



Facility Name & ID Number Lewis Memorial Christian Vlg

# 0021436 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

**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 05/28/2014

	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)	171	57,119	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	171	57,119	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	23,191	15,803	15,181	54,175	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,191	15,803	15,181	54,175	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.85%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
Residential Living, Wellness Center, Senior Home Services

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 09/19/1977

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 155 and days of care provided 11,247

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: 06/30/2014 Fiscal Year: 06/30/2014

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

Facility Name &amp; ID Number

Lewis Memorial Christian Vlg

# 0021436

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

**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	359,845	29,763	53,331	442,939		442,939		442,939		1
2	Food Purchase		372,861		372,861		372,861	(14,059)	358,802		2
3	Housekeeping	217,374	43,470		260,844		260,844		260,844		3
4	Laundry	66,925	15,410		82,335		82,335	(18,932)	63,403		4
5	Heat and Other Utilities			336,617	336,617		336,617	3,324	339,941		5
6	Maintenance	141,222	7,533	119,225	267,980		267,980	8,776	276,756		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	785,366	469,037	509,173	1,763,576		1,763,576	(20,891)	1,742,685		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,080	24,080		24,080		24,080		9
10	Nursing and Medical Records	4,011,512	183,158	71,847	4,266,517		4,266,517	(1,537)	4,264,980		10
10a	Therapy			1,417,252	1,417,252		1,417,252		1,417,252		10a
11	Activities	97,262	6,384	475	104,121		104,121		104,121		11
12	Social Services	149,008	2,344	2,868	154,220		154,220		154,220		12
13	CNA Training										13
14	Program Transportation	40,935		36,527	77,462		77,462	(11,000)	66,462		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,298,717	191,886	1,553,049	6,043,652		6,043,652	(12,537)	6,031,115		16
	<b>C. General Administration</b>										
17	Administrative	185,233	734	824,920	1,010,887		1,010,887	(620,384)	390,503		17
18	Directors Fees										18
19	Professional Services			40,182	40,182		40,182	68,588	108,770		19
20	Dues, Fees, Subscriptions & Promotions			33,314	33,314		33,314		33,314		20
21	Clerical & General Office Expenses	243,796	21,762	295,418	560,976		560,976	232,614	793,590		21
22	Employee Benefits & Payroll Taxes			1,142,690	1,142,690		1,142,690	77,751	1,220,441		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,751	12,751		12,751	31,233	43,984		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			169,384	169,384		169,384	3,157	172,541		26
27	Other (specify):* <b>Marketing</b>	99,633	3,054	32,287	134,974		134,974	(134,974)			27
28	<b>TOTAL General Administration</b>	528,662	25,550	2,550,946	3,105,158		3,105,158	(342,015)	2,763,143		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,612,745	686,473	4,613,168	10,912,386		10,912,386	(375,443)	10,536,943		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			778,425	778,425	778,425	68,328	846,753				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			619,892	619,892	619,892	(354,571)	265,321				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			70,905	70,905	70,905		70,905				35
36	Other (specify):* <b>Deferred Financing Costs</b>			2,973	2,973	2,973		2,973				36
37	<b>TOTAL Ownership</b>			1,472,195	1,472,195	1,472,195	(286,243)	1,185,952				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			562,689	562,689	562,689	(20,905)	541,784				39
40	Barber and Beauty Shops	38,211	1,000		39,211	39,211		39,211				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,161	345,161	345,161		345,161				42
43	Other (specify):* <b>Apt/Congregate</b>	415,564		809,360	1,224,924	1,224,924	(1,224,924)					43
44	<b>TOTAL Special Cost Centers</b>	453,775	1,000	1,717,210	2,171,985	2,171,985	(1,245,829)	926,156				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,066,520	687,473	7,802,573	14,556,566	14,556,566	(1,907,515)	12,649,051				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	(14,059)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(354,571)	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		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,299)	21		24
25	Fund Raising, Advertising and Promotional	(134,974)	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	(1,240,263)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,908,166)</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)	651	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 651</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,907,515)</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 Vlg

ID# 0021436

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Transportation	\$ (11,000)	14	1
2	Late Fees, Finance Charges	(747)	21	2
3	Apartment/Congregate	(1,224,924)	43	3
4	Vending Revenue	(840)	21	4
5	Room Rental	(1,500)	10	5
6	Miscellaneous Revenue	(1,205)	21	6
7	Late Fees, Finance Charges	(10)	6	7
8	Late Fees, Finance Charges	(37)	10	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				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>	(1,240,263)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Vlg# 0021436

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

## 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	(14,059)	0	0	0	0	0	0	0	0	0	0	(14,059)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(18,932)	0	0	0	0	0	0	0	0	0	(18,932)	4
5	Heat and Other Utilities	0	3,324	0	0	0	0	0	0	0	0	0	3,324	5
6	Maintenance	(10)	8,786	0	0	0	0	0	0	0	0	0	8,776	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,069)</b>	<b>(6,822)</b>	<b>0</b>	<b>(20,891)</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	(1,537)	0	0	0	0	0	0	0	0	0	0	(1,537)	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	(11,000)	0	0	0	0	0	0	0	0	0	0	(11,000)	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>(12,537)</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>(12,537)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(620,384)	0	0	0	0	0	0	0	0	0	(620,384)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	68,588	0	0	0	0	0	0	0	0	0	68,588	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(167,091)	399,705	0	0	0	0	0	0	0	0	0	232,614	21
22	Employee Benefits & Payroll Taxes	0	77,751	0	0	0	0	0	0	0	0	0	77,751	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	31,233	0	0	0	0	0	0	0	0	0	31,233	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	3,157	0	0	0	0	0	0	0	0	0	3,157	26
27	Other (specify):*	(134,974)	0	0	0	0	0	0	0	0	0	0	(134,974)	27
28	<b>TOTAL General Administration</b>	<b>(302,065)</b>	<b>(39,950)</b>	<b>0</b>	<b>(342,015)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(328,671)</b>	<b>(46,772)</b>	<b>0</b>	<b>(375,443)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Lewis Memorial Christian Vlg# 0021436

Report Period Beginning:

July 1, 2013 Ending:

Summary B

June 30, 2014

## 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	68,328	0	0	0	0	0	0	0	0	0	68,328	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(354,571)	0	0	0	0	0	0	0	0	0	0	(354,571)	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>(354,571)</b>	<b>68,328</b>	<b>0</b>	<b>(286,243)</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	(20,905)	0	0	0	0	0	0	0	0	0	(20,905)	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):*	(1,224,924)	0	0	0	0	0	0	0	0	0	0	(1,224,924)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,224,924)</b>	<b>(20,905)</b>	<b>0</b>	<b>(1,245,829)</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,908,166)</b>	<b>651</b>	<b>0</b>	<b>(1,907,515)</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
<u>SEE ATTACHED LISTING OF BOARD OF DIRECTORS</u>						

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	<u>5 UTILITIES</u>	\$	<u>Midwest Christian Villages, Inc. dba: Christian Homes, Inc.</u>	<u>100.00%</u>	\$ <u>3,324</u>	\$ <u>3,324</u>	1
2	V	<u>6 MAINTENANCE</u>				<u>8,786</u>	<u>8,786</u>	2
3	V	<u>17 ADMINISTRATIVE</u>	<u>824,920</u>			<u>204,536</u>	<u>(620,384)</u>	3
4	V	<u>19 PROFESSIONAL SERVICES</u>				<u>68,588</u>	<u>68,588</u>	4
5	V	<u>21 CLERICAL</u>				<u>398,648</u>	<u>398,648</u>	5
6	V	<u>22 EMPLOYEE BENEFITS</u>				<u>77,751</u>	<u>77,751</u>	6
7	V	<u>24 TRAVEL AND SEMINARS</u>				<u>31,233</u>	<u>31,233</u>	7
8	V	<u>26 INSURANCE</u>				<u>3,157</u>	<u>3,157</u>	8
9	V	<u>30 DEPRECIATION</u>				<u>68,328</u>	<u>68,328</u>	9
10	V	<u>4 INTEREST</u>				<u>(18,932)</u>	<u>(18,932)</u>	10
11	V	<u>21 OTHER ADMINISTRATIVE</u>				<u>1,057</u>	<u>1,057</u>	11
12	V							12
13	V	<u>39 PHARMACY SERVICES</u>	<u>424,900</u>	<u>SENIOR CARE PHARMACY</u>	<u>0.00%</u>	<u>403,995</u>	<u>(20,905)</u>	13
14	Total		\$ <u>1,249,820</u>			\$ <u>1,250,471</u>	\$ * <u>651</u>	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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	This workpapers is not applicable.										1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13							TOTAL	\$			13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lewis Memorial Christian Vlg

# 0021436

Report Period Beginning: July 1, 2013

Ending: ne 30, 2014

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	<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 Vlg

# 0021436

Report Period Beginning:

July 1, 2013 Ending:

June 30, 2014

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	\$20,870.00	6/30/07	\$ 4,820,517	\$ 4,639,639	5/15/2031	0.0567	\$ 160,739						
2	ILLINOIS FINANCE AUTHORITY	X		REFINANCE DEBT	\$26,452.00	7/1/10	5,500,000	5,429,081	5/15/2027	0.0625	203,062						
3	GO BONDS	X		REFINANCE DEBT	\$1,490.00	Various*	Various*	318,102	6/30/2032	Various*	10,809						
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	TOTAL Facility Related				\$48,812.00		\$ 10,320,517	\$ 10,386,822			\$ 374,610						
<b>B. Non-Facility Related*</b>																	
10	CONGRATE/DUPLEX/WELLNESS CENTER/SHARED HOME										245,282						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$ 245,282						
15	TOTALS (line 9+line14)						\$ 10,320,517	\$ 10,386,822			\$ 619,892						

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 2013 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 2014 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:	2009	_____	8	<b>FOR BHF USE ONLY</b>		
	2010	_____	9			
	2011	_____	10			
	2012	_____	11			
	2013	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lewis Memorial Christian Vlg COUNTY Sangamon  
 FACILITY IDPH LICENSE NUMBER 0021436  
 CONTACT PERSON REGARDING THIS REPORT 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 2013 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 2013.

	(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>116,050.44</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>116,050.44</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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>13,055</u>	<u>2</u>
3	<b>TOTALS</b>	<u>77,000</u>		<u>\$ 321,817</u>	<u>3</u>

**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	\$ 59,752	40	\$ 59,752	\$	\$ 2,091,295	4
5			1978	100,542						5
6			1979	420,937						6
7			2011	5,718,452	142,961	40	142,961		297,836	7
8	Home Office Allocation			126,689	14,664		14,664		88,618	8
	<b>Improvement Type**</b>									
9	1978 Fixed Assets		1978	85,870	-	VARIOUS			85,870	9
10	1979 Fixed Assets		1979	29,226	-	VARIOUS			29,226	10
11	1980 Fixed Assets		1980	827	6	VARIOUS	6		734	11
12	1984 Fixed Assets		1984	6,077	-	VARIOUS			6,077	12
13	1985 Fixed Assets		1985	1,852	-	VARIOUS			1,852	13
14	1986 Fixed Assets		1986	9,923	-	VARIOUS			9,923	14
15	1987 Fixed Assets		1987	3,650	-	VARIOUS			3,650	15
16	1989 Fixed Assets		1989	13,550	-	VARIOUS			13,550	16
17	1990 Fixed Assets		1990	100	-	VARIOUS			100	17
18	1991 Fixed Assets		1991	38,299	-	VARIOUS			38,299	18
19	1992 Fixed Assets		1992	4,078	-	VARIOUS			4,078	19
20	1993 Fixed Assets		1993	129,417	-	VARIOUS			129,417	20
21	1994 Fixed Assets		1994	17,149	-	VARIOUS			17,149	21
22	1995 Fixed Assets		1995	42,240	-	VARIOUS			42,240	22
23	1997 Fixed Assets		1997	39,974	-	VARIOUS			39,974	23
24	1998 Fixed Assets		1998	35,351	-	VARIOUS			35,351	24
25	1999 Fixed Assets		1999	73,686	1,106	VARIOUS	1,106		46,585	25
26	2000 Fixed Assets		2000	8,022	-	VARIOUS			8,022	26
27	2001 Fixed Assets		2001	1,184	-	VARIOUS			1,184	27
28	2002 Fixed Assets		2002	41,376	1,985	VARIOUS	1,985		35,430	28
29	2003 Fixed Assets		2003	27,108	706	VARIOUS	706		26,351	29
30	2004 Fixed Assets		2004	118,226	11,239	VARIOUS	11,239		117,461	30
31	2005 Fixed Assets		2005	45,167	2,693	VARIOUS	2,693		42,569	31
32	2006 Fixed Assets		2006	535,805	34,434	VARIOUS	34,434		275,604	32
33	2007 Fixed Assets		2007	416,028	24,693	VARIOUS	24,693		238,777	33
34	2008 Fixed Assets		2008	2,358,079	124,161	VARIOUS	124,161		761,447	34
35	2009 Fixed Assets		2009	\$ 111,071	\$ 11,107	VARIOUS	\$ 11,107	\$	\$ 52,956	35
36	SNF Refurb project		2010	414,080	41,408		41,408		186,336	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 Vlg

# 0021436

Report Period Beginning:

July 1, 2013 Ending: June 30, 2014

**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	Dining Room Ceiling	2010	30,100	3,010		3,010		13,043	37
38	Back Service Doors	2010	4,182	418		418		1,777	38
39	Replace Laundry Roof Top Alc Unit	2010	37,820	3,782		3,782		16,074	39
40	Gutter Installation on Front Canopy	2010	1,960	196		196		833	40
41	Door Closure for LSC Survey	2010	2,671	267		267		1,024	41
42	Bistro - Architectural Services	2010	5,536	554		554		2,122	42
43	Tamper Switches	2010	580	58		58		218	43
44	Sprinkler Heads	2010	642	64		64		241	44
45	Utility room lumher	2010	845	84		84		310	45
46	Half Wall Extension	2010	3,555	355		355		1,303	46
47	Bistro - Sprinklers	2010	1,503	150		150		539	47
48	Bistro - Duct Work	2010	1,288	129		129		461	48
49	Bistro - Construction	2010	63,570	3,179		3,179		11,390	49
50	Campus Beautification	2010	18,105	1,811		1,811		7,695	50
51	Landscaping	2010	400,013	40,001		40,001		166,672	51
52	FYIO Mine Subsidence	2010	305,566	30,557		30,557		124,773	52
53	Removal of stumps and sign	2010	8,126	813		813		3,250	53
54	Pour Walk - Grade site	2010	18,800	1,880		1,880		7,520	54
55	Sidewalk	2010	35,823	3,582		3,582		13,732	55
56	Backflow Preventer	2010	5,980	598		598		2,243	56
57	Dumpster Pad	2010	38,820	3,882		3,882		14,558	57
58	Parking Lot Sealing & Striping	2010	9,925	993		993		3,639	58
59	Light poles next to sidewalk	2010	4,222	422		422		1,513	59
60	Bistro - Plumbing	2011	2,847	285		285		996	60
61	Bistro - Electrical Work	2011	10,252	1,025		1,025		3,588	61
62	Activity Room Ceiling	2011	5,900	590		590		2,016	62
63	Lounge Remodel	2011	20,386	2,039		2,039		6,965	63
64	EIFS Facia	2011	35,000	3,500		3,500		10,500	64
65	HVAC Unit #8	2011	13,520	1,352		1,352		3,493	65
66	Flag Pole Light	2011	558	56		56		191	66
67	Water and Sewer lines	2011	74,790	7,479		7,479		25,553	67
68	Engineering - Garage and Sewer	2011	1,353.0	135		135		428	68
69	Engineering - Sewer Line	2011	23,195.0	2,320		2,320		7,345	69
70	<b>TOTAL (lines 4 thru 69)</b>		<b>\$ 14,448,298</b>	<b>\$ 586,480</b>		<b>\$ 586,480</b>	<b>\$</b>	<b>\$ 5,183,965</b>	<b>70</b>

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

**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	10
	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>		\$ 14,448,298	\$ 586,480		\$ 586,480	\$	\$ 5,183,965	1
2	Unit 3320 - Landscaping	2011	450	45		45		139	2
3	Sewer Repair	2011	3,230	323		323		996	3
4	Landscaping - Northeast Bldg	2011	10,990	1,099		1,099		3,389	4
5	Grading	2011	389	39		39		117	5
6	Geotechnical Services	2011	2,750	275		275		825	6
7	Irrigation System	2011	1,916	96		96		287	7
8	Garage Roof	2011	1,913	191		191		622	8
9	SNF Storage Building	2011	5,014	501		501		1,630	9
10	Lobby HVAC Unit *2	2012	23,380	2,338		2,338		5,845	10
11	HVAC Unit B	2012	26,590	2,659		2,659		6,648	11
12	Chapel - Replace Walls and Ceiling	2012	8,587	859		859		1,503	12
13	Walk in Cooler	2012	22,500	1,500		1,500		2,500	13
14	DDOR - SNF	2012	525	53		53		88	14
15	Landscaping	2012	35,519	3,552		3,552		8,880	15
16	Light Pole	2012	2,364	158		158		250	16
17	Maintenance Building Garage	2012	51,815	2,073		2,073		5,182	17
18	CHAPEL - ELECTRIC CONDUITS AND WIRING	2013	1,453	73		73		103	18
19	ROOF - KITCHEN AREA AND WEST AND SOUTH	2013	44,680	4,468		4,468		4,840	19
20	FENCE - DUMPSTER ENCLOSURE	2013	7,927	793		793		859	20
21	LANDSCAPING- SHRUB BEDS	2013	3,900	780		780		845	21
22	ROOF KITCHEN MAIN AREA	2014	49,800	1,107		1,107		1,107	22
23	DUCTLESS SPLIT SYSTEM IN SERVER ROOM	2014	7,375	123		123		123	23
24	REPLACE KITCHEN ROOF AREA	2014	50,200	1,255		1,255		1,255	24
25	LANDSCAPE PROJECT	2014	17,494	146		146		146	25
26									26
27									27
28									28
29									29
30									30
31	ROUNDING TO TIE TO GL		(1)	286		286		(1)	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 14,829,058	\$ 611,269		\$ 611,269	\$	\$ 5,232,139	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	\$ 884,599	\$ 132,385	\$ 132,385	\$		\$ 516,468	71
72	Current Year Purchases	385,205	36,163	36,163			36,163	72
73	Fully Depreciated Assets	661,382					661,382	73
74	Home Office Allocation	499,419	48,387	48,387			297,721	74
75	TOTALS	\$ 2,430,605	\$ 216,935	\$ 216,935	\$		\$ 1,511,734	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	Various	Various	\$ 132,255	\$ 13,275	\$ 13,275	\$	Various	\$ 95,863	76
77										77
78										78
79	Home Office Allocation			45,556	5,274	5,274			25,946	79
80	TOTALS			\$ 177,811	\$ 18,549	\$ 18,549	\$		\$ 121,809	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)	\$ 17,759,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 846,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 846,753	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)	\$ 6,865,682	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	\$ 1,618,828	\$ 75,688	\$ 269,110	86
87	Wellness Center Building and Equipment	1,040,645	54,226	395,485	87
88	Duplex Building and Equipment	5,286,029	74,610	2,790,748	88
89					89
90					90
91	TOTALS	\$ 7,945,502	\$ 204,524	\$ 3,455,343	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 194	92
93			93
94			94
95		\$ 194	95

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

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

Facility Name & ID Number Lewis Memorial Christian Vlg

# 0021436

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

**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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 70,905 Description: See Attachment

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<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 Vlg # 0021436 Report Period Beginning: July 1, 2013 Ending: June 30, 2014  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>LMCV</u> only hires certified CNAs</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist		hrs	\$	13,253	\$ 581,641	\$	13,253	\$ 581,641	1
2	Licensed Speech and Language Development Therapist		hrs		3,728	197,048		3,728	197,048	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		16,466	638,563		16,466	638,563	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>			\$	33,447	\$ 1,417,252	\$	33,447	\$ 1,417,252	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lewis Memorial Christian Vlg# 0021436Report Period Beginning: July 1, 2013Ending: June 30, 2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2014 (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	\$ 8,812,930	\$	1
2	Cash-Patient Deposits	20,400		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>235,521</u> )	1,981,156		3
4	Supply Inventory (priced at )	6,279		4
5	Short-Term Investments	8,232,712		5
6	Prepaid Insurance	14,727		6
7	Other Prepaid Expenses	19,963		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int. / Other A/R</u>	151,240		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 19,239,407	\$	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	18,525,544		14
15	Leasehold Improvements, at Historical Cost	3,887,121		15
16	Equipment, at Historical Cost	2,298,647		16
17	Accumulated Depreciation (book methods)	(9,908,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,340,308		21
22	Other Long-Term Assets (spec CIP)	206,980		22
23	Other(specify): <u>Deferred Financing Costs</u>	53,505		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 17,712,130	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 36,951,537	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 525,813	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,400		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	440,183		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,389		32
33	Accrued Interest Payable	75,447		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Liabilities</u>	162,088		36
37	<u>FIN 47 Liability</u>	68,600		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,350,920	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	10,386,822		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Life Right Revenue</u>	588,983		43
44	<u>Due to Life Right Residents</u>	1,024,081		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 11,999,886	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,350,806	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 23,600,731	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 36,951,537	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,721,388	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 21,721,388	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,886,064	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) <u>Net Assets Released from Restriction</u>	(6,721)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,879,343	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)	\$ 23,600,731	24 *

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

Facility Name & ID Number Lewis Memorial Christian Vlg# 0021436Report Period Beginning: July 1, 2013Ending: June 30, 2014

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,661,435	1
2	Discounts and Allowances for all Levels	(6,343,571)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,317,864	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,080,879	6
7	Oxygen	8,245	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 6,089,124	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	39,939	13
14	Non-Patient Meals	14,059	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	719,857	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,223	19
20	Radiology and X-Ray	30,539	20
21	Other Medical Services	109,369	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 956,986	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	93,667	24
25	Interest and Other Investment Income***	354,571	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 448,238	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	1,205	27
28	<b>Retirement Center</b>	1,384,642	28
28a	<b>Miscellaneous</b>	1,244,571	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,630,418	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,442,630	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,763,576	31
32	Health Care	6,043,652	32
33	General Administration	3,105,158	33
<b>B. Capital Expense</b>			
34	Ownership	1,472,195	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,171,985	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>	\$ 14,556,566	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,886,064	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,886,064	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,893,381	44
45	Private Pay - Net Inpatient Revenue	3,413,277	45
46	Medicare - Net Inpatient Revenue	(71,942)	46
47	Other-(specify) <u>HMO</u>	56,820	47
48	Other-(specify) <u>Medicare Advantage/Nursing/Shared Homes</u>	26,328	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,317,864	49

\* 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 Vlg

# 0021436

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

**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	3,976	4,213	\$ 160,707	\$ 38.15	1
2	Assistant Director of Nursing	1,599	1,685	49,195	29.19	2
3	Registered Nurses	17,293	18,364	418,929	22.81	3
4	Licensed Practical Nurses	58,686	61,214	1,207,835	19.73	4
5	CNAs & Orderlies	151,033	155,216	1,875,745	12.08	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,894	2,118	39,935	18.85	9
10	Activity Assistants	4,981	5,396	57,327	10.62	10
11	Social Service Workers	37,479	40,161	605,321	15.07	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	-	-	-		13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	32,725	34,271	362,707	10.58	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	7,699	8,075	141,222	17.49	17
18	Housekeepers	19,101	20,649	217,374	10.53	18
19	Laundry	5,741	6,111	66,925	10.95	19
20	Administrator	2,172	2,204	142,494	64.67	20
21	Assistant Administrator	1,784	1,860	50,165	26.98	21
22	Other Administrative	1,941	2,120	40,453	19.08	22
23	Office Manager	1,941	1,965	58,528	29.79	23
24	Clerical	10,312	10,806	137,390	12.71	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	7,175	7,731	129,288	16.72	31
32	Other Health C: <u>APT/Congergate</u>	6,372	6,746	167,138	24.78	32
33	Other(specify) <u>Marketing/Beauty</u>	5,798	5,987	137,844	23.02	33
34	TOTAL (lines 1 - 33)	379,701	396,890	\$ 6,066,520 *	\$ 15.29	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	1,246	\$ 53,331	3.1.3	35
36	Medical Director	176	24,080	3.9.3	36
37	Medical Records Consultant	60	3,180	3.10.3	37
38	Nurse Consultant	185	24,177	3.10.3	38
39	Pharmacist Consultant	120	4,793	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	45	2,583	3.12.3	45
46	Other(specify)				46
47	<u>Contracted Nursing</u>	607	44,606	3.10.3	47
48					48
49	TOTAL (lines 35 - 48)	2,443	\$ 156,992		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	<a href="#">This workpaper is not applicable</a>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Lewis Memorial Christian Vlg

# 0021436

Report Period Beginning: July 1, 2013 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. LSN & LEADING AGE - \$12432.95
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,707 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. \$ 345,161  
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. \$ 14,059
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.