234	VARIOUS	234		36,614	25
26	2003 Fixed Assets			2003	8,904	58	VARIOUS	58		8,620	26
27	2004 Fixed Assets			2004	94,947		VARIOUS			94,947	27
28	2005 Fixed Assets			2005	41,710		VARIOUS			41,695	28
29	2006 Fixed Assets			2006	532,586	19,116	VARIOUS	19,116		379,557	29
30	2007 Fixed Assets			2007	331,473	11,089	VARIOUS	11,089		237,871	30
31	2008 Fixed Assets			2008	2,352,064	119,564	VARIOUS	119,564		1,246,523	31
32	2009 Fixed Assets			2009	111,071	11,107	VARIOUS	11,107		97,384	32
33	2010 Fixed Assets			2010	1,352,344	132,056	VARIOUS	132,056		1,086,182	33
34	2011 Fixed Assets			2011	109,663	10,965	VARIOUS	10,965		79,827	34
35											35
36	2010 Fixed Assets										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 Village # 0021436 Report Period Beginning: Ending:

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	Maintenance Building Garage	2012	$ 25,907	$ 1,037	25	$ 1,037	$	$ 6,736	37
38	HVAC Unit B	2012	26,590	2,659	10	2,659		17,284	38
39	Chapel - Replace Wals and Ceiling	2012	8,587	859	10	859		4,938	39
40	Walk in Cooler	2012	22,500	1,500	10	1,500		8,500	40
41	Landscaping	2012	35,518	3,552	10	3,552		23,087	41
42	ROOF - KITCHEN AREA AND WEST AND SOUTH	2013	44,680	4,468	10	4,468		22,712	42
43	FENCE - DUMPSTER ENCLOSURE	2013	7,927	793	10	793		4,030	43
44	LANDSCAPING- SHRUB BEDS	2013	3,900	651	5	651		3,836	44
45	ROOF KITCHEN MAIN AREA	2014	100,000	8,340		8,340		35,722	45
46	DUCTLESS SPLIT SYSTEM IN SERVER ROOM	2014	7,375	738	10	738		3,073	46
47	Concrete replace driveway	2014	3,174	212	15	212		811	47
48	Landscape at Main Entrance west side	2014	5,657	566	10	566		2,121	48
49	West Courtyard Landscaping	2015	8,112	811	10	811		4,088	49
50	AC unit Care Plan office	2015	6,455	1,291	5	1,291		2,501	50
51	Water Heater - Skilled Facility	2015	7,890	789	10	789		2,367	51
52	Skilled Water Heater	2015	7,980	798	10	798		2,261	52
53	Variou Onsie Improvements	2015	2,481	248	10	248		641	53
54	Install Flooring in Main Dining & Chapel	2016	47,162	4,716	10	4,716		11,397	54
55	Duplex 3436 Install Flooring	2016	5,627	563	10	563		1,313	55
56	Skilled Dining Room Walls Replace	2016	16,275	1,628	10	1,628		3,662	56
57	Replace Flooring in Unit 201 Oak	2016	920	92	10	92		199	57
58	Landscape 22 Bed Add'l Courtyard	2016	31,285	3,128	10	3,128		6,257	58
59	Install Exhaust Fan in Warming Kitchen	2016	1,530	255	16	255		510	59
60	Duct pressure VVT & Bypass Controller	2016	2,134	213	10	213		427	60
61	500N & 500S Smoke Detectors w/Exit Light	2016	2,930	293	10	293		537	61
62	Fire Caulking per IDHP	2016	28,070	2,807	10	2,807		4,912	62
63	Culligan Water Softener	2016	5,091	509	10	509		849	63
64	GP Conference Room Door	2016	6,035	603	10	603		1,006	64
65	Walk-thru bath tub @ 3420 Unit 2	2017	750	75	10	75		106	65
66	Dining Storage room doors	2017	9,090	909	10	909		1,136	66
67	Walk-thru bath tub @3420 unit 5	2017	750	75	10	75		88	67
68	400 Hall 12 rooms Flooring	2017	21,320	4,264	5	4,264		4,619	68
69	APR Valves on Carrier AC Units GP	2017	4,840	484	10	484		524	69
70	TOTAL (lines 4 thru 69)		$ 17,694,881	$ 686,940		$ 686,940	$	$ 7,478,012	70

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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		$ 17,694,881	$ 686,940		$ 686,940	$	$ 7,478,012	1
2	New Circuits on Emergency panels	2017	3,366	337	10	337		337	2
3	Front Entrance canopy underside replace	2017	5,845	488	10	488		487	3
4	Parking Lot Asphalt milling & overlay	2017	87,415	5,828	10	5,828		5,828	4
5	New Flat Roof on building LMCV	2017	113,865	5,061	15	5,061		5,061	5
6	Landscape Front Main Entryway	2018	27,702	1,385	10	1,385		1,385	6
7	Roof Top Air Handling Unit RTU #6 & 7	2018	24,581	683	15	683		683	7
8	SNF Outdoor Light Pole Replace	2018	25,275	702	15	702		702	8
9	200 Hall Flooring replace 20 rooms	2018	33,565	1,119	10	1,119		1,119	9
10	100 Gallon Water heater	2018	7,520	251	10	251		251	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	Home Office Allocation		9,443	341		341		7,966	33
34	TOTAL (lines 1 thru 33)		$ 18,033,458	$ 703,133		$ 703,133	$	$ 7,501,830	34

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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	$ 2,020,268	$ 262,897	$ 262,897	$		$ 1,356,918	71
72	Current Year Purchases	197,138	22,942	22,942			22,942	72
73	Fully Depreciated Assets	358,585					358,585	73
74	Home Office Allocation	315,840	51,300	51,300			235,159	74
75	TOTALS	$ 2,891,831	$ 337,140	$ 337,140	$		$ 1,973,605	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	$ 23,745	$ 23,745	$		$ 187,471	76
77										77
78										78
79	Home Office Allocation			17,772	9,881	9,881			16,116	79
80	TOTALS			$ 219,077	$ 33,626	$ 33,626	$		$ 203,586	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)	$ 21,465,500	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,073,899	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,073,899	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)	$ 9,679,021	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	$ 1,669,683	$ 68,722	$ 537,463	86
87	Wellness Center Building and Equipment	1,075,930	58,860	617,927	87
88	Duplex Building and Equipment	5,708,319	256,473	3,673,801	88
89					89
90					90
91	TOTALS	$ 8,453,932	$ 384,056	$ 4,829,191	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 54,913	92
93	Home Office Allocation	70,652	93
94			94
95		$ 125,565	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 Village # 0021436 Report Period Beginning: Ending:

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

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: $ 35,122 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 Village # 0021436 Report Period Beginning: Ending:

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 Village # 0021436 Report Period Beginning: Ending:

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	$	12,268	$ 616,916	$	12,268	$ 616,916	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		3,865	124,893		3,865	124,893	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		16,435	696,579		16,435	696,579	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				575,620		575,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					80,000		80,000	12
13	Other (specify): BILLABLE SUPPLIES	V39					338,835		338,835	13
14	TOTAL			$	32,568	$ 1,438,388	$ 994,455	32,568	$ 2,432,843	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 Village # 0021436 Report Period Beginning: Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund. As of _____ (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	$ 11,941	$	1
2	Cash-Patient Deposits	38,898		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 473,006)	2,173,297		3
4	Supply Inventory (priced at)	11,240		4
5	Short-Term Investments	11,982,860		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,358		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Ent Fee/Int/Other Receivables	175,196		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,415,790	$	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	26,448,439		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,695,822		16
17	Accumulated Depreciation (book methods)	(14,157,990)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	842,236		21
22	Other Long-Term Assets (spe CIP	54,913		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,192,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,607,972	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (11,728,592)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,898		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	323,578		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	Other Liabilities	857,961		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (10,416,754)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	14,085,800		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fee Revenue	1,287,854		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,373,654	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,956,900	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 25,651,072	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,607,972	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 25,107,147	1
2	Restatements (describe):		2
3	**Restricted Contributions**	282	3
4	**Net assets released to be used in operations**	(1,505)	4
5	**Net assets released to be used for capital purchases**	(17,593)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 25,088,331	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	562,744	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)**	$ 562,744	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**		18
19			19
20			20
21			21
22	**Rounding**	(3)	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 25,651,072	24 *

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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	$ 15,189,215	1
2	Discounts and Allowances for all Levels	(11,372,144)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,817,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,504,564	6
7	Oxygen	22,633	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,527,197	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	1,772	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	966,307	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	105,163	19
20	Radiology and X-Ray	72,206	20
21	Other Medical Services	593,651	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,739,099	23
	D. Non-Operating Revenue		
24	Contributions	127,183	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 127,183	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	1,636,177	28
28a	Misc Revenue	319,768	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,955,945	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,166,495	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,710,754	31
32	Health Care	6,786,472	32
33	General Administration	3,651,048	33
	B. Capital Expense		
34	Ownership	1,388,484	34
	C. Ancillary Expense		
35	Special Cost Centers	2,682,840	35
36	Provider Participation Fee	384,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,603,751	40
41	**Income before Income Taxes (line 30 minus line 40)****	562,744	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 562,744	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,712,228	44
45	Private Pay - Net Inpatient Revenue	4,166,032	45
46	Medicare - Net Inpatient Revenue	(1,643,094)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(1,157,722)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,260,373)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,817,071	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 Village # 0021436 Report Period Beginning: Ending:

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	1,835	2,242	$ 138,475	$ 61.76	1
2	Assistant Director of Nursing	3,784	4,254	144,636	34.00	2
3	Registered Nurses	37,566	41,764	989,968	23.70	3
4	Licensed Practical Nurses	56,788	63,793	1,463,320	22.94	4
5	CNAs & Orderlies	142,346	149,408	1,953,920	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,007	2,103	38,456	18.29	9
10	Activity Assistants	5,134	5,391	56,884	10.55	10
11	Social Service Workers	11,450	12,219	204,530	16.74	11
12	Dietician					12
13	Food Service Supervisor	1,352	1,510	30,791	20.39	13
14	Head Cook	5,911	6,123	64,869	10.59	14
15	Cook Helpers/Assistants	26,004	27,430	256,242	9.34	15
16	Dishwashers					16
17	Maintenance Workers	6,012	6,249	103,466	16.56	17
18	Housekeepers	21,182	22,552	245,658	10.89	18
19	Laundry	5,531	5,685	69,701	12.26	19
20	Administrator	3,303	3,383	314,282	92.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,389	16,272	171,313	10.53	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	2,537	2,656	39,657	14.93	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING/AL	38,997	41,748	791,978	18.97	33
34	TOTAL (lines 1 - 33)	387,128	414,782	$ 7,078,146 *	$ 17.06	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	1,396	$ 63,597	V01-3	35
36	Medical Director	731	86,520	V09-3	36
37	Medical Records Consultant	60	3,525	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	5,217	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	724	V11-3	44
45	Social Service Consultant	8	724	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,324	$ 160,307		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 Village # 0021436 Report Period Beginning: Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Schaaf	Executive Director		$ 127,480
Brandy Black	Administrator		46,037
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 173,516

B. Administrative - Other

Description	Amount
Management Fees	$ 890,985
TOTAL (agree to Schedule V, line 17, col. 3)	$ 890,985
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 3,032
Davis & Campbell	Legal	34,688
Receivable Mgmt Services	Collections	3,666
Polsinelli Shugart	Legal	6,822
Sandberg Phoenix & Von Gontard	Legal	7,687
EL Pruitt	Legal	150
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 56,045

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,346
Unemployment Compensation Insurance	6,159
FICA Taxes	469,985
Employee Health Insurance	543,318
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	29,740
Employee Uniforms	(3,943)
Employee Expense	16,903
457 Plan Expense	5,960
Home Office Allocation	138,289
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,368,757

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)	
Patient Background Checks	
PSO Memorial Medical Center	1,421
License	2,062
Dues	16,122
Subscriptions	17,381
Convenience Fees	5
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,991

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,516
In-State Travel	5,195
Seminar Expense	3,760
Home Office Allocation	65,413
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 78,884

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: Ending:

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 - $15,344.52**

(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. $ **29,784** 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. $ **384,153**
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. $ **8,620**

(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