



Facility Name & ID Number Lewis Memorial Christian Village

# 0021436 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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 05/07/2012

	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	56,730	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	56,730	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	21,346	13,277	17,105	51,728	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,346	13,277	17,105	51,728	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.18%

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 15,439

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

Facility Name &amp; ID Number

Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2011

Ending:

June 30, 2012

**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	374,093	40,079	62,280	476,452		476,452		476,452		1
2	Food Purchase		364,951		364,951		364,951	(12,159)	352,792		2
3	Housekeeping	220,760	52,208		272,968		272,968		272,968		3
4	Laundry	87,768	13,518		101,286		101,286	21,021	122,307		4
5	Heat and Other Utilities			252,241	252,241		252,241	(10,709)	241,532		5
6	Maintenance	111,924	11,015	105,457	228,396		228,396	5,723	234,119		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	794,545	481,771	419,978	1,696,294		1,696,294	3,876	1,700,170		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,044	15,044		15,044		15,044		9
10	Nursing and Medical Records	3,721,004	292,877	28,930	4,042,811		4,042,811	(3,767)	4,039,044		10
10a	Therapy			1,600,863	1,600,863		1,600,863		1,600,863		10a
11	Activities	108,768	2,420	4,101	115,289		115,289		115,289		11
12	Social Services	202,527	7,587	8,601	218,715		218,715		218,715		12
13	CNA Training										13
14	Program Transportation			89,963	89,963		89,963		89,963		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,032,299	302,884	1,747,502	6,082,685		6,082,685	(3,767)	6,078,918		16
	<b>C. General Administration</b>										
17	Administrative	53,412	603	830,839	884,854		884,854	(704,966)	179,888		17
18	Directors Fees										18
19	Professional Services			28,862	28,862		28,862	66,383	95,245		19
20	Dues, Fees, Subscriptions & Promotions			24,245	24,245		24,245		24,245		20
21	Clerical & General Office Expenses	195,612	34,672	238,317	468,601		468,601	232,968	701,569		21
22	Employee Benefits & Payroll Taxes			1,152,212	1,152,212		1,152,212	62,703	1,214,915		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,052	10,052		10,052	22,967	33,019		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			102,963	102,963		102,963	(13,578)	89,385		26
27	Other (specify):* <b>Marketing</b>	82,816	1,743	33,676	118,235		118,235	(118,235)			27
28	<b>TOTAL General Administration</b>	331,840	37,018	2,421,166	2,790,024		2,790,024	(451,758)	2,338,266		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,158,684	821,673	4,588,646	10,569,003		10,569,003	(451,649)	10,117,354		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.

## 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			601,795	601,795	601,795	45,922	647,717				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			359,865	359,865	359,865	(359,865)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			107,886	107,886	107,886		107,886				35
36	Other (specify):* <b>Deferred Financing Costs</b>			2,973	2,973	2,973		2,973				36
37	<b>TOTAL Ownership</b>			1,072,519	1,072,519	1,072,519	(313,943)	758,576				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			766,148	766,148	766,148	(42,602)	723,546				39
40	Barber and Beauty Shops	43,223	1,295	364,881	409,399	409,399		409,399				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* <b>Apt/Congregate</b>	442,321		809,699	1,252,020	1,252,020	(1,252,020)					43
44	<b>TOTAL Special Cost Centers</b>	485,544	1,295	1,940,728	2,427,567	2,427,567	(1,294,622)	1,132,945				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,644,228	822,968	7,601,893	14,069,089	14,069,089	(2,060,214)	12,008,875				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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,159)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,969)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(218,305)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,233)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(141,560)	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	(5,240)	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	(53,878)	21		24
25	Fund Raising, Advertising and Promotional	(118,235)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,254,261)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,819,840)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(240,374)	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (240,374)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (2,060,214)</b>		<b>37</b>

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

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

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

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 2011

Ending: June 30, 2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Garage Rental - Nursing	\$ (384)	10	1
2	Late Fee	(261)	21	2
3	Apartment/Congregate	(1,252,020)	43	3
4	Vending Revenue	(1,446)	21	4
5	Late Fee	(150)	10	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
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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	<b>Total</b>	(1,254,261)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village# 0021436

Report Period Beginning:

July 1, 2011

Ending:

June 30, 2012

## 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	(12,159)	0	0	0	0	0	0	0	0	0	0	(12,159)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	21,021	0	0	0	0	0	0	0	0	0	21,021	4
5	Heat and Other Utilities	(12,969)	2,260	0	0	0	0	0	0	0	0	0	(10,709)	5
6	Maintenance	0	5,723	0	0	0	0	0	0	0	0	0	5,723	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(25,128)</b>	<b>29,004</b>	<b>0</b>	<b>3,876</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	(3,767)	0	0	0	0	0	0	0	0	0	0	(3,767)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(3,767)</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>(3,767)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(704,966)	0	0	0	0	0	0	0	0	0	(704,966)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	66,383	0	0	0	0	0	0	0	0	0	66,383	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(60,825)	293,793	0	0	0	0	0	0	0	0	0	232,968	21
22	Employee Benefits & Payroll Taxes	0	62,703	0	0	0	0	0	0	0	0	0	62,703	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	22,967	0	0	0	0	0	0	0	0	0	22,967	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	(13,578)	0	0	0	0	0	0	0	0	0	(13,578)	26
27	Other (specify):*	(118,235)	0	0	0	0	0	0	0	0	0	0	(118,235)	27
28	<b>TOTAL General Administration</b>	<b>(179,060)</b>	<b>(272,698)</b>	<b>0</b>	<b>(451,758)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(207,955)</b>	<b>(243,694)</b>	<b>0</b>	<b>(451,649)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Lewis Memorial Christian Village# 0021436

Report Period Beginning:

July 1, 2011 Ending:

Summary B

June 30, 2012

## 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	45,922	0	0	0	0	0	0	0	0	0	45,922	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(359,865)	0	0	0	0	0	0	0	0	0	0	(359,865)	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>(359,865)</b>	<b>45,922</b>	<b>0</b>	<b>(313,943)</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	(42,602)	0	0	0	0	0	0	0	0	0	(42,602)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,252,020)	0	0	0	0	0	0	0	0	0	0	(1,252,020)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,252,020)</b>	<b>(42,602)</b>	<b>0</b>	<b>(1,294,622)</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,819,840)</b>	<b>(240,374)</b>	<b>0</b>	<b>(2,060,214)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 2,260	\$ 2,260	1
2	V	6 Maintenance				5,723	5,723	2
3	V	17 Administrative	830,839			125,873	(704,966)	3
4	V	19 Professional Services				66,383	66,383	4
5	V	21 Clerical				293,793	293,793	5
6	V	22 Employee Benefits				62,703	62,703	6
7	V	24 Travel & Seminars				22,967	22,967	7
8	V	26 Insurance				(13,578)	(13,578)	8
9	V	30 Depreciation				45,922	45,922	9
10	V	4 Interest				21,021	21,021	10
11	V							11
12	V							12
13	V	39 Pharmacy Services	519,535	Senior Care Pharmacy	0.00%	476,933	(42,602)	13
14	Total		\$ 1,350,374			\$ 1,110,000	\$ * (240,374)	14

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

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

## 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.									
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13								TOTAL	\$	

\* 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, 2011

Ending: ne 30, 2012

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

Facility Name & ID Number

Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2011 Ending:

June 30, 2012

**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**					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	\$ 4,558,623	5/15/2031	0.0567	\$ 104,956					
2	Illinois Finance Authority		X	Refinance Debt		7/1/10	5,500,000	5,441,700	5/15/2027	0.0613	100,383					
3	GO Bonds	X		Refinance Debt	\$2,092.00	Various*	Various*	361,167	6/30/2032	Various*	12,966					
4	*this is an allocation of the total GO bond debt which includes several different series with several different rates of interest										4					
5											5					
<b>Working Capital</b>																
6											6					
7											7					
8											8					
9	<b>TOTAL Facility Related</b>				\$2,092.00		\$ 10,320,517	\$ 10,361,490			\$ 218,305					
<b>B. Non-Facility Related*</b>																
10	Congregate/Duplex/Wellness Center/Shared Home										141,560					
11											11					
12											12					
13											13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 141,560					
15	<b>TOTALS (line 9+line14)</b>						\$ 10,320,517	\$ 10,361,490			\$ 359,865					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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 2011 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 2012 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:		2007	_____	8	
		2008	_____	9	
		2009	_____	10	
		2010	_____	11	
		2011	_____	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2011 \$		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.**

## 2011 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 2011 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 2011.

	(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 Attachments</u>	<u>See Attachments</u>	\$ <u>97,605.00</u>	\$ _____
2.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
3.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
4.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
5.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
6.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
7.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
8.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
9.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
10.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u><u>97,605.00</u></u>	\$ <u><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?      X   YES                   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.    **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 77,000 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>77,000</u>	<u>Various</u>	<u>\$ 308,762</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>9,630</u>	<u>2</u>
3	<b>TOTALS</b>	<b>77,000</b>		<b>\$ 318,392</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		\$ 1,971,791	4
5				1978	100,542		40				5
6				1979	420,937		20				6
7				2011	5,718,452	11,913	40	11,913		11,913	7
8	Home Office Allocation				94,364	10,710		10,710		58,146	8
	Improvement Type**										
9	1978 Fixed Assets			1978	85,870		Various			85,870	9
10	1979 Fixed Assets			1979	29,532	7	Various	7		29,428	10
11	1980 Fixed Assets			1980	521		Various			521	11
12	1983 Fixed Assets			1983	417		Various			417	12
13	1984 Fixed Assets			1984	6,077		Various			6,077	13
14	1985 Fixed Assets			1985	1,852		Various			1,852	14
15	1986 Fixed Assets			1986	9,923		Various			9,923	15
16	1987 Fixed Assets			1987	3,650		Various			3,650	16
17	1989 Fixed Assets			1989	15,750		Various			15,750	17
18	1990 Fixed Assets			1990	100		Various			100	18
19	1991 Fixed Assets			1991	39,423		Various			39,423	19
20	1992 Fixed Assets			1992	7,016		Various			7,016	20
21	1993 Fixed Assets			1993	127,234		Various			127,234	21
22	1994 Fixed Assets			1994	25,332		Various			25,332	22
23	1995 Fixed Assets			1995	45,940		Various			45,949	23
24	1996 Fixed Assets			1996	5,783		Various			5,783	24
25	1997 Fixed Assets			1997	47,168		Various			47,168	25
26	1998 Fixed Assets			1998	37,220		Various			37,220	26
27	1999 Fixed Assets			1999	60,556	1,107	Various	1,107		31,245	27
28	2000 Fixed Assets			2000	21,152		Various			21,152	28
29	2001 Fixed Assets			2001	1,184		Various			1,184	29
30	2002 Fixed Assets			2002	34,136	1,900	Various	1,900		28,231	30
31	2003 Fixed Assets			2003	27,108	2,065	Various	2,065		23,692	31
32	2004 Fixed Assets			2004	94,601	9,461	Various	9,461		74,919	32
33	2005 Fixed Assets			2005	77,530	8,025	Various	8,025		55,452	33
34	2006 Fixed Assets			2006	479,564	23,977	Various	23,977		142,750	34
35	2007 Fixed Assets			2007	377,643	30,129	Various	30,129		170,028	35
36	Generator & Rooftop unit			2/29/2008	61,600	6,160	10	6,160		27,207	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

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	4 100 Gallon Water Heaters	5/27/2008	\$ 48,000	\$ 4,800	10	\$ 4,800	\$	\$ 20,000	37
38	Install 4 door closers and manual pull	9/26/2008	2,931	293	10	293		1,123	38
39	Install weatherproof exit lights	9/24/2008	5,600	560	10	560		2,147	39
40	Window valances - 34 rooms	12/22/2008	3,821	764	5	764		2,738	40
41	Rooftop unit #4	6/30/2009	18,240	1,824	10	1,824		5,624	41
42	Sidewalks - remove old and pour new	4/30/2009	4,609	461	10	461		1,037	42
43	Sliding Shower Door	7/30/2009	895	90	10	90		270	43
44	Replacement Windows	7/30/2009	897	90	10	90		270	44
45	Replaced Door Closers in 300 Wing	7/17/2009	1,503	150	10	150		450	45
46	SNF Shower Refurb	12/9/2009	76,536	7,654	10	7,654		21,069	46
47	Dining Room Ceiling	3/31/2010	30,100	3,010	10	3,010		7,533	47
48	Back Service Doors	4/16/2010	4,182	418	10	418		1,012	48
49	SNF Refurb Project	1/31/2010	414,080	41,408	10	41,408		110,534	49
50	Replace Laundry Roof Top A/C Unit	4/27/2010	37,820	3,782	10	3,782		9,150	50
51	Gutter Installation on Front Canopy	4/30/2010	1,960	196	10	196		474	51
52	Landscaping	5/31/2010	400,013	40,001	10	40,001		93,445	52
53	Water main extension, architectural services	4/12/2010	18,105	1,811	10	1,811		4,381	53
54	FY10 Mine Subsidence	6/30/2010	305,566	30,557	10	30,557		68,836	54
55	Removal of Stumps and Sign	7/31/2010	8,126	813	10	813		1,625	55
56	Pour Walk - Grade Site	7/31/2010	18,800	1,880	10	1,880		3,760	56
57	Door Closure for LSC Survev	9/15/2010	2,671	490	10	490		490	57
58	Bistro - Architectural Services	9/30/2010	5,536	1,015	10	1,015		1,015	58
59	Sidewalk	9/30/2010	35,823	6,568	10	6,568		6,568	59
60	Sprinkler Heads	10/31/2010	642	112	10	112		112	60
61	Tamper Switches	10/31/2010	580	102	10	102		102	61
62	Dumpster Pad	10/31/2010	38,820	6,794	10	6,794		6,794	62
63	Backflow Preventer	10/31/2010	5,980	1,047	10	1,047		1,047	63
64	Half Wall Extension	11/30/2010	3,555	592	10	592		592	64
65	Utility Room Lumber	11/30/2010	845	141	10	141		141	65
66	Parking Lot Sealing and Striping	11/30/2010	9,925	1,654	10	1,654		1,654	66
67	Bistro - Sprinklers	12/1/2010	1,503	238	10	238		238	67
68	Light Poles Next to Sidewalk	12/2/2010	4,222	668	10	668		668	68
69	Bistro - Construction: install suspended ceiling, countertops and fl	12/31/2010	63,570	5,033	20	5,033		5,033	69
70	TOTAL (lines 4 thru 69)		\$ 11,920,463	\$ 330,221		\$ 330,221	\$	\$ 3,486,355	70

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

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning:

July 1, 2011 Ending: June 30, 2012

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 11,920,463	\$ 330,221		\$ 330,221	\$	\$ 3,486,355	1
2	Bistro - Duct Work	12/31/2010	1,288	204	10	204		204	2
3	Bistro - Electrical Work	1/31/2011	10,252	1,538	10	1,538		1,538	3
4	Bistro - Plumbing	1/31/2011	2,847	427	10	427		427	4
5	Lounge Remodel: install suspended ceiling and lighting, new floor,	2/28/2011	20,386	2,888	10	2,888		2,888	5
6	Activity Room Ceiling	2/28/2011	5,900	836	10	836		836	6
7	Flag Pole Light	2/28/2011	558	79	10	79		79	7
8	Water and Sewer Lines	2/28/2011	74,790	10,595	10	10,595		10,595	8
9	Garage Roof	4/30/2011	1,913	239	10	239		239	9
10	SNF Storage Building	4/30/2011	5,014	627	10	627		627	10
11	Engineering - Garage and Sewer	5/31/2011	1,353	158	10	158		158	11
12	Engineering - Sewer Line	5/31/2011	23,195	2,706	10	2,706		2,706	12
13	Sewer Repair	6/30/2011	3,230	350	10	350		350	13
14	Landscaping - Northeast Bldg	6/30/2011	10,990	1,191	10	1,191		1,191	14
15	Unit 3320 - Landscaping	6/30/2011	450	49	10	49		49	15
16	EIFS Facia	7/18/2011	35,000	3,500	10	3,500		3,500	16
17	HVAC Unit #8	12/26/2011	13,520	789	10	789		789	17
18	HVAC Unit #3	1/19/2012	26,590	1,330	10	1,330		1,330	18
19	Lobby AVAC Unit #2	1/10/2012	23,380	1,169	10	1,169		1,169	19
20	Maintenance Building Garage	1/30/2012	51,815	1,036	25	1,036		1,036	20
21	Geotechnical Services	7/1/2011	2,750	275	10	275		275	21
22	Grading	7/1/2011	389	39	20	39		39	22
23	Irrigation System	7/1/2011	1,916	96	10	96		96	23
24	Landscaping	1/23/2012	35,519	1,776	10	1,776		1,776	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,273,508	\$ 362,118		\$ 362,118	\$	\$ 3,518,252	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 690,422	\$ 84,469	\$ 84,469	\$	Various	\$ 354,009	71
72	Current Year Purchases	224,544	22,061	22,061		Various	22,061	72
73	Fully Depreciated Assets	696,125	74,362	74,362		Various	696,125	73
74	Home Office Allocation	381,468	31,960	31,960			163,243	74
75	TOTALS	\$ 1,992,559	\$ 212,852	\$ 212,852	\$		\$ 1,235,438	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attachment			\$ 83,733	\$ 20,933	\$ 20,933	\$		\$ 73,024	76
77										77
78										78
79	Home Office Allocation			28,658	3,252	3,252			10,652	79
80	TOTALS			\$ 112,391	\$ 24,185	\$ 24,185	\$		\$ 83,676	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,696,850	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 599,155	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 599,155	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)	\$ 4,837,366	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	\$ 1,619,866	\$ 66,415	\$ 118,295	86
87	Wellness Center Bldg & Equipment	1,430,584	50,764	372,107	87
88	Duplex Bldg & Equipment	5,228,182	123,743	2,591,829	88
89					89
90					90
91	TOTALS	\$ 8,278,632	\$ 240,922	\$ 3,082,231	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 133,418	92
93			93
94			94
95		\$ 133,418	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning: July 1, 2011

Ending: June 30, 2012

**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

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

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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: \$ 107,886 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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2011 Ending: June 30, 2012  
**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>LMCV</u> only hires certified CNAs.</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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	15,451	\$ 694,857	\$	15,451	\$ 694,857	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		4,092	225,299		4,092	225,299	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a-3	hrs		19,040	680,707		19,040	680,707	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>			\$	38,583	\$ 1,600,863	\$	38,583	\$ 1,600,863	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, 2011Ending: June 30, 2012

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2012 (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	\$ 7,488,178	\$	1
2	Cash-Patient Deposits	25,810		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>153,803</u> )	2,178,737		3
4	Supply Inventory (priced at )	9,367		4
5	Short-Term Investments	7,242,621		5
6	Prepaid Insurance	500		6
7	Other Prepaid Expenses	10,563		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest</u>	36,819		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 16,992,595	\$	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	18,212,137		14
15	Leasehold Improvements, at Historical Cost	3,973,476		15
16	Equipment, at Historical Cost	1,892,816		16
17	Accumulated Depreciation (book methods)	(8,128,749)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,287,634		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Fees</u>	59,450		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 17,605,526	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 34,598,121	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 904,235	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,810		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	370,651		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,464		32
33	Accrued Interest Payable	78,147		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Liabilities</u>	813,623		36
37	<u>FIN 47 Liability</u>	69,687		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,312,617	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	10,361,490		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Life Right Revenue</u>	463,268		43
44	<u>Due to Life Right Residents</u>	1,017,847		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 11,842,605	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 14,155,222	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 20,442,899	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 34,598,121	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 19,308,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 19,308,554	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,134,345	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)	\$ 1,134,345	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 20,442,899	24 *

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

**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		
<b>I. Revenue</b>		<b>Amount</b>		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 9,730,962	1	
2	Discounts and Allowances for all Levels	(4,305,152)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,425,810</b>	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	6,414,462	6	
7	Oxygen	52,044	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 6,466,506</b>	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	37,839	13	
14	Non-Patient Meals	12,159	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,038,401	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	128,061	19	
20	Radiology and X-Ray	64,332	20	
21	Other Medical Services	231,367	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,512,159</b>	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions	84,824	24	
25	Interest and Other Investment Income***	297,784	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 382,608</b>	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	<b>1,500</b>	27	
28	<u>Apartment/Duplex</u>	<u>1,232,202</u>	28	
28a	<u>Gain/Loss on Investments &amp; Equipment</u>	<u>182,649</u>	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,416,351</b>	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 15,203,434</b>	30	

		2		
<b>II. Expenses</b>		<b>Amount</b>		
<b>A. Operating Expenses</b>				
31	General Services	1,696,294	31	
32	Health Care	6,082,685	32	
33	General Administration	2,790,024	33	
<b>B. Capital Expense</b>				
34	Ownership	1,072,519	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	2,427,567	35	
36	Provider Participation Fee		36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,069,089</b>	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,134,345</b>	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,134,345</b>	43	

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,626,507	44
45	Private Pay - Net Inpatient Revenue	2,499,957	45
46	Medicare - Net Inpatient Revenue	109,792	46
47	Other-(specify) <u>HMO</u>	179,286	47
48	Other-(specify) <u>Medicare Advantage/Nursing/Shared Homes</u>	10,268	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,425,810</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning: July 1, 2011

Ending: June 30, 2012

**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	6,520	7,131	\$ 242,235	\$ 33.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,658	21,540	440,974	20.47	3
4	Licensed Practical Nurses	49,389	52,120	993,344	19.06	4
5	CNAs & Orderlies	135,131	140,626	1,779,412	12.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,839	2,088	38,232	18.31	9
10	Activity Assistants	6,229	6,906	70,536	10.21	10
11	Social Service Workers	9,750	10,676	202,527	18.97	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,208	40,282	18.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,988	33,664	333,811	9.92	15
16	Dishwashers					16
17	Maintenance Workers	6,020	6,717	111,924	16.66	17
18	Housekeepers	19,942	21,715	220,760	10.17	18
19	Laundry	7,148	8,204	87,768	10.70	19
20	Administrator	1,048	1,474	53,412	36.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,820	2,088	58,660	28.09	23
24	Clerical	10,158	10,862	136,952	12.61	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	10,806	11,557	265,039	22.93	31
32	Other Health C: <u>Apt/Congergate</u>	28,620	30,554	442,321	14.48	32
33	Other(specify) <u>Marketing/Beauty</u>	5,869	6,662	126,039	18.92	33
34	TOTAL (lines 1 - 33)	353,015	376,792	\$ 5,644,228 *	\$ 14.98	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	1,264	\$ 61,955	3.1.3	35
36	Medical Director	416	15,044	3.9.3	36
37	Medical Records Consultant	60	3,100	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	5,508	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	4	242	3.11.3	44
45	Social Service Consultant	66	3,860	3.12.3	45
46	Other(specify) <u>Interim DON</u>	2,320	67,900	3.10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,250	\$ 157,609		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



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Lewis Memorial Christian Village

# 0021436

Report Period Beginning: July 1, 2011 Ending: June 30, 2011

## 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. LSN & Leading Age - \$9,911
- (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. \$ 35,733 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.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 364,881  
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. \$ 12,159
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: CliftonLarsonAllen 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.