

Facility Name & ID Number Lewis Memorial Christian Village# 0021436 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

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 bedsN/A

	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	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</u>	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	<u>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	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	<u>19,078</u>	<u>15,474</u>	<u>18,012</u>	<u>52,564</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,078</u>	<u>15,474</u>	<u>18,012</u>	<u>52,564</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.91%

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 09/19/1977

J. 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 16,787Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	359,879	46,949	32,866	439,694		439,694	(44)	439,650		1
2	Food Purchase		346,235		346,235		346,235	(3,121)	343,114		2
3	Housekeeping	271,439	56,410	45	327,894		327,894		327,894		3
4	Laundry										4
5	Heat and Other Utilities			169,662	169,662		169,662	16,584	186,246		5
6	Maintenance	123,841	19,990	115,592	259,423		259,423	7,085	266,508		6
7	Other (specify):* Trash Removal			18,078	18,078		18,078		18,078		7
8	TOTAL General Services	755,159	469,584	336,243	1,560,986		1,560,986	20,504	1,581,490		8
	B. Health Care and Programs										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	2,952,682	779,895	73,430	3,806,007		3,806,007	(10)	3,805,997		10
10a	Therapy			1,191,162	1,191,162		1,191,162		1,191,162		10a
11	Activities	11,647			11,647		11,647		11,647		11
12	Social Services	227,401	8,844	7,224	243,469		243,469		243,469		12
13	CNA Training										13
14	Program Transportation			1,637	1,637		1,637	(80)	1,557		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,191,730	788,739	1,277,953	5,258,422		5,258,422	(90)	5,258,332		16
	C. General Administration										
17	Administrative	152,891	2,128	569,311	724,330		724,330	(395,571)	328,759		17
18	Directors Fees										18
19	Professional Services			45,132	45,132		45,132	57,515	102,647		19
20	Dues, Fees, Subscriptions & Promotions			86,629	86,629		86,629	(43,030)	43,599		20
21	Clerical & General Office Expenses	374,206	26,081	144,729	545,016		545,016	(50,729)	494,287		21
22	Employee Benefits & Payroll Taxes			943,343	943,343		943,343	40,128	983,471		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,473	15,473		15,473	25,989	41,462		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			76,462	76,462		76,462	1,651	78,113		26
27	Other (specify):*										27
28	TOTAL General Administration	527,097	28,209	1,881,079	2,436,385		2,436,385	(364,047)	2,072,338		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,473,986	1,286,532	3,495,275	9,255,793		9,255,793	(343,633)	8,912,160		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lewis Memorial Christian Village

#0021436

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June 30, 2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			230,901	230,901	230,901	34,187	265,088				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,927	127,927	127,927	(115,536)	12,391				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bond Costs			40,709	40,709	40,709	(1,035)	39,674				36
37	TOTAL Ownership			399,537	399,537	399,537	(82,384)	317,153				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			69,047	69,047	69,047		69,047				39
40	Barber and Beauty Shops	37,384	1,247		38,631	38,631		38,631				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863	84,863		84,863				42
43	Other (specify):* Apt./Congregate			903,980	903,980	903,980	(903,980)					43
44	TOTAL Special Cost Centers	37,384	1,247	1,057,890	1,096,521	1,096,521	(903,980)	192,541				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,511,370	1,287,779	4,952,702	10,751,851	10,751,851	(1,329,997)	9,421,854				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: July 1, 2006

Ending: June 30, 2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,121)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(848)	21		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	(114,952)	32		10
11	Discounts, Allowances, Rebates & Refunds	(70)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(27,593)	32		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	(60,637)	21		24
25	Fund Raising, Advertising and Promotional	(43,030)	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	(1,080,751)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,329,997)		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,329,997)		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	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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 2006

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Activity	\$ 527	21	1
2	Miscellaneous Income	(1,035)	36	2
3	Exempt Interest Income - Endowment	26,156	32	3
4	Gain on Sale of Investment	(605)	32	4
5	Late Fees	(44)	1	5
6	Late Fees	(117)	6	6
7	Late Fees	(10)	10	7
8	Late Fees	(566)	21	8
9	Apt/Congregate	(903,980)	43	9
10	Marketing Salaries	(189,553)	21	10
11	Marketing Supplies	(2,999)	21	11
12	Loss on Sale of Equipment	1,080	32	12
13	Fines and Penalties	(7,505)	21	13
14	Marketing Other	(2,020)	21	14
15	Transportation Revenue	(80)	14	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,080,751)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village

0021436

Report Period Beginning:

July 1, 2006

Ending:

June 30, 2007

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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	1
2	Food Purchase	(3,121)	0	0	0	0	0	0	0	0	0	0	(3,121)	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	16,584	0	0	0	0	0	0	0	0	0	16,584	5
6	Maintenance	(117)	7,202	0	0	0	0	0	0	0	0	0	7,085	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,282)	23,786	0	20,504	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	(80)	0	0	0	0	0	0	0	0	0	0	(80)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(90)	0	0	0	0	0	0	0	0	0	0	(90)	16
	C. General Administration													
17	Administrative	0	(395,571)	0	0	0	0	0	0	0	0	0	(395,571)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	57,515	0	0	0	0	0	0	0	0	0	57,515	19
20	Fees, Subscriptions & Promotions	(43,030)	0	0	0	0	0	0	0	0	0	0	(43,030)	20
21	Clerical & General Office Expenses	(263,671)	212,942	0	0	0	0	0	0	0	0	0	(50,729)	21
22	Employee Benefits & Payroll Taxes	0	40,128	0	0	0	0	0	0	0	0	0	40,128	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	25,989	0	0	0	0	0	0	0	0	0	25,989	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,651	0	0	0	0	0	0	0	0	0	1,651	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(306,701)	(57,346)	0	(364,047)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(310,073)	(33,560)	0	(343,633)	29								

STATE OF ILLINOIS

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Summary B
June 30, 2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,005	33,182	0	0	0	0	0	0	0	0	0	34,187	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115,914)	378	0	0	0	0	0	0	0	0	0	(115,536)	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):*	(1,035)	0	0	0	0	0	0	0	0	0	0	(1,035)	36
37	TOTAL Ownership	(115,944)	33,560	0	(82,384)	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	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):*	(903,980)	0	0	0	0	0	0	0	0	0	0	(903,980)	43
44	TOTAL Special Cost Centers	(903,980)	0	0	0	0	0	0	0	0	0	0	(903,980)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,329,997)	0	0	0	0	0	0	0	0	0	0	(1,329,997)	45

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 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 16,584	\$ 16,584
2	V	6 Maintenance				7,202	7,202
3	V	17 Administrative	516,441			120,870	(395,571)
4	V	19 Professional Services				57,515	57,515
5	V	21 Clerical				212,942	212,942
6	V	22 Employee Benefits				40,128	40,128
7	V	32 Interest				378	378
8	V	24 Travel & Seminars				25,989	25,989
9	V	26 Insurance				1,651	1,651
10	V	30 Depreciation				33,182	33,182
11	V						
12	V						
13	V						
14	Total		\$ 516,441			\$ 516,441	\$ *

* 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: July 1, 2006 Ending: June 30, 2007

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

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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 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									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIB Mortgage		X	Refinance Building & Equip.	Varies	4/1/2002	\$ 1,920,000	\$	4/1/2027	0.0779	\$ 110,101	1
2	2007-A Bonds	X		Refinance old debt		6/30/2007	1,999,548	1,999,548	6/30/2031	0.0560	17,226	2
3	Financing Fee										600	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,919,548	\$ 1,999,548			\$ 127,927	9
	B. Non-Facility Related*											
10	2001-Y GR Bonds	X		Refinance Debt	\$2,893.00	10/1/2001	475,000	457,267	10/1/2031	0.0600	27,593	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				\$2,893.00		\$ 475,000	\$ 457,267			\$ 27,593	14
15	TOTALS (line 9+line14)						\$ 4,394,548	\$ 2,456,815			\$ 155,520	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>82,881.00</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>
TOTALS		\$ <u>82,881.00</u>	\$ <u></u>

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? 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

July 1, 2006 Ending:

June 30, 2007

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 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

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	<u>Facility</u>	<u>55,000</u>	<u>Various</u>	<u>\$ 308,762</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>9,347</u>	<u>2</u>
3	TOTALS	55,000		\$ 318,109	3

Facility Name & ID Number Lewis Memorial Christian Village

0021436

Report Period Beginning:

July 1, 2006 Ending: June 30, 2007

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		
	Beds*	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	\$ 1,675,565	4
5				1978	100,542		40				5
6				1979	420,937		20				6
7											7
8	Home Office Allocation				80,605	9,992		9,992		126,304	8
	Improvement Type**										
9	Bldg Improvement			1979	306	6	38	6		168	9
10	Exhaust Fan			1983	417		15			417	10
11	Door Assembly			1985	1,244		20			1,244	11
12	Bldg Improvement			1986	573		20			573	12
13	Pass-thru WD			1986	664	18	20	18		664	13
14	Remodeling			1987	800	27	20	27		800	14
15	Rooftop Compressor			1988	3,408		10			3,408	15
16	A/C Unit			1989	4,406		8			4,406	16
17	Remodeling			1989	6,193	310	20	310		5,683	17
18	Tile, Cover Base			1989	6,600		5			6,600	18
19	Wall Paper			1989	826		5			826	19
20	Cabinets			1990	100		15			100	20
21	Roof Top A/C Unit			1991	4,158		10			4,158	21
22	Drapery Hardware			1991	1,124		5			1,124	22
23	Carpeting			1992	640		5			640	23
24	Curtain Track			1992	523		5			523	24
25	Curtain Track			1992	4,124		5			4,124	25
26	Receptacle			1992	575		10			575	26
27	Curtain Track			1992	565		5			565	27
28	Curtain Track			1992	1,229		5			1,229	28
29	Nurse Station Remodel			1993	30,556	1,528	20	1,528		21,025	29
30	Wallcoverings			1993	751		5			751	30
31	Wallcoverings			1994	3,747		5			3,747	31
32	A/C Compressors			1994	1,506		10			1,506	32
33	Exhaust Fans			1994	2,183	146	15	146		2,032	33
34	Roof Entire Building			1993	125,670	8,378	15	8,378		114,259	34
35	Downspout Repairs			1994	6,000	400	15	400		5,400	35
36	Ceiling Tile			1994	1,149		10			1,149	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lewis Memorial Christian Village

0021436

Report Period Beginning:

July 1, 2006 Ending: June 30, 2007

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	Wallpaper/Floor Covering	1994	\$ 20,655	\$	5	\$	\$	\$ 20,655	37
38	Lounge Remodel	1995	14,653		5			14,653	38
39	Volunteer Room Expansion	1995	8,435		10			8,435	39
40	Remodel Wing 100	1995	23,645		10			23,645	40
41	Remodel Shower Wing	1995	42,240		5			42,249	41
42	Wallcovering	1995	35,194		5			35,194	42
43	Stainless Steel Floor Cooler	1996	1,873		5			1,873	43
44	Wallcovering	1996	3,910		5			3,910	44
45	Wallcovering	1996	22,106		5			22,106	45
46	Gas Meter & Lines	1997	7,378		5			7,378	46
47	Maglocks & Keypad	1997	7,194	483	10	483		7,194	47
48	Nurse Call System	1997	9,727	649	10	649		9,727	48
49	Wallcovering	1997	28,134		5			28,134	49
50	Exhaust Fan	1997	12,370	1,237	10	1,237		12,267	50
51	Upgrade Energy Management System	1997	14,513	1,451	10	1,451		14,389	51
52	Upgrade Antennae System	1997	2,400		5			2,400	52
53	Wallcoverings - 400 Wing	1997	21,389		10			21,389	53
54	Wallcovering	1997	6,836		5			6,836	54
55	Fire Safety Gas Valve	1998	617		5			617	55
56	Locks	1998	782		5			782	56
57	Wiring for Network	1998	625		5			625	57
58	Outlets for Kronos	1998	664		5			664	58
59	Entrance Canopy	1998	3,667		5			3,667	59
60	Fire Alarm Control Panel	1998	28,154	2,815	10	2,815		24,162	60
61	Repl Fire Alarm Device	1999	4,800	480	10	480		4,040	61
62	Kitchen Hood	1999	6,910	691	10	691		5,758	62
63	Fire Alarm Devices	1999	4,600	460	10	460		4,064	63
64	Replace 8 Shower Valves	2000	10,084		5			10,084	64
65	Panduit Raceway	2000	13,130	1,313	10	1,313		10,176	65
66	Kitchen Ceiling	2000	5,923	592	10	592		4,341	66
67	Kitchen Walls	2000	2,099	210	10	210		1,488	67
68	CARPET #207	2000	1,344		5			1,344	68
69	WATER HEATERS	2001	37,299	3,730	10	3,730		23,623	69
70	TOTAL (lines 4 thru 69)		\$ 3,502,301	\$ 91,082		\$ 92,087	\$ 1,005	\$ 2,367,434	70

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

Facility Name & ID Number Lewis Memorial Christian Village

0021436

Report Period Beginning:

July 1, 2006 Ending: June 30, 2007

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		\$ 3,502,301	\$ 91,082		\$ 92,087	\$ 1,005	\$ 2,367,434	1
2	NATURAL GAS REGULATOR	2001	1,184	118	10	118		747	2
3	40 GALLON WATER HEATER	2001	506	51	10	51		310	3
4	Remodel Shower-Wing 200	1/21/2002	3,500	350	10	350		1,925	4
5	(2) Horton Single Swing Security Door	3/28/2002	4,094	273	15	273		1,456	5
6	Rooftop A/C-Heat Unit	1/15/2002	3,762	251	15	251		1,381	6
7	Carpet Installation-TV Lounge & 2 Dwys	5/30/2002	1,787	299	5	299		1,787	7
8	Heating/AC Unit	4/15/2002	1,348	90	15	90		473	8
9	Replacement of Heat/AC Unit Pump	4/30/2002	1,449	97	15	97		509	9
10	(3) Touch Security Lock Systems	9/6/2002	4,599	460	10	460		2,223	10
11	Install New Door Closers - 300 Wing	11/1/2002	13,990	933	15	933		4,354	11
12	Burglar Alarm Equipment	12/12/2002	2,896	290	10	290		1,329	12
13	Repair Fire Alarm System - 2 Detectors	6/5/2003	639	64	10	64		261	13
14	Shelving for Walk-In Cooler	6/30/2003	1,154	58	20	58		237	14
15	AC Compressor - Copeland	6/30/2003	1,295	108	12	108		441	15
16	Power Supplies for Fire Alarm Panel	7/31/2003	1,354	135	10	135		540	16
17	New Compressor - Walk In Freezer	10/29/2003	1,378	115	12	115		431	17
18	(12) Heat/AC Units for Various Areas	10/4/2003	13,343	1,334	10	1,334		5,003	18
19	5 Fan Cycling Control	11/24/2003	712	142	5	142		521	19
20	(14) Outside Globe Lights	12/26/2003	1,500	150	10	150		538	20
21	Therapy Room	6/30/2004	70,047	7,005	10	7,005		21,599	21
22	(22)GE Zoneline Units & Installation	11/2/2004	20,750	2,075	10	2,075		5,533	22
23	Security Light on Front of Bldg	12/28/2004	922	92	10	92		238	23
24	Floor Tile/Cove Base - Rm 102	4/8/2005	713	142	5	142		339	24
25	(2)Rooftops A/C Units	6/17/2005	20,827	2,083	10	2,083		4,340	25
26	(20)GE Zoneline Units	6/23/2005	16,678	2,085	8	2,085		4,344	26
27	Network Cabling Project	7/1/2004	20,397	2,040	10	2,040		6,120	27
28	Land Improvements	6/30/1978	85,870		20			85,870	28
29	Parking Lot & Drives	6/30/1979	23,654		20			23,654	29
30	Landscapings	10/31/1979	5,572		20			5,572	30
31	Concrete (Garage)	7/31/1980	521		20			521	31
32	Landscaping	9/30/1984	6,077		20			6,077	32
33	Landscaping	10/21/1985	1,852		20			1,852	33
34	TOTAL (lines 1 thru 33)		\$ 3,836,671	\$ 111,922		\$ 112,927	\$ 1,005	\$ 2,557,959	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:

July 1, 2006 Ending: June 30, 2007

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		\$ 3,836,671	\$ 111,922		\$ 112,927	\$ 1,005	\$ 2,557,959	1
2	Road & Drainage	12/18/1986	3,236	64	20	64		3,236	2
3	Green View Landscaping	8/29/1986	2,700	11	20	11		2,700	3
4	Trimming - Stump Removal	9/30/1986	2,500	21	20	21		2,500	4
5	Land Improvement - Pro Scv	11/30/1986	250		10			250	5
6	Gravel Access Road	4/29/1987	250		10			250	6
7	Fire Hydrant	8/1/1987	2,600	130	20	130		2,589	7
8	Parking Lot Resurface	6/30/1991	34,141		20			34,141	8
9	Land Improvements	6/28/1993	1,564		8			1,564	9
10	Parking Lot Resurface	6/30/1997	5,713		10			5,713	10
11	Courtyard Landscaping	6/10/1998	5,134		3			5,134	11
12	36x24x8 Concrete Pad for Dumpster	5/28/2002	5,134	343	5	343		1,768	12
13	Asphalt Patching & Crack Sealing	7/11/2002	4,104	513	8	513		2,565	13
14	Repave Asphalt	6/5/2003	5,033	629	8	629		2,568	14
15	1000W Parking Lot Light	12/9/2003	700	70	8	70		251	15
16	Underground Electric Conduit	7/1/2004	4,150	415	10	415		1,245	16
17	10x8 Enclosed Shelter	11/29/1995	3,700		10			3,700	17
18	Garage	1/1/1999	44,246	1,106	40	1,106		9,401	18
19	12' Screened Gazbo	9/24/2004	1,958	196	10	196		555	19
20	New Nurse Call System for Nurs	9/24/2004	38,650	3,865	10	3,865		4,509	20
21	Install New Computers and Condense	9/24/2004	3,218	1,073	3	1,073		1,252	21
22	Installation of 2 digital Thermostat	8/12/2005	851	170	5	170		326	22
23	Nurse Call System 300 Wing	10/14/2005	26,138	2,614	10	2,614		4,574	23
24	Reclaim Rehab Unit Remodeling	8/1/2006	151,619	13,898	10	13,898		13,898	24
25	Install New Drain Trough	12/13/2005	1,893	189	10	189		300	25
26	Concrete Sidewalks W/Handicaps	7/27/2005	4,205	421	10	421		841	26
27	Renovating/Expanding SNF and Int.	8/1/2006	37,781	1,732	20	1,732		1,732	27
28	Rehab/Reclaim Unit	8/1/2006	45,858	2,102	20	2,102		2,102	28
29	Canopy Addition and Exterior Renovating	8/1/2006	22,899	1,048	20	1,048		1,048	29
30	LMCV Renovations	8/1/2006	262,054	12,011	20	12,011		12,011	30
31	Exterior Improvements/Canopy addition	10/31/2006	2,096	79	20	79		79	31
32	Vending Electrical Work in breakroom	12/27/2006	790	46	10	46		46	32
33	Carpet in Employee Breakroom	1/23/2007	1,935	194	5	194		194	33
34	TOTAL (lines 1 thru 33)		\$ 4,563,771	\$ 154,862		\$ 155,867	\$ 1,005	\$ 2,681,001	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:

July 1, 2006 Ending: June 30, 2007

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 12C, Carried Forward		\$ 4,563,771	\$ 154,862		\$ 155,867	\$ 1,005	\$ 2,681,001	1
2	Painting Fascia	1/2/2007	800	80	5	80		80	2
3	Carbon Monoxide Alarms	1/4/2007	1,285	321	2	321		321	3
4	Exterior Improvements - sidewalks, roof, soffit, shingles	3/31/2007	213,341	3,555	20	3,555		3,555	4
5	Painting Phase I hallway and dayroom	4/1/2007	60,540	3,027	5	3,027		3,027	5
6	8 chairs for breakroom	4/1/2007	892	15	15	15		15	6
7	Lighting for Unit 400	5/1/2007	3,840	64	10	64		64	7
8	Geotechnical Services 3/16 - 5/15	5/1/2007	12,843	214	10	214		214	8
9	Dining Hall Cabinets	6/1/2007	796	7	10	7		7	9
10	Carpet - Unit 400, corridor, dayroom	6/18/2007	22,730	189	10	189		189	10
11	Remove old and pour new	11/28/2006	8,717	387	15	387		387	11
12	Pavement and Landscape design coordination	12/31/2006	773	45	10	45		45	12
13	Pavement & Landscape design	5/1/2007	2,792	44	10	44		44	13
14	Geotechnical Services 6/1 - 6/15	6/20/2007	9,737	81	10	81		81	14
15	Geotechnical Services 5/15 - 5/31	6/7/2007	8,138	68	10	68		68	15
16	Replace 2 exterior light poles	5/22/2007	1,300	22	10	22		22	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,912,295	\$ 162,981		\$ 163,986	\$ 1,005	\$ 2,689,120	34

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

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	\$ 611,207	\$ 72,894	\$ 72,894	\$	Various	\$ 208,242	71
72	Current Year Purchases	58,533	4,013	4,013		Various	4,013	72
73	Fully Depreciated Assets	608,688				Various	608,688	73
74	Home Office Allocation	170,095	21,084	21,084			37,476	74
75	TOTALS	\$ 1,448,523	\$ 97,991	\$ 97,991	\$		\$ 858,419	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	1993	13,290				3	13,290	77
78										78
79	Home Office Allocation			16,998	2,107	2,107			5,875	79
80	TOTALS			\$ 68,647	\$ 2,107	\$ 2,107	\$		\$ 57,524	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)	\$ 6,747,574	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,079	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,084	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)	\$ 3,605,063	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	\$ 483,470	\$ 14,217	\$ 349,562	86
87	Congregate Bldg, Land Impr & Equip	3,493,096	82,935	1,418,714	87
88	Wellness Center Bldg. & Equip	666,818	17,256	120,215	88
89	Duplex Bldg, Land Impr & Equip	4,014,550	98,738	1,755,113	89
90					90
91	TOTALS	\$ 8,657,934	\$ 213,146	\$ 3,643,604	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 23,215	92
93			93
94			94
95		\$ 23,215	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?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? Not eligible for training</p> <p><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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	This workpaper is not applicable	hrs							4
5	Physician Care		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 & ID Number Lewis Memorial Christian Village# 0021436Report Period Beginning: July 1, 2006

Ending:

June 30, 2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of June 30, 2007 (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	\$ 6,534,880	\$	1
2	Cash-Patient Deposits	21,699		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (185,911))	1,812,503		3
4	Supply Inventory (priced at)	30,516		4
5	Short-Term Investments	240,050		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,509		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	4,309		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,647,466	\$	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	12,406,860		14
15	Leasehold Improvements, at Historical Cost	737,415		15
16	Equipment, at Historical Cost	1,614,458		16
17	Accumulated Depreciation (book methods)	(7,079,012)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	877,499		21
22	Other Long-Term Assets (spe <u>Deferred Financing</u>	74,211		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,940,193	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,587,659	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 533,885	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,699		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,927		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,441		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Liabilities</u>	20,974		36
37	<u>FIN 47 Liability</u>	58,980		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 911,906	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,454,994		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Life Right Revenue</u>	1,500,440		43
44	<u>Due Life Right Residents</u>	2,154,755		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,110,189	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,022,095	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,565,564	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,587,659	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,087,151	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Insurance Accrual	51,001	3
4	Prior Period Adjustment - FIN 47	(58,980)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,079,172	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,486,393	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,486,393	17
B. Transfers (Itemize):			
18	Rounding	(1)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,565,564	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lewis Memorial Christian Village# 0021436Report Period Beginning: July 1, 2006Ending: June 30, 2007**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,547,352	1
2	Discounts and Allowances for all Levels	(808,104)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,739,248	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,993,338	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,993,338	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	45,175	13
14	Non-Patient Meals	3,121	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	848	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,165	19
20	Radiology and X-Ray	17,796	20
21	Other Medical Services	45,739	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 162,844	23
D. Non-Operating Revenue			
24	Contributions	83,330	24
25	Interest and Other Investment Income***	168,701	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 252,031	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apartment/Duplex</u>	1,057,937	28
28a	<u>Gain/Loss on Investments and Equipment</u>	32,846	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,090,783	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,238,244	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,560,986	31
32	Health Care	5,258,422	32
33	General Administration	2,436,385	33
B. Capital Expense			
34	Ownership	399,537	34
C. Ancillary Expense			
35	Special Cost Centers	1,011,658	35
36	Provider Participation Fee	84,863	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,751,851	40
41	Income before Income Taxes (line 30 minus line 40)**	1,486,393	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,486,393	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: July 1, 2006

Ending:

June 30, 2007

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	1,253	1,473	\$ 65,680	\$ 44.59	1
2	Assistant Director of Nursing	1,246	1,454	34,570	23.78	2
3	Registered Nurses	3,081	3,727	85,906	23.05	3
4	Licensed Practical Nurses	49,220	53,718	1,005,927	18.73	4
5	CNAs & Orderlies	116,375	125,126	1,510,141	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,297	5,895	67,836	11.51	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,842	13,931	226,975	16.29	11
12	Dietician					12
13	Food Service Supervisor	3,369	3,829	60,038	15.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,972	32,136	299,840	9.33	15
16	Dishwashers					16
17	Maintenance Workers	6,850	7,961	123,841	15.56	17
18	Housekeepers	23,681	25,851	271,439	10.50	18
19	Laundry					19
20	Administrator	25,991	3,210	152,891	47.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,117	2,303	46,730	20.29	23
24	Clerical	8,336	8,779	101,383	11.55	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(specify)	10,801	11,907	156,165	13.12	32
33	Other(specify)	10,902	11,871	302,008	25.44	33
34	TOTAL (lines 1 - 33)	311,333	313,171	\$ 4,511,370 *	\$ 14.41	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	633	\$ 30,272	3.1.3	35
36	Medical Director	48	4,500	3.9.3	36
37	Medical Records Consultant	48	2,940	3.10.3	37
38	Nurse Consultant	24	1,334	3.10.3	38
39	Pharmacist Consultant	192	4,493	3.10.3	39
40	Physical Therapy Consultant	8,997	550,623	3.10a.3	40
41	Occupational Therapy Consultant	8,236	516,207	3.10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,787	124,332	3.10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	113	5,822	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	20,078	\$ 1,240,523		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	628	\$ 55,231	3.10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	628	\$ 55,231		53

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 Services Network - 6,813.88
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,999 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 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 benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,121
- (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: LarsonAllen 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? NO If no, please explain. It will be sent when the audit is complete
- (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 \$5,000, 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.