		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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
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 7/1/19 to 6/30/20 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: 7/1/19 Ending: 6/30/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,586	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,586	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,665	15,894	13,311	56,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,665	15,894	13,311	56,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.87%

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 8,646

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: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	412,815	41,319	59,279	513,413		513,413		513,413			1
2	Food Purchase		373,554		373,554		373,554	(5,238)	368,316			2
3	Housekeeping	278,951	63,478	2,212	344,641		344,641		344,641			3
4	Laundry	90,757	748		91,505		91,505		91,505			4
5	Heat and Other Utilities			289,321	289,321		289,321	(16,132)	273,189			5
6	Maintenance	146,481	11,897	169,959	328,337		328,337	4,681	333,018			6
7	Other (specify):* Trash			13,235	13,235		13,235		13,235			7
8	TOTAL General Services	929,004	490,996	534,006	1,954,006		1,954,006	(16,689)	1,937,317			8
	B. Health Care and Programs											
9	Medical Director			87,485	87,485		87,485		87,485			9
10	Nursing and Medical Records	5,416,528	257,532	94,565	5,768,625		5,768,625	(12,610)	5,756,015			10
10a	Therapy			1,501,871	1,501,871		1,501,871		1,501,871			10a
11	Activities	108,360	8,190	2,841	119,391		119,391		119,391			11
12	Social Services	217,555	414	10,715	228,684		228,684		228,684			12
13	CNA Training											13
14	Program Transportation			3,870	3,870		3,870	(3,870)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,742,443	266,136	1,701,347	7,709,926		7,709,926	(16,480)	7,693,446			16
	C. General Administration											
17	Administrative	106,974		932,502	1,039,476		1,039,476	(758,011)	281,465			17
18	Directors Fees											18
19	Professional Services			79,967	79,967		79,967	78,028	157,995			19
20	Dues, Fees, Subscriptions & Promotions			29,087	29,087		29,087	4,223	33,310			20
21	Clerical & General Office Expenses	323,643	26,763	723,836	1,074,242		1,074,242	8,239	1,082,481			21
22	Employee Benefits & Payroll Taxes			1,343,417	1,343,417		1,343,417	121,663	1,465,080			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,175	3,175		3,175	27,332	30,507			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			263,070	263,070		263,070	57,185	320,255			26
27	Other (specify):* Marketing	260,450	1,529	48,013	309,992		309,992	(309,992)				27
28	TOTAL General Administration	691,067	28,292	3,423,067	4,142,426		4,142,426	(771,333)	3,371,093			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,362,514	785,424	5,658,420	13,806,358		13,806,358	(804,502)	13,001,856			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: 7/1/19 Ending: 6/30/20

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			1,036,819	1,036,819		1,036,819	90,886	1,127,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			615,959	615,959		615,959	(315,771)	300,188			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,241	26,241		26,241		26,241			35
36	Other (specify):* Deferred Financing Costs			6,139	6,139		6,139		6,139			36
37	**TOTAL Ownership**			1,685,158	1,685,158		1,685,158	(224,885)	1,460,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			997,602	997,602		997,602	(40,681)	956,921			39
40	Barber and Beauty Shops	31,642	1,428		33,070		33,070		33,070			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			386,601	386,601		386,601		386,601			42
43	Other (specify):* Apt/Congregate	491,985		958,656	1,450,641		1,450,641	(1,450,641)				43
44	**TOTAL Special Cost Centers**	523,627	1,428	2,342,859	2,867,914		2,867,914	(1,491,322)	1,376,592			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,886,141	786,852	9,686,437	18,359,430		18,359,430	(2,520,709)	15,838,721			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: 7/1/19 Ending: 6/30/20

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,902)	2		4
5	Telephone, TV & Radio in Resident Rooms	(18,767)	05		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	(315,771)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,555)	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	(54,247)	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	(404,080)	21		24
25	Fund Raising, Advertising and Promotional	(309,992)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,637,940)		$	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)	235,545	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 235,545		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,402,395)		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: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation	$ (3,870)	14	1
2	Late Fees, Finance Charges	(273)	21	2
3	Apartment/Congregate	(1,560,872)	43	3
4	Vending Revenue	(2,336)	02	4
5	Miscellaneous Revenue	(884)	21	5
6	Lobbying Expense	(696)	20	6
7	Medical Records Income	(55)	10	7
8	Collection Expense	(66,554)	19	8
9	Marketing Program for MMC & St John	(2,400)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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32				32
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34				34
35				35
36				36
37				37
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,637,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	(5,238)	0	0	0	0	0	0	0	0	0	0	(5,238)	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	(18,767)	2,635	0	0	0	0	0	0	0	0	0	(16,132)	5
6	Maintenance	0	4,681	0	0	0	0	0	0	0	0	0	4,681	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(24,005)	7,316	0	0	0	0	0	0	0	0	0	(16,689)	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	(12,610)	0	0	0	0	0	0	0	0	0	0	(12,610)	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	(3,870)	0	0	0	0	0	0	0	0	0	0	(3,870)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(16,480)	0	0	0	0	0	0	0	0	0	0	(16,480)	16
	C. General Administration													
17	Administrative	0	(758,011)	0	0	0	0	0	0	0	0	0	(758,011)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(66,554)	144,582	0	0	0	0	0	0	0	0	0	78,028	19
20	Fees, Subscriptions & Promotions	(3,096)	7,319	0	0	0	0	0	0	0	0	0	4,223	20
21	Clerical & General Office Expenses	(459,484)	467,723	0	0	0	0	0	0	0	0	0	8,239	21
22	Employee Benefits & Payroll Taxes	0	121,663	0	0	0	0	0	0	0	0	0	121,663	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	27,332	0	0	0	0	0	0	0	0	0	27,332	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	57,185	0	0	0	0	0	0	0	0	0	57,185	26
27	Other (specify):*	(309,992)	0	0	0	0	0	0	0	0	0	0	(309,992)	27
28	**TOTAL General Administration**	(839,126)	67,793	0	0	0	0	0	0	0	0	0	(771,333)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(879,611)	75,109	0	0	0	0	0	0	0	0	0	(804,502)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 **Report Period Beginning:** 7/1/19 **Ending:** 6/30/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	90,886	0	0	0	0	0	0	0	0	0	90,886	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(315,771)	0	0	0	0	0	0	0	0	0	0	(315,771)	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**	(315,771)	90,886	0	0	0	0	0	0	0	0	0	(224,885)	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	(40,681)	0	0	0	0	0	0	0	0	0	(40,681)	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):*	(1,560,872)	110,231	0	0	0	0	0	0	0	0	0	(1,450,641)	43
44	**TOTAL Special Cost Centers**	(1,560,872)	69,550	0	0	0	0	0	0	0	0	0	(1,491,322)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,756,254)	235,545	0	0	0	0	0	0	0	0	0	(2,520,709)	45

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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%	$ 2,635	$ 2,635	1
2	V	6	Maintenance				4,681	4,681	2
3	V	17	Administrative	932,502			174,491	(758,011)	3
4	V	19	Professional Services				144,582	144,582	4
5	V	21	Clerical				384,709	384,709	5
6	V	22	Employee Benefits				121,663	121,663	6
7	V	20	Dues & Subscriptions				7,319	7,319	7
8	V	24	Travel and Seminars				27,332	27,332	8
9	V	26	Insurance				57,185	57,185	9
10	V	30	Depreciation				90,886	90,886	10
11	V	21	Other Administrative Expense				83,014	83,014	11
12	V	43	Apt/Congregate/Wellness				110,231	110,231	12
13	V	39	Pharmacy Services	762,617	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	721,936	(40,681)	13
14	Total			$ 1,695,119			$ 1,930,664	$ * 235,545	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: 7/1/19 Ending: 6/30/20

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	Worksheet N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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27								27
28								28
29								29
30								30

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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: 7/1/19 Ending: 6/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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: 7/1/19 Ending: 6/30/20

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			12/12/18	$ 4,080,891	$ 4,040,332	5/15/2040	0.0500	$ 194,562	1
2	Illinois Finance Authority		X			7/1/10	5,500,000	2,474,254	5/15/2027	0.0625	343,810	2
3	Illinois Finance Authority		X			3/1/16	5,646,005	7,387,473	5/15/2040	0.0500	72,136	3
4	GO Bonds	X			Various	Various	Various*	175,702	6/30/2032	Various*	5,451	4
5												5
	Working Capital											
6	Interest Offset										(315,771)	6
7												7
8												8
9	TOTAL Facility Related						$ 15,226,896	$ 14,077,761			$ 300,188	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	*This is an allocation of the total GO Bond Debt, which includes several different series with several different rates of Interest.											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,226,896	$ 14,077,761			$ 300,188	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: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attachment	See Attachment	$ 96,347.40	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 96,347.40	$

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 7/1/19 Ending: 6/30/20

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			14,700	2
3	TOTALS	105,787		$ 323,462	3

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 59,751		$ 59,751	$	$ 2,449,802	4
5			1978		521,479						5
6			2012		5,647,901	141,197		141,197		1,141,346	6
7			2016		3,172,339	126,894		126,894		507,574	7
8	Home Office Allocation				193,219	5,324		5,324		110,344	8
	Improvement Type**										
9	1978 Fixed Assets			1978	85,870		VARIOUS			85,870	9
10	1979 Fixed Assets			1979	23,654		VARIOUS			23,654	10
11	1980 Fixed Assets			1980	827	6	VARIOUS	6		771	11
12	1986 Fixed Assets			1986	3,236		VARIOUS			3,236	12
13	1987 Fixed Assets			1987	2,600		VARIOUS			2,600	13
14	1991 Fixed Assets			1991	34,141		VARIOUS			34,141	14
15	1993 Fixed Assets			1993	125,670		VARIOUS			125,670	15
16	1997 Fixed Assets			1997	5,713		VARIOUS			5,713	16
17	1999 Fixed Assets			1999	44,246	1,106	VARIOUS	1,106		23,782	17
18	2002 Fixed Assets			2002						(163)	18
19	2003 Fixed Assets			2003	6,187	58	VARIOUS	58		6,019	19
20	2004 Fixed Assets			2004	74,197		VARIOUS			74,197	20
21	2005 Fixed Assets			2005	25,032		VARIOUS			25,032	21
22	2006 Fixed Assets			2006	531,796	19,116	VARIOUS	19,116		416,998	22
23	2007 Fixed Assets			2007	250,728	10,667	VARIOUS	10,667		178,646	23
24	2008 Fixed Assets			2008	2,336,882	111,364	VARIOUS	111,364		1,454,226	24
25	2009 Fixed Assets			2009	99,385	2,562	VARIOUS	2,562		98,475	25
26	2010 Fixed Assets			2010	1,346,202	89,020	VARIOUS	89,020		1,301,526	26
27	2011 Fixed Assets			2011	109,661	10,965	VARIOUS	10,965		101,758	27
28	2012 Fixed Assets			2012	119,103	9,606	VARIOUS	9,606		79,757	28
29	2013 Fixed Assets			2013	56,507	5,261	VARIOUS	5,261		41,099	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	ROOF KITCHEN MAIN AREA	2014	$ 100,000	$ 8,340		$ 8,340	$	$ 52,402	37
38	DUCTLESS SPLIT SYSTEM IN SERVER ROOM	2014	7,375	738	10	738		4,548	38
39	Concrete replace driveway	2014	3,174	212	15	212		1,234	39
40	Landscape at Main Entrance west side	2014	5,656	566	10	566		3,252	40
41	West Courtyard Landscaping	2015	8,112	811	10	811		4,123	41
42									42
43	Water Heater - Skilled Facility	2015	7,890	789	10	789		3,839	43
44	Skilled Water Heater	2015	7,980	798	10	798		3,857	44
45	Variou Onsie Improvements	2015	2,481	248	10	248		1,137	45
46	Install Flooring in Main Dining & Chapel	2016	47,162	4,716	10	4,716		20,830	46
47	Duplex 3436 Install Flooring	2016	5,627	563	10	563		2,439	47
48	Skilled Dining Room Walls Replace	2016	16,275	1,628	10	1,628		6,917	48
49	Replace Flooring in Unit 201 Oak	2016	920	92	10	92		383	49
50	Landscape 22 Bed Add'l Courtyard	2016	31,285	3,128	10	3,128		12,514	50
51	Install Exhaust Fan in Warming Kitchen	2016	1,530	255	16	255		1,020	51
52	Duct pressure VVT & Bypass Controller	2016	2,134	213	10	213		854	52
53	500N & 500S Smoke Detectors w/Exit Light	2016	2,930	293	10	293		1,123	53
54	Fire Caulking per IDHP	2016	28,070	2,807	10	2,807		10,526	54
55	Culligan Water Softener	2016	5,091	509	10	509		1,867	55
56	GP Conference Room Door	2016	6,035	603	10	603		2,213	56
57	Walk-thru bath tub @ 3420 Unit 2	2017	750	75	10	75		256	57
58	Dining Storage room doors	2017	9,090	909	10	909		2,954	58
59	Walk-thru bath tub @3420 unit 5	2017	750	75	10	75		238	59
60	400 Hall 12 rooms Flooring	2017	21,320	4,264	5	4,264		13,147	60
61	APR Valves on Carrier AC Units GP	2017	4,840	484	10	484		1,492	61
62	New Circuits on Emergency panels	2017	3,366	337	10	337		1,010	62
63	Front Entrance canopy underside replace	2017	5,845	585	10	585		1,656	63
64	Parking Lot Asphalt milling & overlay	2017	87,415	8,742	10	8,742		23,311	64
65	New Flat Roof on building LMCV	2017	113,865	7,591	15	7,591		20,243	65
66	Landscape Front Main Entryway	2018	27,702	2,770	10	2,770		6,925	66
67	Roof Top Air Handling Unit RTU #6 & 7	2018	24,581	1,639	15	1,639		3,960	67
68	SNF Outdoor Light Pole Replace	2018	25,275	1,685	15	1,685		4,072	68
69	200 Hall Flooring replace 20 rooms	2018	33,565	3,357	10	3,357		7,832	69
70	TOTAL (lines 4 thru 69)		$ 17,751,496	$ 652,718		$ 652,718	$	$ 8,514,247	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: 7/1/19 Ending: 6/30/20

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		$ 17,751,496	$ 652,718		$ 652,718	$	$ 8,514,247	1
2	100 Gallon Water heater	2018	7,520	752	10	752		1,755	2
3	Raditaor for Generac Generator	2018	3,519	704	5	704		1,408	3
4	Southwest Section of Roof Replace	2018	79,830	5,322	15	5,322		10,644	4
5	Entrance Area & Hall Flooring	2018	2,189	219	10	219		438	5
6	Outdoor Can Canopy Lights install	2018	1,169	234	5	234		468	6
7	Unit 3300 & 3400 Shrub Trees	2018	3,075	615	5	615		1,230	7
8	Fire Sprinkler Dry Accelerator	2018	2,398	480	5	480		919	8
9	Courtyard Shrubs trees landscaping	2018	9,091	1,818	5	1,818		3,485	9
10	Retaining Wall behind 3422 W. Washington	2018	10,748	1,075	10	1,075		2,060	10
11	Gracepoint HVAC RTU Evap Coil	2018	16,705	3,341	5	3,341		6,125	11
12	Concrete Sidwalk on 3400 block	2018	4,592	459	10	459		842	12
13	300 Center Hall Faucet/ Sewer Pipe	2018	4,635	464	10	464		811	13
14	Gracepoint North AC unit reheat coils	2018	30,444	3,044	10	3,044		5,074	14
15	20 Evergreen Trees	2018	5,950	595	10	595		992	15
16	Fire metal doors / Oak wood	2018	6,605	660	10	660		1,046	16
17	Paint Main Lobby & Hall Project	2018	55,114	5,511	10	5,511		8,726	17
18	Public Mens Restroom Urinal Wall	2018	1,778	178	10	178		282	18
19	Retaining wall between 3326/ 3332 units	2019	3,278	328	10	328		519	19
20	Retaining wall between build 3438/3436	2019	3,892	389	10	389		584	20
21	100 Hall & Rooms Flooring	2019	34,748	3,475	10	3,475		4,923	21
22	200 Hall & Extention Area Flooring	2019	14,969	1,497	10	1,497		2,121	22
23	300/400 Hall & Front Common Area Floor	2019	35,159	3,516	10	3,516		4,981	23
24	Med Room & File Room off Lobby Floor	2019	2,671	267	10	267		378	24
25	SNF Entryway Carpet	2019	1,412	282	5	282		376	25
26	Canada Red Chokecherry Tree (3)	2019	1,162	116	10	116		155	26
27	Jamestown Maple Tree (2)	2019	1,162	116	10	116		155	27
28	Pink Kousa Dogwood Tree	2019	1,163	116	10	116		155	28
29	Gracepoint Paint Project	2019	29,150	2,915	10	2,915		2,915	29
30	Market Analysis PMD Advisory	2019	44,271	4,427	10	4,427		4,427	30
31	Flooring of Springfiled Carpet	2019	4,579	1,526	3	1,526		1,526	31
32	Courtyard trees, bushes, & rock	2019	6,071	607	10	607		607	32
33	LED Energy Efficient light fixtures	2019	11,440	1,144	10	1,144		1,144	33
34	TOTAL (lines 1 thru 33)		$ 18,191,985	$ 698,911		$ 698,911	$	$ 8,585,517	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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 18,191,985	$ 698,911		$ 698,911	$	$ 8,585,517	1
2	Driveway Concrete 25x33	2019	6,187	516	10	516		516	2
3	Westside sidewalks Concrete 877sq ft	2019	6,139	512	10	512		512	3
4	Receiving Area 42x15 Asphalt	2019	4,750	396	10	396		396	4
5	LED Energy Efficient light fixtures	2020	8,385	419	10	419		419	5
6	SNF Resident Room Paint Project	2020	32,200	1,610	10	1,610		1,610	6
7	SNF Common Area Tiles Replace	2020	1,602	223	3	223		223	7
8	Jetted Sewer Behind Build	2020	635	71	3	71		71	8
9	Prairie Signs Circle Channel Taces	2020	998	83	3	83		83	9
10	300 Hall Engery Effic Fixtures	2020	4,356	109	10	109		109	10
11	Edwards Fire Alarm Control Panel	2020	9,360	78	10	78		78	11
12	Lighting LED Halls 200	2020	7,929	132	5	132		132	12
13	SNF Common Area Window Treatments	2020	26,349	220	10	220		220	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	Rounding		1					(1)	33
34	TOTAL (lines 1 thru 33)		$ 18,300,876	$ 703,278		$ 703,278	$	$ 8,589,883	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: 7/1/19 Ending: 6/30/20

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	$ 1,971,506	$ 262,789	$ 262,789	$	Various	$ 1,429,675	71
72	Current Year Purchases	226,845	44,682	44,682		Various	44,682	72
73	Fully Depreciated Assets	104,751	13,238	13,238		Various	104,751	73
74	Home Office Allocation	558,328	82,369	82,369			306,833	74
75	TOTALS	$ 2,861,430	$ 403,078	$ 403,078	$		$ 1,885,941	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			$ 177,203	$ 18,156	$ 18,156	$	4	$ 133,700	76
77										77
78										78
79	Home Office Allocation			17,387	1,383	1,383			15,850	79
80	TOTALS			$ 194,590	$ 19,539	$ 19,539	$		$ 149,550	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)	$ 21,680,358	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,125,895	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,125,895	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)	$ 10,625,374	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	$ 1,654,651	$ 68,152	$ 642,271	86
87	Wellness Center Building and Equipment	1,122,641	49,560	717,653	87
88	Duplex Building and Equipment	5,713,611	253,588	4,061,756	88
89					89
90					90
91	TOTALS	$ 8,490,903	$ 371,300	$ 5,421,680	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 235,912	92
93			93
94			94
95		$ 235,912	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: 7/1/19 Ending: 6/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 26,241 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: 7/1/19 Ending: 6/30/20

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.

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	$	12,752	$ 640,420	$	12,752	$ 640,420	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,931	122,520		3,931	122,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		16,830	738,931		16,830	738,931	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				567,089		567,089	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						58,634		58,634	12
13	Other (specify): Radiology						80,010		80,010	13
14	TOTAL			$	33,513	$ 1,501,871	$ 705,733	33,513	$ 2,207,604	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: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (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	$ 8,028	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 580,666)	1,912,912		3
4	Supply Inventory (priced at)	18,825		4
5	Short-Term Investments	11,400,142		5
6	Prepaid Insurance	2,932		6
7	Other Prepaid Expenses	48,985		7
8	Accounts Receivable (owners or related parties)	14,770,674		8
9	Other(specify): AR Other	35,240		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 28,197,738	$	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	22,589,354		14
15	Leasehold Improvements, at Historical Cost	4,174,223		15
16	Equipment, at Historical Cost	2,315,288		16
17	Accumulated Depreciation (book methods)	(15,614,027)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,950,990		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing Costs	209,308		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,933,898	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 44,131,636	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	449,179		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,864		32
33	Accrued Interest Payable	699,576		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities/Due to Auxiliary	152,370		36
37	Security Deposits Payable	1,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,360,989	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	14,077,761		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	2,030,182		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,107,943	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,468,932	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 26,662,704	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 44,131,636	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 26,115,055	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 26,115,055	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	547,650	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) Rounding	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 547,649	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 26,662,704	24 *

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

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 13,709,043	1
2	Discounts and Allowances for all Levels	(8,455,245)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,253,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,626,701	6
7	Oxygen	23,282	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,649,983	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,123	13
14	Non-Patient Meals	2,902	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,016,175	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	93,409	19
20	Radiology and X-Ray	103,137	20
21	Other Medical Services	421,288	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,659,034	23
	D. Non-Operating Revenue		
24	Contributions	375,498	24
25	Interest and Other Investment Income***	315,771	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 691,269	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Apt/Duplex	1,688,925	28
28a	Miscellaneous	(35,929)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,652,996	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,907,080	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,954,006	31
32	Health Care	7,709,926	32
33	General Administration	4,142,426	33
	B. Capital Expense		
34	Ownership	1,685,158	34
	C. Ancillary Expense		
35	Special Cost Centers	2,481,313	35
36	Provider Participation Fee	386,601	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,359,430	40
41	**Income before Income Taxes (line 30 minus line 40)****	547,650	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 547,650	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,473,234	44
45	Private Pay - Net Inpatient Revenue	4,203,712	45
46	Medicare - Net Inpatient Revenue	(2,012,667)	46
47	Other-(specify) HMO/HMO Ancillary/ Med Adv/Hospice	(1,333,427)	47
48	Other-(specify) Nursing/Outpatient Part B	(77,054)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,253,798	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: 7/1/19 Ending: 6/30/20

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	2,774	2,925	$ 103,891	$ 35.52	1
2	Assistant Director of Nursing	3,166	3,617	116,489	32.21	2
3	Registered Nurses	25,929	27,487	879,923	32.01	3
4	Licensed Practical Nurses	73,616	82,215	1,643,959	20.00	4
5	CNAs & Orderlies	153,280	166,053	2,629,026	15.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,250	39,429	17.52	9
10	Activity Assistants	5,589	5,842	68,931	11.80	10
11	Social Service Workers	13,479	14,552	217,555	14.95	11
12	Dietician					12
13	Food Service Supervisor	2,128	2,406	47,814	19.87	13
14	Head Cook	8,677	9,379	107,006	11.41	14
15	Cook Helpers/Assistants	25,257	27,863	257,995	9.26	15
16	Dishwashers					16
17	Maintenance Workers	8,175	8,654	146,481	16.93	17
18	Housekeepers	21,429	24,160	278,951	11.55	18
19	Laundry	6,696	7,622	90,758	11.91	19
20	Administrator	1,600	1,734	106,974	61.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,992	2,255	67,241	29.82	23
24	Clerical	130,147	14,409	256,402	17.79	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	1,851	1,982	43,240	21.82	31
32	Other Health C: Barber and Beauty	2,291	2,568	31,642	12.32	32
33	Other(specify) Duplex/Apts/Mark	30,532	32,717	752,434	23.00	33
34	TOTAL (lines 1 - 33)	520,696	440,690	$ 7,886,141 *	$ 17.89	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	1,081	$ 55,203	V01-3	35
36	Medical Director	708	87,485	V09-3	36
37	Medical Records Consultant	60	1,500	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	17,118	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	22	2,624	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,991	$ 163,930		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: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christine Hopson	Executive Director		$ 106,974
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,974

B. Administrative - Other

Description	Amount
Management Fees	$ 932,502
TOTAL (agree to Schedule V, line 17, col. 3)	$ 932,502
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Surveys	$ 2,203
Davis & Campbell	Collections	30,083
Receivable Mgmt Services	Collections	1,402
Polsinelli Shugart	Legal	11,211
Delaney, Delaney & Voorn	Collections	35,069
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 79,967

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,070
Unemployment Compensation Insurance	17,169
FICA Taxes	550,708
Employee Health Insurance	574,336
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	48,554
Employee Uniforms	536
Employee Expense	19,102
457 Plan Expense	942
Home Office Allocation	121,663
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,465,080

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)	
Lobbying Expense Offset	(696)
Home Office Allocation	7,319
License	3,246
Dues	18,359
Subscriptions	5,082
Marketing Program for MMC & St John	2,400
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 830
In-State Travel	1,096
Seminar Expense	1,248
Home Office Allocation	27,332
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30,507

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Vlg # 0021436 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 - $16,793.01**

(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. $ **33,421** 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. $ **386,601**
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. $ **2,902**

(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 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.