

		FOR BHF USE					

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**2010**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2010)**

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 License 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>62711</u>          Number City Zip Code</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> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/19/1977</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Susan McGhee</u> <b>Telephone Number:</b> <u>314-587-7903</u>  <b>Email Address:</b> _____</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 <u>July 1, 2009</u> to <u>June 30, 2010</u> 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 border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Tim Phillippe</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>LarsonAllen LLP</u> <u>600 Washington, Suite 1800 St. Louis, MO 63101</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>314-925-4379</u> <b>Fax #</b> <u>314-925-4350</u></td> <td></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></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>Allan B. Larson, CPA</u> <u>Principal</u>		(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington, Suite 1800 St. Louis, MO 63101</u>		(Telephone) <u>314-925-4379</u> <b>Fax #</b> <u>314-925-4350</u>	
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Facility Name & ID Number Lewis Memorial Christian Village

# 0021436 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	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	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	18,407	14,864	18,868	52,139	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,407	14,864	18,868	52,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.16%

D. How many bed-hold days during this year were paid by the Department?

0 (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 Service

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  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 9/19/1977

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 16,428

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 6/30/10 Fiscal Year: 6/30/10

\* 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, 2009 Ending: June 30, 2010

**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
	<b>A. General Services</b>										
1	Dietary	392,037	46,992	24,945	463,974		463,974		463,974		1
2	Food Purchase		370,937		370,937		370,937	(4,366)	366,571		2
3	Housekeeping	179,662	48,045		227,707		227,707		227,707		3
4	Laundry	107,867	11,992		119,859		119,859	11,358	131,217		4
5	Heat and Other Utilities			233,607	233,607		233,607	1,373	234,980		5
6	Maintenance	133,948	13,573	91,448	238,969		238,969	6,205	245,174		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	813,514	491,539	350,000	1,655,053		1,655,053	14,570	1,669,623		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	3,654,360	787,803	24,945	4,467,108	(544,728)	3,922,380	(769)	3,921,611		10
10a	Therapy			1,423,689	1,423,689		1,423,689		1,423,689		10a
11	Activities	112,022	524		112,546		112,546		112,546		11
12	Social Services	205,046	11,012	13,364	229,422		229,422		229,422		12
13	CNA Training										13
14	Program Transportation			32,331	32,331		32,331	(60)	32,271		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,971,428	799,339	1,498,829	6,269,596	(544,728)	5,724,868	(829)	5,724,039		16
	<b>C. General Administration</b>										
17	Administrative	249,597	1,782	741,398	992,777		992,777	(637,396)	355,381		17
18	Directors Fees										18
19	Professional Services			(5,206)	(5,206)		(5,206)	48,447	43,241		19
20	Dues, Fees, Subscriptions & Promotions			23,259	23,259		23,259		23,259		20
21	Clerical & General Office Expenses	182,798	24,263	115,240	322,301		322,301	256,945	579,246		21
22	Employee Benefits & Payroll Taxes			1,051,070	1,051,070		1,051,070	46,699	1,097,769		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,761	10,761		10,761	22,792	33,553		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,479	108,479		108,479	1,842	110,321		26
27	Other (specify):* <b>Marketing</b>	85,078	4,146	30,082	119,306		119,306	(119,306)			27
28	<b>TOTAL General Administration</b>	517,473	30,191	2,075,083	2,622,747		2,622,747	(379,977)	2,242,770		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,302,415	1,321,069	3,923,912	10,547,396	(544,728)	10,002,668	(366,236)	9,636,432		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:

July 1, 2009

Ending:

June 30, 2010

## 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	
	<b>D. Ownership</b>											
30	Depreciation			424,877	424,877		424,877	30,573	455,450			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			282,380	282,380		282,380	(205,663)	76,717			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			90,594	90,594		90,594		90,594			35
36	Other (specify):*			2,973	2,973		2,973		2,973			36
37	<b>TOTAL Ownership</b>			800,824	800,824		800,824	(175,090)	625,734			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			220,882	220,882	544,728	765,610		765,610			39
40	Barber and Beauty Shops	40,911	1,574		42,485		42,485		42,485			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			597,031	597,031		597,031	(597,031)				43
44	<b>TOTAL Special Cost Centers</b>	40,911	1,574	902,776	945,261	544,728	1,489,989	(597,031)	892,958			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,343,326	1,322,643	5,627,512	12,293,481		12,293,481	(1,138,357)	11,155,124			45

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

**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	(4,366)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,452)	5		5
6	Rented Facility Space	(50)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(205,663)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,520)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,609)	21		24
25	Fund Raising, Advertising and Promotional	(119,306)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(599,669)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (951,635)		\$	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)	(186,722)	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (186,722)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,138,357)		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	X		544,728	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 544,728	47

**BHF USE ONLY**

48		49		50		51		52
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Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Garage Rental - Nursing	\$ (769)	10	1
2	Late Fee	(2)	6	2
3	Late Fee	(250)	21	3
4	Apartment/Congregate	(597,031)	43	4
5	Transportation	(60)	14	5
6	Vending Revenue	(1,557)	21	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
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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>	(599,669)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village# 0021436

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,366)	0	0	0	0	0	0	0	0	0	0	(4,366)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	11,358	0	0	0	0	0	0	0	0	0	11,358	4
5	Heat and Other Utilities	(10,452)	11,825	0	0	0	0	0	0	0	0	0	1,373	5
6	Maintenance	(2)	6,207	0	0	0	0	0	0	0	0	0	6,205	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,820)</b>	<b>29,390</b>	<b>0</b>	<b>14,570</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	(769)	0	0	0	0	0	0	0	0	0	0	(769)	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	(60)	0	0	0	0	0	0	0	0	0	0	(60)	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>(829)</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>(829)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(637,396)	0	0	0	0	0	0	0	0	0	(637,396)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	48,447	0	0	0	0	0	0	0	0	0	48,447	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(13,986)	270,931	0	0	0	0	0	0	0	0	0	256,945	21
22	Employee Benefits & Payroll Taxes	0	46,699	0	0	0	0	0	0	0	0	0	46,699	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	22,792	0	0	0	0	0	0	0	0	0	22,792	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	1,842	0	0	0	0	0	0	0	0	0	1,842	26
27	Other (specify):*	(119,306)	0	0	0	0	0	0	0	0	0	0	(119,306)	27
28	<b>TOTAL General Administration</b>	<b>(133,292)</b>	<b>(246,685)</b>	<b>0</b>	<b>(379,977)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(148,941)</b>	<b>(217,295)</b>	<b>0</b>	<b>(366,236)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Lewis Memorial Christian Village# 0021436

Report Period Beginning:

July 1, 2009 Ending:

Summary B

June 30, 2010

## 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	0	30,573	0	0	0	0	0	0	0	0	0	30,573	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(205,663)	0	0	0	0	0	0	0	0	0	0	(205,663)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(205,663)</b>	<b>30,573</b>	<b>0</b>	<b>(175,090)</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):*	(597,031)	0	0	0	0	0	0	0	0	0	0	(597,031)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(597,031)</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>(597,031)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(951,635)</b>	<b>(186,722)</b>	<b>0</b>	<b>(1,138,357)</b>	<b>45</b>								

**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	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc	100.00%	\$ 11,825	\$ 11,825	1
2	V	6 Maintenance				6,207	6,207	2
3	V	17 Administrative	741,398			104,002	(637,396)	3
4	V	19 Professional Services				48,447	48,447	4
5	V	21 Clerical				270,931	270,931	5
6	V	22 Employee Benefits				46,699	46,699	6
7	V	24 Travel & Seminars				22,792	22,792	7
8	V	26 Insurance				1,842	1,842	8
9	V	30 Depreciation				30,573	30,573	9
10	V	4 Interest				11,358	11,358	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 741,398			\$ 554,676	\$ * (186,722)	14

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

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	<b>This workpaper is not applicable.</b>								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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:

July 1, 2009

Ending: ne 30, 2010

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	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	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, 2009 Ending:

June 30, 2010

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		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Illinois Finance Authority		X	Refinance Debt		6/30/07	\$ 4,820,517	\$ 4,820,517	5/15/2031	0.0567	\$ 258,465	1					
2	GO Bonds	X		Refinance Debt	\$1,879.00	Various*	Various*	404,665	6/30/2032	Various*	23,915	2					
3	*this is an allocation of the total GO bond debt which includes several different series with several different rates of interest																
4												4					
5												5					
	<b>Working Capital</b>																
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$1,879.00		\$ 4,820,517	\$ 5,225,182			\$ 282,380	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 4,820,517	\$ 5,225,182			\$ 282,380	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2009 report.			\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2010 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.			\$		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2005	_____	8	<b>FOR BHF USE ONLY</b>		
	2006	_____	9			
	2007	_____	10			
	2008	_____	11			
	2009	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



Facility Name & ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2009 Ending:

June 30, 2010

**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>8,464</u>	<u>2</u>
3	<b>TOTALS</b>	<b>55,000</b>		\$ <b>317,226</b>	<b>3</b>

**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	\$ 59,751	40	\$ 59,751	\$	\$ 1,852,289	4
5			1978	100,542		40				5
6			1979	420,937		20				6
7										7
8	Home Office Allocation			87,303	6,486		6,486		174,042	8
	<b>Improvement Type**</b>									
9	Improvements		1978	85,870					85,870	9
10	Improvements		1979	29,532	6	various	6		29,414	10
11	Improvements		1980	521					521	11
12	Improvements		1983	417					417	12
13	Improvements		1984	6,077					6,077	13
14	Improvements		1985	3,096					3,096	14
15	Improvements		1986	9,923					9,923	15
16	Improvements		1987	3,650					3,650	16
17	Improvements		1988	3,408					3,408	17
18	Improvements		1989	20,982	148	various	148		20,982	18
19	Improvements		1990	100					100	19
20	Improvements		1991	39,423					39,423	20
21	Improvements		1992	7,656					7,656	21
22	Improvements		1993	158,541	1,528	various	1,528		154,594	22
23	Improvements		1994	35,240					35,240	23
24	Improvements		1995	92,673					92,673	24
25	Improvements		1996	5,783					5,783	25
26	Improvements		1997	105,927					105,927	26
27	Improvements		1998	35,976					35,976	27
28	Improvements		1999	60,556	1,107	various	1,107		29,031	28
29	Improvements		2000	32,580	917	various	917		32,580	29
30	Improvements		2001	1,690	170	various	170		1,557	30
31	Improvements		2002	39,423	3,104	various	3,104		26,854	31
32	Improvements		2003	27,108	2,695	various	2,695		18,973	32
33	Improvements		2004	94,601	9,461	various	9,461		55,997	33
34	Improvements		2005	77,530	8,180	various	8,180		39,247	34
35	Improvements		2006	479,564	23,977	various	23,977		93,896	35
36	Carpet in employee breakroom		2007	1,935	387	5	387		1,355	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:

July 1, 2009 Ending: June 30, 2010

## 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	Exterior Improvements - sidewalks, roof, soffit, shingles	2007	\$ 213,341	\$ 10,668	20	\$ 10,668	\$	\$ 35,557	37
38	Painting Phase I hallway and dayroom	2007	60,540	12,108	5	12,108		39,351	38
39	Lighting for Unit 400	2007	3,840	384	10	384		1,216	39
40	Carpet - Unit 400, corridor, dayroom	2007	22,730	2,273	10	2,273		7,008	40
41	Pavement & Landscape design	2007	2,792	288	10	288		884	41
42	Install cabling and Nurse Call System	2007	57,045	5,700	10	5,700		17,100	42
43	7 closet doors	2007	7,711	771	10	771		2,056	43
44	Labor & Materials Roof Work	2007	4,059	406	10	406		1,049	44
45	3 Exit Pole Lights	2007	3,650	365	10	365		973	45
46	Generator & Rooftop unit	2008	61,600	6,160	10	6,160		14,887	46
47	4 100 Gallon Water Heaters	2008	48,000	4,800	10	4,800		10,400	47
48	Install 4 door closers and manual pull	2008	2,931	293	10	293		537	48
49	Install weatherproof exit lights	2008	5,600	560	10	560		1,027	49
50	Window valances - 34 rooms	2008	3,821	764	5	764		1,210	50
51	Rooftop unit #4	2009	18,240	1,824	10	1,824		1,976	51
52	Sidewalks - remove old and pour new	2009	4,609	461	10	461		115	52
53	Sliding Shower Door	2009	895	90	10	90		90	53
54	Replacement Windows	2009	897	90	10	90		90	54
55	Replaced Door Closers in 300 Wing	2009	1,503	150	10	150		150	55
56	Dining Room Ceiling	2010	30,100	1,003	10	1,003		1,003	56
57	Back Service Doors	2010	4,182	105	10	105		105	57
58	SNF Refurb Project	2010	414,080	20,704	10	20,704		20,704	58
59	SNF Shower Refurb	2010	76,536	4,465	10	4,465		4,465	59
60	Replace Laundry Roof Top A/C Unit	2010	37,820	946	10	946		946	60
61	Gutter Installation on Front Canopy	2010	1,960	49	10	49		49	61
62	Landscaping	2010	400,013	6,667	10	6,667		6,667	62
63	FY10 Mine Subsidence	2010	305,566	2,546	10	2,546		2,546	63
64	Architectural drawings	2010	4,470	112	10	112		112	64
65	Water main extension	2010	13,635	340	10	340		340	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,167,560	\$ 203,009		\$ 203,009	\$	\$ 3,139,164	70

\*\*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	\$ 534,348	\$ 60,674	\$ 60,674	\$	Various	\$ 285,620	71
72	Current Year Purchases	100,334	13,554	13,554		Various	13,554	72
73	Fully Depreciated Assets	718,658	9,346	9,346		Various	718,658	73
74	Home Office Allocation	279,886	20,793	20,793			42,587	74
75	TOTALS	\$ 1,633,226	\$ 104,367	\$ 104,367	\$		\$ 1,060,419	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	See attachment			\$ 97,023	\$ 17,362	\$ 17,362	\$		\$ 52,528	76
77										77
78										78
79	Home Office Allocation			44,347	3,295	3,295			15,660	79
80	TOTALS			\$ 141,370	\$ 20,657	\$ 20,657	\$		\$ 68,188	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)	\$ 8,259,382	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 328,033	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 328,033	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,267,771	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Shared Home	\$ 723,713	\$ 17,293	\$ 17,293	86
87	Wellness Center Bldg & Equip	1,001,990	28,843	183,825	87
88	Duplex Bldg & Equip	4,519,664	102,611	2,389,521	88
89					89
90					90
91	TOTALS	\$ 6,245,367	\$ 148,747	\$ 2,590,639	91

G. Construction-in-Progress

	Description	Cost	
92	Resident Room and Therapy A	\$ 91,826	92
93	Bistro and Life Trail	17,930	93
94	Home Office Allocation	64,002	94
95		\$ 173,758	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: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

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

**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: \$ 90,594 Description: See attached schedule

(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

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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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? <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><u>Administrator only hires certified students</u></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	8,877	\$ 583,768	\$	8,877	\$ 583,768	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,583	174,753		2,583	174,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		10,795	665,168		10,795	665,168	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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	22,255	\$ 1,423,689	\$	22,255	\$ 1,423,689	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, 2009Ending: June 30, 2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2010 (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	\$ 6,229,081	\$	1
2	Cash-Patient Deposits	26,838		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>86,483</u> )	1,427,791		3
4	Supply Inventory (priced at )	15,853		4
5	Short-Term Investments	6,492,832		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,821		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest/Pledges Receivable</u>	66,937		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 14,272,153	\$	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	10,790,784		14
15	Leasehold Improvements, at Historical Cost	3,696,639		15
16	Equipment, at Historical Cost	1,620,152		16
17	Accumulated Depreciation (book methods)	(6,915,247)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	845,211		21
22	Other Long-Term Assets (spe CIP)	109,756		22
23	Other(specify): <u>Deferred Financing Fees</u>	65,395		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,521,452	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 24,793,605	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 318,931	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,838		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	367,928		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,404		32
33	Accrued Interest Payable	43,385		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Liabilities</u>	82,759		36
37	<u>FIN 47 Liability</u>	71,688		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 950,933	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,225,182		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Life Right Revenue</u>	633,808		43
44	<u>Due to Life Right Residents</u>	851,530		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,710,520	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,661,453	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 17,132,152	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 24,793,605	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>14,906,549</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>14,906,549</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,225,603</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>2,225,603</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>17,132,152</b>	<b>24</b> *

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

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

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	\$ 10,714,407	1
2	Discounts and Allowances for all Levels	(3,087,786)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,626,621	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,810,895	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,810,895	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	44,296	13
14	Non-Patient Meals	4,366	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,717	19
20	Radiology and X-Ray	35,683	20
21	Other Medical Services	214,786	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 363,898	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	183,304	24
25	Interest and Other Investment Income***	219,026	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 402,330	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	908,282	27
28	Apartment/Duplex	556,774	28
28a	Gain/Loss on Investments & Equipment	(149,716)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,315,340	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,519,084	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,655,053	31
32	Health Care	6,269,596	32
33	General Administration	2,622,747	33
<b>B. Capital Expense</b>			
34	Ownership	800,824	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	860,398	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>	\$ 12,293,481	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,225,603	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,225,603	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, 2009

Ending:

June 30, 2010

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	4,291	4,291	\$ 202,688	\$ 47.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,075	17,614	366,110	20.79	3
4	Licensed Practical Nurses	44,730	47,089	849,646	18.04	4
5	CNAs & Orderlies	131,378	134,882	1,796,233	13.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,528	5,528	63,145	11.42	8
9	Activity Director	1,883	1,883	36,072	19.16	9
10	Activity Assistants	5,982	5,982	59,221	9.90	10
11	Social Service Workers	7,559	8,691	152,660	17.57	11
12	Dietician					12
13	Food Service Supervisor	4,070	4,070	62,867	15.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,214	33,975	329,170	9.69	15
16	Dishwashers					16
17	Maintenance Workers	8,109	8,542	133,949	15.68	17
18	Housekeepers	15,966	17,102	179,662	10.51	18
19	Laundry	8,828	9,349	107,867	11.54	19
20	Administrator	4,659	4,659	249,597	53.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,805	1,805	55,582	30.79	23
24	Clerical	9,502	10,767	127,216	11.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,839	1,839	40,666	22.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,859	5,859	75,712	12.92	31
32	Other Health Care supervisor, MDS c	14,678	14,678	300,824	20.49	32
33	Other(specify) marketing, beauty	6,188	6,321	154,439	24.43	33
34	TOTAL (lines 1 - 33)	331,143	344,926	\$ 5,343,326 *	\$ 15.49	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	474	\$ 23,084	3.1.3	35
36	Medical Director	40	4,500	3.9.3	36
37	Medical Records Consultant	60	4,540	3.10.3	37
38	Nurse Consultant	95	4,963	3.10.3	38
39	Pharmacist Consultant	120	5,478	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	92	5,101	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	881	\$ 47,666		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 &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning: July 1, 2009 Ending: June 30, 201

**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 - \$10,429
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,666 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (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. \$ 4,366
- (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. \$ \_\_\_\_\_  
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
- (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.