FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051078

Facility Name: Concordia Village Care Center

Address: 4101 West Iles Avenue (Number) Springfield (City) 62711 (Zip Code)

County: Sangamon

Telephone Number: (217)793-9429 **Fax #** (217)793-1333

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2012

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Paul Ogier **Telephone Number:** (314)968-9313
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 5/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Paul Ogier
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Joshua W. Wilks, CPA, Partner
(Firm Name & Address) ClfitonLarsonAllen LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	64	15,680	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		TOTALS	64	15,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	118	11,971	3,297	15,386	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	118	11,971	3,297	15,386	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.13%

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)
None

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/1/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 3,297

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	312,078	13,908	5,712	331,698		331,698		331,698			1
2	Food Purchase		67,655		67,655		67,655	(3,651)	64,004			2
3	Housekeeping	6,843	1,530	1,380	9,753		9,753		9,753			3
4	Laundry	8,789	10,166	482	19,437		19,437		19,437			4
5	Heat and Other Utilities			138,884	138,884		138,884		138,884			5
6	Maintenance	45,843	6,884	72,496	125,223		125,223	(7,053)	118,170			6
7	Other (specify):*											7
8	**TOTAL General Services**	373,553	100,143	218,954	692,650		692,650	(10,704)	681,946			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,659,107	53,090	28,420	1,740,617		1,740,617		1,740,617			10
10a	Therapy		3,235	412,434	415,669		415,669		415,669			10a
11	Activities	46,866	5,066	4,538	56,470		56,470		56,470			11
12	Social Services	25,393	167		25,560		25,560		25,560			12
13	CNA Training											13
14	Program Transportation	3,881	2,162	742	6,785		6,785	(171)	6,614			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,735,247	63,720	462,634	2,261,601		2,261,601	(171)	2,261,430			16
	C. General Administration											
17	Administrative	88,027			88,027		88,027		88,027			17
18	Directors Fees											18
19	Professional Services			286,106	286,106		286,106	120,494	406,600			19
20	Dues, Fees, Subscriptions & Promotions			12,635	12,635		12,635		12,635			20
21	Clerical & General Office Expenses	188,220	23,899	161,626	373,745		373,745	(131,503)	242,242			21
22	Employee Benefits & Payroll Taxes			635,631	635,631		635,631		635,631			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,072	13,072		13,072		13,072			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,063	54,063		54,063		54,063			26
27	Other (specify):* **Marketing**	39,890	5,873	551	46,314		46,314	(46,314)				27
28	**TOTAL General Administration**	316,137	29,772	1,163,684	1,509,593		1,509,593	(57,323)	1,452,270			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,424,937	193,635	1,845,272	4,463,844		4,463,844	(68,198)	4,395,646			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Concordia Village Care Center #0051078 **Report Period Beginning:** 5/1/2012 **Ending:** 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			556,315	556,315		556,315	(110,388)	445,927			30
31	Amortization of Pre-Op. & Org.			7,395	7,395		7,395		7,395			31
32	Interest			542,459	542,459		542,459	(12,942)	529,517			32
33	Real Estate Taxes			14,951	14,951		14,951		14,951			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,121,120	1,121,120		1,121,120	(123,330)	997,790			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,913	13,878	173,791		173,791		173,791			39
40	Barber and Beauty Shops		19,371		19,371		19,371	(19,371)				40
41	Coffee and Gift Shops			1,456	1,456		1,456		1,456			41
42	Provider Participation Fee			108,402	108,402		108,402		108,402			42
43	Other (specify):* AL/IL/Marketing	1,217,902	604,182	5,655,532	7,477,616		7,477,616	(7,477,616)				43
44	**TOTAL Special Cost Centers**	1,217,902	783,466	5,779,268	7,780,636		7,780,636	(7,496,987)	283,649			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,642,839	977,101	8,745,660	13,365,600		13,365,600	(7,688,515)	5,677,085			45

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,651)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,940)	6		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	(12,920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,144)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(7,783,354)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,809,009)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,809,009)		37

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

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

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

Concordia Village Care Center

ID# 0051078

Report Period Beginning: 5/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Income	$ (19,371)	40	1
2	Transportation Income	(171)	14	2
3	Non-care SNF Asset Depreciation	(121,482)	30	3
4	Miscellaneous Income	(1,721)	21	4
5	Interest on Past Due Accounts	(22)	32	5
6	Maintenance Services Income	(113)	6	6
7	Uncompensated Care	(127,303)	21	7
8	Finance and Late Fees	(335)	21	8
9	Marketing Expenses	(46,314)	27	9
10	IL and AL Expenses	(7,477,616)	43	10
11	SNF Automobile Depreciation	11,094	30	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	**Total**	(7,783,354)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concordia Village Care Center **#** 0051078 **Report Period Beginning:** 5/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,651)	0	0	0	0	0	0	0	0	0	0	(3,651)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,053)	0	0	0	0	0	0	0	0	0	0	(7,053)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,704)	0	0	0	0	0	0	0	0	0	0	(10,704)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	(171)	0	0	0	0	0	0	0	0	0	0	(171)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(171)	0	0	0	0	0	0	0	0	0	0	(171)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	120,494	0	0	0	0	0	0	0	0	0	120,494	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(131,503)	0	0	0	0	0	0	0	0	0	0	(131,503)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(46,314)	0	0	0	0	0	0	0	0	0	0	(46,314)	27
28	**TOTAL General Administration**	(177,817)	120,494	0	0	0	0	0	0	0	0	0	(57,323)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(188,692)	120,494	0	0	0	0	0	0	0	0	0	(68,198)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concordia Village Care Center # 0051078 **Report Period Beginning:** 5/1/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(110,388)	0	0	0	0	0	0	0	0	0	0	(110,388)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,942)	0	0	0	0	0	0	0	0	0	0	(12,942)	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	**TOTAL Ownership**	(123,330)	0	0	0	0	0	0	0	0	0	0	(123,330)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(19,371)	0	0	0	0	0	0	0	0	0	0	(19,371)	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):*	(7,477,616)	0	0	0	0	0	0	0	0	0	0	(7,477,616)	43
44	**TOTAL Special Cost Centers**	(7,496,987)	0	0	0	0	0	0	0	0	0	0	(7,496,987)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(7,809,009)	120,494	0	0	0	0	0	0	0	0	0	(7,688,515)	45

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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 Board Listing at PG6-Supp				Lutheran Senior Servi	St. Louis, MO	Home Office

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. [X] 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	19	Management Fee	$ 284,867	Lutheran Senior Services	100.00%	$ 405,361	$ 120,494	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 284,867			$ 405,361	$ * 120,494	14

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Janice R. Beane	BOD						1
2	Monica Boesdorfer	BOD						2
3	John M. Brandt	BOD						3
4	Joh R. Carls	BOD						4
5	Mark Gerberding	BOD						5
6	John R. Kotovsky	BOD						6
7	Orlando A. Krueger	BOD						7
8	Victor J. Muchow	BOD						8
9	Sharon L. O'Brien	BOD						9
10	H.A. Olsen	BOD						10
11	Mike Raso	BOD						11
12	Rev. Dr. Alvin J. Schmidt	BOD						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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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 Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

Name of Related Organization: Lutheran Senior Services
Street Address: 1150 Hanley Industrial Court
City / State / Zip Code: St. Louis, MO 63144
Phone Number: (314-968-9313
Fax Number: (314-968-5590

	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	17	Home Office	Direct Costs	10,973,737	31	$ 10,973,737	$ 0	284,867	$ 284,867	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,973,737	$		$ 284,867	25

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Health and Educational Facilities Authority						$	$			$	1
2	2010 Bonds		X	Campus Expansion		10/13/2010	12,369,734	12,369,734	2042	various	542,459	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 12,369,734	$ 12,369,734			$ 542,459	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 12,369,734	$ 12,369,734			$ 542,459	15

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.)**

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 14,951	2
3. Under or (over) accrual (line 2 minus line 1).		$ 14,951	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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 14,951	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008		9
2009		10
2010		11
2011		12

	FOR BHF USE ONLY		
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 Concordia Village Care Center COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051078

CONTACT PERSON REGARDING THIS REPORT Paul Ogier

TELEPHONE 314-968-9313 FAX #: 314-968-5590

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-02.0-400-068	Land 17.61 acres	$ 136,058.88	$ 14,951.00
2.	21-02.0-400-029	Land 6.95 acres	$ 8,028.34	$
3.	21-02.0-400-066	Land 4.62 acres	$ 5,537.70	$
4.	21-02.0-400-067	Land 3.94 acres	$ 4,722.66	$
5.	21-02.0-400-070	Land 4.67 acres	$ 5,597.62	$
6.	21-02.0-400-34	Land	$ 532.44	$
7.	21-02.0-400-35	Land	$ 745.72	$
8.	21-02.0-400-39	Land	$ 66.88	$
9.	21-02.0-400-40	Land	$ 66.88	$
10.	21-02.0-400-41	Land	$ 759.78	$
11.	21-02.0-400-43	Land	$ 554.98	$
12.	21-02.0-400-44	Land	$ 831.08	$
13.	21-02.0-400-47	Land	$ 688.32	$
14.	21-02.0-400-48	Land	$ 229.80	$

15.	21-02.0-400-52	Land	$ 853.24	$
16.	21-02.0-400-54	Land	$ 66.88	$
17.	21-02.0-400-59	Land	$ 759.78	$
		TOTALS	$ 166,100.98	$ 14,951.00

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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.

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,445 B. General Construction Type: Exterior Masonary Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Concordia Village operates 48 Assisted Living Units, 23 Patio Homes, 111 Independent Living Units

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Care Center	120,000	2010	$ 77,462	1
2					2
3	TOTALS	120,000		$ 77,462	3

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64			2011	$ 9,122,010	$ 306,512	Various	$ 306,512	$	$ 306,512	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS REMOVED & FILLED IN - MAIN CORRIDOR/ABOVE EN			4/17/2012	3,064	153	15	153		153	9
10	PHONE SYSTEM UPGRADE+ 5 HANDSET - SNF CENTER (RECEPTI			6/7/2012	3,201	124	15	124		124	10
11	FLOORING, VINYL-NURSES STATION			11/1/2012	3,919	131	5	131		131	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,132,194	$ 306,920		$ 306,920	$	$ 306,920	70

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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	$ 17,019	$ 2,469	$ 2,469	$		$ 3,075	71
72	Current Year Purchases	905,086	125,443	125,443			125,443	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 922,105	$ 127,912	$ 127,912	$		$ 128,518	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	Facility	DODGE CARAVAN, 2000	9/29/2000	$ 20,792	$	$	$	5	$ 20,792	76
77	Facility	BUS, 12+2,2009 FORD E-SERIE	6/23/2009	50,940	7,277	7,277		7	25,470	77
78	Facility	TRUCK,PICKUP,'09 FORD F-2	7/13/2009	26,721	3,817	3,817		7	13,361	78
79										79
80	TOTALS			$ 98,453	$ 11,094	$ 11,094	$		$ 59,623	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)	$ 10,230,214	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 445,927	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 445,927	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)	$ 495,061	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	SNF - Laundry	$ 1,840,846	$ 69,232	$ 69,232	86
87	SNF - Site Improvements - 2009	538,862	27,126	93,842	87
88	SNF - Building Improvements - 2009	544,600	25,124	88,133	88
89	Independent Living	33,600,159	1,399,302	5,828,048	89
90	Assisted Living	8,549,062	385,700	1,344,752	90
91	TOTALS	$ 45,073,529	$ 1,906,484	$ 7,424,007	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	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 Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	2,586	$ 171,763	$	2,586	$ 171,763	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		587	48,325	2,509	587	50,834	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		2,914	192,346	726	2,914	193,072	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				90,733		90,733	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	TOTAL			$	6,087	$ 412,434	$ 93,968	6,087	$ 506,402	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 Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,792,141	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	394,908		3
4	Supply Inventory (priced at)	44,063		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,347		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	136,473		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,389,932	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,721		12
13	Land	1,126,732		13
14	Buildings, at Historical Cost	51,481,692		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,695,319		16
17	Accumulated Depreciation (book methods)	(7,919,069)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Marketing Costs	590,959		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,993,354	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 59,383,286	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,518	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	239,702		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,983		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	10,987		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 424,190	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	889,594		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to LSS - Related Party	48,740,160		43
44	Entrance Fees and Resident Deposits	18,360,858		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 67,990,612	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 68,414,802	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (9,031,516)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 59,383,286	$	48

*(See instructions.)

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,237,551)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,237,551)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,793,965)	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)**	$ (1,793,965)	17
	B. Transfers (Itemize):		
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)**	$ (9,031,516)	24 *

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,029,809	1
2	Discounts and Allowances for all Levels	(350,866)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,678,943	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	854,782	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 854,782	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,773	13
14	Non-Patient Meals	3,651	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,795	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,081	19
20	Radiology and X-Ray	2,071	20
21	Other Medical Services	38,659	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 156,030	23
	D. Non-Operating Revenue		
24	Contributions	7,040	24
25	Interest and Other Investment Income***	12,920	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,960	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	2,026	28
28a	IL and AL Revenue	6,859,896	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,861,922	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,571,637	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	692,650	31
32	Health Care	2,261,601	32
33	General Administration	1,509,593	33
	B. Capital Expense		
34	Ownership	1,121,120	34
	C. Ancillary Expense		
35	Special Cost Centers	7,672,234	35
36	Provider Participation Fee	108,402	36
	D. Other Expenses (specify):		
37	Rounding	2	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,365,602	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,793,965)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,793,965)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 25,134	44
45	Private Pay - Net Inpatient Revenue	2,942,624	45
46	Medicare - Net Inpatient Revenue	722,447	46
47	Other-(specify) Benevolent Care	(11,262)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,678,943	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 Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,907	2,080	$ 69,483	$ 33.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,989	13,140	363,108	27.63	3
4	Licensed Practical Nurses	17,216	18,229	437,227	23.99	4
5	CNAs & Orderlies	52,129	61,287	772,606	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,143	2,370	50,747	21.41	10
11	Social Service Workers	983	1,048	25,393	24.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,184	28,635	354,888	12.39	15
16	Dishwashers					16
17	Maintenance Workers	2,384	2,667	45,843	17.19	17
18	Housekeepers	594	641	6,843	10.68	18
19	Laundry	801	852	8,789	10.32	19
20	Administrator	1,960	2,080	88,027	42.32	20
21	Assistant Administrator					21
22	Other Administrative	9,824	10,763	188,220	17.49	22
23	Office Manager					23
24	Clerical					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	1,021	1,141	16,683	14.62	31
32	Other Health C: Marketing CC	1,597	1,720	38,751	22.53	32
33	Other(specify) IL and AL	86,771	91,259	1,176,231	12.89	33
34	TOTAL (lines 1 - 33)	214,503	237,912	$ 3,642,839 *	$ 15.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	7	$ 400	1-3	35
36	Medical Director	Monthly	16,500	9-3	36
37	Medical Records Consultant	17	1,390	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	510	1,785	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	534	$ 20,075		49

C. CONTRACT NURSES

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

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MaryAnn Walker	Care Center Administrator	0	$ 88,027
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,027

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Lutheran Senior Services	Management Services	$ 284,867
CliftonLarsonAllen LLP	Accounting Services	920
Smith,Hemmesch,Burke,Brannigan	Legal Services	319
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 286,106

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,570
Unemployment Compensation Insurance	7,878
FICA Taxes	203,297
Employee Health Insurance	252,548
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	4,655
Life Insurance	3,708
Pension	3,127
Savings and Revenue Sharing Plan	57,848
TOTAL (agree to Schedule V, line 22, col.8)	$ 635,631

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,491
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 85	850
LSN	1,565
AAHSA	619
State Journal Register	1,451
Other	1,669
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,635

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,172
Seminar Expense	7,900
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,072

**See instructions.

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Concordia Village Care Center # 0051078 Report Period Beginning: 5/1/2012 Ending: 12/31/2012

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 - $3,683; AAHSA $1,456**

(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?

(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?

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,246** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **108,402**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,651**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** 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? **100**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.