

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0021436</u></p> <p><b>Facility Name:</b> <u>Lewis Memorial Christian Village</u></p> <p><b>Address:</b> <u>3400 West Washington Street</u> <u>Springfield</u> <u>62707</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Sangamon</u></p> <p><b>Telephone Number:</b> <u>217-787-9600</u> <b>Fax #</b> <u>217-787-9601</u></p> <p><b>HFS ID Number:</b> <u>51-0173104001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/1977</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501c3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Brenda Lavin</u> <b>Telephone Number:</b> <u>217-732-5136</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Tim Phillippe</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>Deborah Elsey</u> <u>Principal</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) <u>Larson, Allen &amp; Weishair &amp; Co LLP</u> <u>220 South 6th Street, #300, Minneapolis, MN 55402</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>612-376-4642</u> Fax # <u>612-376-4850</u></td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span> </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Tim Phillippe</u>		(Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) <u>Deborah Elsey</u> <u>Principal</u>		(Firm Name & Address) <u>Larson, Allen &amp; Weishair &amp; Co LLP</u> <u>220 South 6th Street, #300, Minneapolis, MN 55402</u>		(Telephone) <u>612-376-4642</u> Fax # <u>612-376-4850</u>
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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 1/31/06

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	155	39,590	1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	0	16,985	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

## B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
		8	SNF	4,826		6,719	14,880	26,425	8
9	SNF/PED					9
10	ICF	13,156	12,522	567	26,245	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,982	19,241	15,447	52,670	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.10%D. How many bed-hold days during this year were paid by the Department?  
NONE (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Residential Living, Wellness Center, Senior Home ServicesF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO I. On what date did you start providing long term care at this location?  
Date started 09/19/1977J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 155 and days of care provided 14,403Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRAU  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

\* 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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	374,554	33,570	4,993	413,117		413,117		413,117		1
2	Food Purchase		320,966		320,966		320,966	(4,823)	316,143		2
3	Housekeeping	270,064	48,112	164	318,340		318,340		318,340		3
4	Laundry										4
5	Heat and Other Utilities			157,736	157,736		157,736	12,122	169,858		5
6	Maintenance	119,965	13,271	78,116	211,352		211,352	15,141	226,493		6
7	Other (specify):* <b>Trash Removal</b>			13,924	13,924		13,924		13,924		7
8	<b>TOTAL General Services</b>	764,583	415,919	254,933	1,435,435		1,435,435	22,440	1,457,875		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,750	3,750		3,750		3,750		9
10	Nursing and Medical Records	2,933,775	622,785	30,983	3,587,543		3,587,543	(260)	3,587,283		10
10a	Therapy			866,998	866,998		866,998		866,998		10a
11	Activities	12,358			12,358		12,358		12,358		11
12	Social Services	217,838	7,960	14,892	240,690		240,690	(834)	239,856		12
13	CNA Training										13
14	Program Transportation			645	645		645		645		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,163,971	630,745	917,268	4,711,984		4,711,984	(1,094)	4,710,890		16
	<b>C. General Administration</b>										
17	Administrative	253,586	866	523,681	778,133		778,133	(411,317)	366,816		17
18	Directors Fees										18
19	Professional Services			2,528	2,528		2,528	25,379	27,907		19
20	Dues, Fees, Subscriptions & Promotions			68,966	68,966		68,966	(24,858)	44,108		20
21	Clerical & General Office Expenses	294,532	22,400	85,869	402,801		402,801	482	403,283		21
22	Employee Benefits & Payroll Taxes			846,696	846,696		846,696	32,747	879,443		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,226	17,226		17,226	20,748	37,974		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			112,074	112,074		112,074	4,005	116,079		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	548,118	23,266	1,657,040	2,228,424		2,228,424	(352,814)	1,875,610		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,476,672	1,069,930	2,829,241	8,375,843		8,375,843	(331,468)	8,044,375		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 &amp; ID Number

Lewis Memorial Christian Village

#0021436

Report Period Beginning:

Ending:

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			182,489	182,489		182,489	35,882	218,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,751	105,751		105,751	(96,791)	8,960			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Bond Costs</b>			1,962	1,962		1,962	(1,727)	235			36
37	<b>TOTAL Ownership</b>			290,202	290,202		290,202	(62,636)	227,566			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			40,968	40,968		40,968		40,968			39
40	Barber and Beauty Shops	35,421	2,384	20	37,825		37,825		37,825			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* <b>Apt/Congregate</b>			852,904	852,904		852,904	(852,904)				43
44	<b>TOTAL Special Cost Centers</b>	35,421	2,384	978,755	1,016,560		1,016,560	(852,904)	163,656			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,512,093	1,072,314	4,098,198	9,682,605		9,682,605	(1,247,008)	8,435,597			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,823)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,005	30		9
10	Interest and Other Investment Income	(121,472)	32		10
11	Discounts, Allowances, Rebates & Refunds	(102)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,096)	21		24
25	Fund Raising, Advertising and Promotional	(24,858)	20		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	(992,322)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,170,668)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,340)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (76,340)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,247,008)</b>		<b>37</b>

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

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

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

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: \_\_\_\_\_

Ending: \_\_\_\_\_

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ (834)	12	1
2	Activity	(1,329)	21	2
3	Miscellaneous Income	(1,727)	36	3
4	Exempt Interest Income - Endowment	23,638	32	4
5	Gain on Sale of Investment	574	32	5
6	Late Fees	(77)	6	6
7	Late Fees	(260)	10	7
8	Late Fees	(592)	21	8
9	Apt/Congregate	(852,904)	43	9
10	Marketing Salaries	(156,356)	21	10
11	Marketing Other	(2,455)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(992,322)		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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,823)	0	0	0	0	0	0	0	0	0	0	(4,823)	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	12,122	0	0	0	0	0	0	0	0	0	12,122	5
6	Maintenance	(77)	15,218	0	0	0	0	0	0	0	0	0	15,141	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,900)</b>	<b>27,340</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>22,440</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(834)	0	0	0	0	0	0	0	0	0	0	(834)	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	<b>TOTAL Health Care and Programs</b>	<b>(1,094)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,094)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(411,317)	0	0	0	0	0	0	0	0	0	(411,317)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,379	0	0	0	0	0	0	0	0	0	25,379	19
20	Fees, Subscriptions & Promotions	(24,858)	0	0	0	0	0	0	0	0	0	0	(24,858)	20
21	Clerical & General Office Expenses	(188,930)	189,412	0	0	0	0	0	0	0	0	0	482	21
22	Employee Benefits & Payroll Taxes	0	32,747	0	0	0	0	0	0	0	0	0	32,747	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	20,748	0	0	0	0	0	0	0	0	0	20,748	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	4,005	0	0	0	0	0	0	0	0	0	4,005	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(213,788)</b>	<b>(139,026)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(352,814)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(219,782)</b>	<b>(111,686)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(331,468)</b>	<b>29</b>

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 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)	
	<b>D. Ownership</b>													
30	Depreciation	1,005	34,877	0	0	0	0	0	0	0	0	0	35,882	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97,260)	469	0	0	0	0	0	0	0	0	0	(96,791)	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):*	(1,727)	0	0	0	0	0	0	0	0	0	0	(1,727)	36
37	<b>TOTAL Ownership</b>	<b>(97,982)</b>	<b>35,346</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(62,636)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(852,904)	0	0	0	0	0	0	0	0	0	0	(852,904)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(852,904)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(852,904)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,170,668)</b>	<b>(76,340)</b>	<b>0</b>	0	0	0	0	0	0	0	0	<b>(1,247,008)</b>	<b>45</b>

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. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of the board of directors.						

**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		Christian Homes, Inc	100.00%	\$ 12,122	\$ 12,122	1
2	V	6 Maintenance				15,218	15,218	2
3	V	17 Administrative	523,681			112,364	(411,317)	3
4	V	19 Professional Services				25,379	25,379	4
5	V	21 Clerical				189,412	189,412	5
6	V	22 Employee Benefits				32,747	32,747	6
7	V	24 Travel & Seminar				20,748	20,748	7
8	V	26 Insurance				4,005	4,005	8
9	V	30 Depreciation				34,877	34,877	9
10	V	32 Interest				469	469	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 523,681			\$ 447,341	\$ * (76,340)	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 (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	This workpaper is not applicable.								\$	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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<u>This workpaper is not applicable.</u>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	CIB Mortgage		X	Refinance Bldg & Equip	Varies	4/1/2002	\$ 1,920,000	\$ 1,757,477	4/1/2027	0.0583	\$ 105,151	1
2	Financing Fee										600	2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 1,920,000	\$ 1,757,477			\$ 105,751	9
	<b>B. Non-Facility Related*</b>											
10	Revenue Bonds 2001-Y	X		Refinance Debt	Varies	10/1/2001	475,000	464,154	10/1/2031	0.0600	29,169	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$ 475,000	\$ 464,154			\$ 29,169	14
15	<b>TOTALS (line 9+line14)</b>						\$ 2,395,000	\$ 2,221,631			\$ 134,920	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 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.)		\$ N/A	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	
2001	8																						
2002	9																						
2003	10																						
2004	11																						
2005	12																						
<b>FOR BHF USE ONLY</b>																							
13	FROM R. E. TAX STATEMENT FOR 2005 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

**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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2005 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 Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>See Attached List</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
6. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
7. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
8. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
9. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocation:**

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

**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: 55,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	55,000	Various	\$ 308,762	1
2	Home Office Allocation			10,164	2
3	TOTALS	55,000		\$ 318,926	3

Facility Name & ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

Ending:

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	155		1977	\$ 2,286,830	\$ 56,166	40	\$ 57,171	\$ 1,005	\$ 1,619,399
5			1978	100,542		40			
6			1979	420,937		20			
7									
8	Home Office Allocations			84,851	10,626		10,626		26,578
	Improvement Type**								
9	Bldg Improvement		1979	306	6	38	6		162
10	Exhaust Fan		1983	417		15			417
11	Door Assembly		1985	1,244	4	20	4		1,244
12	Bldg Improvement		1986	573	17	20	17		573
13	Pass-thru WD		1986	664	33	20	33		646
14	Remodeling		1987	800	40	20	40		773
15	Rooftop Compressor		1988	3,408		10			3,408
16	A/C Unit		1989	4,406		8			4,406
17	Remodeling		1989	6,193	310	20	310		5,373
18	Tile, Cover Base		1989	6,600		5			6,600
19	Wall Paper		1989	826		5			826
20	Cabinets		1990	100		15			100
21	Roof Top A/C Unit		1991	4,158		10			4,158
22	Drapery Hardware		1991	1,124		5			1,124
23	Carpeting		1992	640		5			640
24	Curtain Track		1992	523		5			523
25	Curtain Track		1992	4,124		5			4,124
26	Receptacle		1992	575		10			575
27	Curtain Track		1992	565		5			565
28	Curtain Track		1992	1,229		5			1,229
29	Nurse Station Remodel		1993	30,556	1,528	20	1,528		19,497
30	Wallcoverings		1993	751		5			751
31	Wallcoverings		1994	3,747		5			3,747
32	A/C Compressors		1994	1,506		10			1,506
33									
34									
35									
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 &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

Ending:

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Exhaust Fans	1994	\$ 2,183	\$ 146	15	\$ 146	\$	\$ 1,886		37
38	Roof Entire Building	1993	125,670	8,378	15	8,378		105,881		38
39	Downspout Repairs	1994	6,000	400	15	400		5,000		39
40	Ceiling Tile	1994	1,149		10			1,149		40
41	Wallpaper/Floor Covering	1994	20,655		5			20,655		41
42	Lounge Remodel	1995	14,653		5			14,653		42
43	Volunteer Room Expansion	1995	8,435	671	10	671		8,435		43
44	Remodel Wing 100	1995	23,645		10			23,645		44
45	Remodel Shower Wing	1995	42,240		5			42,240		45
46	Wallcovering	1995	35,194		5			35,194		46
47	Stainless Steel Floor Cooler	1996	1,873		5			1,873		47
48	Wallcovering	1996	3,910		5			3,910		48
49	Wallcovering	1996	22,106		5			22,106		49
50	Gas Meter & Lines	1997	7,378		5			7,378		50
51	Maglocks & Keypad	1997	7,194	719	10	719		6,711		51
52	Nurse Call System	1997	9,727	973	10	973		9,078		52
53	Wallcovering	1997	28,134		5			28,134		53
54	Exhaust Fan	1997	12,370	1,237	10	1,237		11,030		54
55	Upgrade Energy Management System	1997	14,513	1,451	10	1,451		12,938		55
56	Upgrade Antennae System	1997	2,400		5			2,400		56
57	Wallcoverings - 400 Wing	1997	21,389		10			21,389		57
58	Wallcovering	1997	6,836		5			6,836		58
59	Fire Safety Gas Valve	1998	617		5			617		59
60	Locks	1998	782		5			782		60
61	Wiring for Network	1998	625		5			625		61
62	Outlets for Kronos	1998	664		5			664		62
63	Entrance Canopy	1998	3,667		5			3,667		63
64	Fire Alarm Control Panel	1998	28,154	2,815	10	2,815		21,347		64
65	Repl Fire Alarm Device	1999	4,800	480	10	480		3,560		65
66	Kitchen Hood	1999	6,910	691	10	691		5,067		66
67	Fire Alarm Devices	1999	4,600	460	10	460		3,373		67
68	Replace 8 Shower Valves	2000	10,084		5			10,084		68
69										69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,446,752	\$ 87,151		\$ 88,156	\$ 1,005	\$ 2,151,260		70

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

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

Ending:

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,446,752	\$ 87,151		\$ 88,156	\$ 1,005	\$ 2,151,260	1
2	Panduit Raceway	2000	13,130	1,313	10	1,313		8,863	2
3	Kitchen Ceiling	2000	5,923	592	10	592		3,749	3
4	Kitchen Walls	2000	2,099	210	10	210		1,278	4
5	CARPET #207	2000	1,344	21	5	21		1,344	5
6	WATER HEATERS	2001	37,299	3,730	10	3,730		19,893	6
7	NATURAL GAS REGULATOR	2001	1,184	118	10	118		629	7
8	40 GALLON WATER HEATER	2001	506	51	10	51		259	8
9	Remodel Shower-Wing 200	1/21/2002	3,500	350	10	350		1,575	9
10	(2) Horton Single Swing Security Door	3/28/2002	4,094	273	15	273		1,183	10
11	Rooftop A/C-Heat Unit	1/15/2002	3,762	251	15	251		1,130	11
12	Carpet Installation-TV Lounge & 2 Dwavs	5/30/2002	1,787	357	5	357		1,488	12
13	Heating/AC Unit	4/15/2002	1,348	90	15	90		383	13
14	Replacement of Heat/AC Unit Pump	4/30/2002	1,449	97	15	97		412	14
15	(3) Touch Security Lock Systems	9/6/2002	4,599	460	10	460		1,763	15
16	Install New Door Closers - 300 Wing	11/1/2002	13,990	933	15	933		3,421	16
17	Burglar Alarm Equipment	12/12/2002	2,896	290	10	290		1,039	17
18	Repair Fire Alarm System - 2 Detectors	6/5/2003	639	64	10	64		197	18
19	Shelving for Walk-In Cooler	6/30/2003	1,154	58	20	58		179	19
20	AC Compressor - Copeland	6/30/2003	1,295	108	12	108		333	20
21	Power Supplies for Fire Alarm Panel	7/31/2003	1,354	135	10	135		405	21
22	New Compressor - Walk In Freezer	10/29/2003	1,378	115	12	115		316	22
23	(12) Heat/AC Units for Various Areas	10/4/2003	13,343	1,334	10	1,334		3,669	23
24	5 Fan Cycling Control	11/24/2003	712	142	5	142		379	24
25	(14) Outside Globe Lights	12/26/2003	1,500	150	10	150		388	25
26	Therapy Room	6/30/2004	70,047	7,005	10	7,005		14,594	26
27	(22)GE Zoneline Units & Installation	11/2/2004	20,750	2,075	10	2,075		3,458	27
28	Security Light on Front of Bldg	12/28/2004	922	92	10	92		146	28
29	Floor Tile/Cove Base - Rm 102	4/8/2005	713	142	5	142		179	29
30	(2)Rooftops A/C Units	6/17/2005	20,827	2,083	10	2,083		2,257	30
31	(20)GE Zoneline Units	6/23/2005	16,678	2,085	8	2,085		2,259	31
32	Network Cabling Project	7/1/2004	20,397	2,040	10	2,040		4,080	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,717,371	\$ 113,915		\$ 114,920	\$ 1,005	\$ 2,232,508	34

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

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

Ending:

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,717,371	\$ 113,915		\$ 114,920	\$ 1,005	\$ 2,232,508	1
2	Land Improvements	6/30/1978	85,870		20			85,870	2
3	Parking Lot & Drives	6/30/1979	23,654		20			23,654	3
4	Landscapings	10/31/1979	5,572		20			5,572	4
5	Concrete (Garage)	7/31/1980	521		20			521	5
6	Landscaping	9/30/1984	6,077		20			6,077	6
7	Landscaping	10/21/1985	1,852	15	20	15		1,852	7
8	Road & Drainage	12/18/1986	3,236	162	20	162		3,172	8
9	Green View Landscaping	8/29/1986	2,700	135	20	135		2,689	9
10	Trimming - Stump Removal	9/30/1986	2,500	125	20	125		2,479	10
11	Land Improvement - Pro Scv	11/30/1986	250		10			250	11
12	Gravel Access Road	4/29/1987	250		10			250	12
13	Fire Hydrant	8/1/1987	2,600	130	20	130		2,459	13
14	Parking Lot Resurface	6/30/1991	34,141		20			34,141	14
15	Land Improvements	6/28/1993	1,564		8			1,564	15
16	Parking Lot Resurface	6/30/1997	5,713		10			5,713	16
17	Courtyard Landscaping	6/10/1998	5,134	342	3	342		5,134	17
18	36x24x8 Concrete Pad for Dumpster	5/28/2002	5,134		5			1,425	18
19	Asphalt Patching & Crack Sealing	7/11/2002	4,104	513	8	513		2,052	19
20	Repave Asphalt	6/5/2003	5,033	629	8	629		1,939	20
21	1000W Parking Lot Light	12/9/2003	700	70	8	70		181	21
22	Underground Electric Conduit	7/1/2004	4,150	415	10	415		830	22
23	10x8 Enclosed Shelter	11/29/1995	3,700	123	10	123		3,700	23
24	Garage	1/1/1999	44,246	1,106	40	1,106		8,295	24
25	12' Screened Gazbo	9/24/2004	1,958	196	10	196		359	25
26	New Nurse Call System for Nurs	9/24/2004	38,650	644	10	644		644	26
27	Install New Computers and Condense	9/24/2004	3,218	179	10	179		179	27
28	Installation of 2 digital Thermostat	8/12/2005	851	156	5	156		156	28
29	Nurse Call System 300 Wing	10/14/2005	26,138	1,960	10	1,960		1,960	29
30	Reclaim Rehab Unit Remodeling	12/31/2005	151,619						30
31	Install New Drain Trough	12/13/2005	1,893	110	10	110		110	31
32	Concrete Sidewalks W/Handicaps	7/27/2005	4,205	421	10	421		421	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,194,604	\$ 121,346		\$ 122,351	\$ 1,005	\$ 2,436,156	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 Depreciation-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	\$ 562,426	\$ 61,778	\$ 61,778	\$	Various	\$ 306,633	71
72	Current Year Purchases	170,388	9,877	9,877		Various	9,877	72
73	Fully Depreciated Assets	491,547				Various	491,547	73
74	Home Office Allocation	172,756	21,635	21,635			130,475	74
75	TOTALS	\$ 1,397,117	\$ 93,290	\$ 93,290	\$		\$ 938,532	75

D. Vehicle Depreciation (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	Patient Transportation	1989 Ford Bus	1989	\$ 38,359	\$	\$		8	\$ 38,359	76
77	Patient Transportation	1993 Chevy PU w/blade	1998	13,290				3	13,290	77
78										78
79	Home Office Allocation			20,888	2,616	2,616			2,618	79
80	TOTALS			\$ 72,537	\$ 2,616	\$ 2,616	\$		\$ 54,267	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 5,983,184 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 217,252 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,257 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,005 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,428,955 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	Apartment Bldg, Land Impr & Equip	\$ 479,846	\$ 13,747	\$ 335,345	86
87	Congregate Bldg, Land Impr & Equip	3,469,652	84,572	1,335,779	87
88	Wellness Center Bldg, & Equip	666,818	17,278	102,959	88
89	Duplex Bldg, Land Impr & Equip	4,013,345	102,780	1,656,375	89
90					90
91	TOTALS	\$ 8,629,661	\$ 218,377	\$ 3,430,458	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 368,424	92
93	Home Office Allocation	4,635	93
94			94
95		\$ 373,059	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
If NO, see instructions.

		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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$	\$	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.

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist	This	hrs											2
3	Licensed Recreational Therapist	workpaper	hrs											3
4	Licensed Physical Therapist	is not	hrs											4
5	Physician Care	applicable.	visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$			\$		\$	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 &amp; 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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,740,998	\$	1
2	Cash-Patient Deposits	8,817		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (131,536) )	1,603,805		3
4	Supply Inventory (priced at FIFO )	21,396		4
5	Short-Term Investments	1,779,704		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,192		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,183,264		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,353,176	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	11,754,674		14
15	Leasehold Improvements, at Historical Cost	705,959		15
16	Equipment, at Historical Cost	1,554,790		16
17	Accumulated Depreciation (book methods)	(6,699,732)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,253,940		21
22	Other Long-Term Assets (spt CIP)	368,424		22
23	Other(specify): <b>Deferred Bond Costs</b>	40,709		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,287,526	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,640,702	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 336,000	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,558		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	239,182		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,834		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Accrued Liabilities</b>	47,964		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 722,538	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,757,477		40
41	Bonds Payable	464,154		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Deferred Life Right Revenue</b>	1,392,055		43
44	<b>Due Life Right Residents</b>	2,217,327		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,831,013	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,553,551	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,087,151	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 15,640,702	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 7,452,177	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 7,452,177	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,634,973	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,634,973	17
<b>B. Transfers (Itemize):</b>			
18	Roudning	1	18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 1	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 9,087,151	24 *

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

Facility Name &amp; 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.

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,719,950	1
2	Discounts and Allowances for all Levels	(836,174)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,883,776	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,600,574	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,600,574	8
<b>C. Other Operating Revenue</b>			
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	39,913	13
14	Non-Patient Meals	4,823	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,370	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,918	19
20	Radiology and X-Ray	22,549	20
21	Other Medical Services	5,777	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 116,350	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	460,131	24
25	Interest and Other Investment Income***	121,472	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 581,603	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		1,144,324	28
28a		(9,049)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,135,275	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,317,578	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,435,435	31
32	Health Care	4,711,984	32
33	General Administration	2,228,424	33
<b>B. Capital Expense</b>			
34	Ownership	290,202	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	931,697	35
36	Provider Participation Fee	84,863	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,682,605	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,634,973	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,634,973	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,718	1,916	\$ 139,362	\$ 72.74	1
2	Assistant Director of Nursing	2,149	2,435	54,842	22.52	2
3	Registered Nurses	5,432	6,195	133,717	21.58	3
4	Licensed Practical Nurses	46,729	50,533	901,937	17.85	4
5	CNAs & Orderlies	115,799	122,635	1,419,045	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,012	10,063	118,280	11.75	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,324	13,670	218,147	15.96	11
12	Dietician					12
13	Food Service Supervisor	3,999	4,163	90,890	21.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,047	31,310	283,664	9.06	15
16	Dishwashers					16
17	Maintenance Workers	7,265	7,929	119,965	15.13	17
18	Housekeepers	20,484	21,764	220,320	10.12	18
19	Laundry	3,717	4,287	49,744	11.60	19
20	Administrator	1,849	1,986	143,766	72.39	20
21	Assistant Administrator	3,251	3,473	109,820	31.62	21
22	Other Administrative					22
23	Office Manager	1,860	1,980	31,745	16.03	23
24	Clerical	5,858	6,570	83,011	12.63	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					31
32	Other Health Care Director of Admiss	8,549	8,922	98,016	10.99	32
33	Other(specify) Marketing, Comm	10,961	11,844	295,822	24.98	33
34	TOTAL (lines 1 - 33)	290,003	311,675	\$ 4,512,093 *	\$ 14.48	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	64	\$ 2,982	3.1.3	35
36	Medical Director	48	3,750	3.9.3	36
37	Medical Records Consultant	48	2,860	3.10.3	37
38	Nurse Consultant	242	15,279	3.10.3	38
39	Pharmacist Consultant	192	4,408	3.10.3	39
40	Physical Therapy Consultant	6,674	374,643	3.10a.3	40
41	Occupational Therapy Consultant	6,993	406,378	3.10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,334	85,976	3.10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	222	11,415	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	15,817	\$ 907,691		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Doug Maris	Administrator	0	\$ 143,766	Workers' Compensation Insurance	\$ 167,523	IDPH License Fee	\$	
Deanna Wagner	Asst Administrator	0	109,820	Unemployment Compensation Insurance	20,023	Advertising: Employee Recruitment	24,607	
				FICA Taxes	327,536	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	302,800	Patient Background Checks		
				Employee Meals		License	9,966	
				Illinois Municipal Retirement Fund (IMRF)*		Dues	7,708	
				Employee Uniforms	(8,800)	Subscriptions	1,562	
				Employee Expense	18,107	Miscellaneous	265	
				Employee Physicals	19,505	Advertising & Promotion	24,858	
						Less: Public Relations Expense (	)	
						Non-allowable advertising	(24,858)	
						Yellow page advertising (	)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 253,586	Home Office Allocation	32,747	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 44,108	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$ 879,443	G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Expense			\$ 523,681				Out-of-State Travel	\$
							In-State Travel	9,704
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 523,681				Seminar Expense	6,372
C. Professional Services							Miscellaneous	1,150
Vendor/Payee	Type		Amount				Home Office Allocation	20,748
Davis & Campbell	Legal		\$ 2,025				Entertainment Expense (	)
Ostrand & Kelley	Legal		423				(agree to Sch. V, line 24, col. 8)	
Barbara Jackson	Bus Driver		80				TOTAL	\$ 37,974
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,528	TOTAL		\$		

\* 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. Life Svcs Network \$3,310
- (3) Did the nursing home make political contributions or payments to a political 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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,256 Line 3.10.2
- (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 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. \$ 84,863  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? 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: Eck, Schafer & Punke LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.