FOR BHF USE

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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: 0025023

Facility Name: Lutheran Care Center

Address: 702 West Cumberland Road (Number) Altamont (City) 62411 (Zip Code)

County: Effingham

Telephone Number: (618) 483-6136 **Fax #** (618) 483-5607

HFS ID Number:

Date of Initial License for Current Owners: 10/01/1980

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 10/1/11 to 9/30/12 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 N/A

	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	96	Skilled (SNF)	96	35,136	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	96	TOTALS	96	35,136	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	9,089	14,139	2,828	26,056	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,089	14,139	2,828	26,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.16%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

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 [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 10/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 96 and days of care provided 2,828

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/12 Fiscal Year: 9/30/12

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	312,375	37,270	6,528	356,173		356,173		356,173			1
2	Food Purchase		198,082		198,082		198,082	(25,586)	172,496			2
3	Housekeeping	94,135	19,375		113,510		113,510		113,510			3
4	Laundry	103,637	19,432		123,069		123,069		123,069			4
5	Heat and Other Utilities			106,688	106,688		106,688		106,688			5
6	Maintenance	48,607	6,293	33,374	88,274		88,274	128	88,402			6
7	Other (specify):*											7
8	TOTAL General Services	558,754	280,452	146,590	985,796		985,796	(25,458)	960,338			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,254,066	56,413	3,000	1,313,479		1,313,479		1,313,479			10
10a	Therapy											10a
11	Activities	166,847	1,962	1,862	170,671		170,671		170,671			11
12	Social Services	51,132	651	578	52,361		52,361		52,361			12
13	CNA Training											13
14	Program Transportation		670		670		670		670			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,472,045	59,696	11,440	1,543,181		1,543,181		1,543,181			16
	C. General Administration											
17	Administrative	81,948			81,948		81,948		81,948			17
18	Directors Fees											18
19	Professional Services			72,813	72,813		72,813		72,813			19
20	Dues, Fees, Subscriptions & Promotions			10,049	10,049		10,049	(259)	9,790			20
21	Clerical & General Office Expenses	120,128	6,416	43,790	170,334		170,334	(3,780)	166,554			21
22	Employee Benefits & Payroll Taxes			633,429	633,429		633,429	(11,394)	622,035			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,609	3,609		3,609		3,609			24
25	Other Admin. Staff Transportation		6,948		6,948		6,948		6,948			25
26	Insurance-Prop.Liab.Malpractice			61,114	61,114		61,114		61,114			26
27	Other (specify):*											27
28	TOTAL General Administration	202,076	13,364	824,804	1,040,244		1,040,244	(15,433)	1,024,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,232,875	353,512	982,834	3,569,221		3,569,221	(40,891)	3,528,330			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 Lutheran Care Center #0025023 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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			146,797	146,797		146,797	2,825	149,622			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,843	4,843		4,843	(1,698)	3,145			32
33	Real Estate Taxes			224	224		224	(224)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,328	4,328		4,328		4,328			35
36	Other (specify):*											36
37	**TOTAL Ownership**			156,192	156,192		156,192	903	157,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	174,664	78,383		253,047		253,047		253,047			39
40	Barber and Beauty Shops			18,731	18,731		18,731		18,731			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,236	221,236		221,236		221,236			42
43	Other (specify):* **Non-Allowable Cos**	329,280	72,408	356,105	757,793		757,793	(757,793)				43
44	**TOTAL Special Cost Centers**	503,944	150,791	596,072	1,250,807		1,250,807	(757,793)	493,014			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,736,819	504,303	1,735,098	4,976,220		4,976,220	(797,781)	4,178,439			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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	(25,586)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,215)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,953	30		9
10	Interest and Other Investment Income	(1,698)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,007)	43		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	(11,343)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,234)	20		28
29	Other-Attach Schedule See Pg 5A	(745,651)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (797,781)		$	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))**	$ (797,781)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/1/11

Ending: 9/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Medicare lab expense	$ (9,731)	43	1
2	Disallow Medicare x-ray expense	(13,227)	43	2
3	Disallow Medicare outpatient expense	(2,476)	43	3
4	Disallow personal purchases	(1,788)	43	4
5	Disallow non-care related real estate taxes	(224)	33	5
6	Disallow non-care related salaries	(329,280)	43	6
7	Disallow non-care related supplies	(72,408)	43	7
8	Disallow non-care related expenses	(302,318)	43	8
9	Disallow non-allowable chamber dues	(100)	20	9
10	Disallow promotional advertising	(157)	20	10
11				11
12	Offset miscellaneous revenue against misc. expense	(2,548)	21	12
13	Offset telephone income against telephone expense	0	21	13
14	Offset uniform income against uniform expense	(11,394)	22	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**	(745,651)		49

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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
N/A		N/A		N/A		

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 [X] 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			$	N/A		$	$	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			$			$	$ *	14

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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									$		1
2	See attached schedule of Board of Directors										2
3	Note: No members of the Board of Directors provided services to the nursing home nor owned business entities that provided services to the nursing home.										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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 [X]

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

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2				N/A						2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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**		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				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Mid-IL Bank & Trust		X	Line of Credit		06/18/11			06/18/13	0.0500	4,090	6
7	LSN		X	Amort int for wk comp	$4,002.00	12/01/09	139,719	11,963	12/01/13	0.0200	753	7
8												8
9	TOTAL Facility Related				$4,002.00		$ 139,719	$ 11,963			$ 4,843	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,698)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,698)	14
15	TOTALS (line 9+line14)						$ 139,719	$ 11,963			$ 3,145	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* 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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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.)	2011	$ 224	2
3. Under or (over) accrual (line 2 minus line 1).		$ 224	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.)	Non-Care	$ (224)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

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

Facility is a not-for-profit therefore not subject to real estate tax.
Non-care related real estate taxes have been removed from report on Sch V, Line 33, Col 7.

	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 Lutheran Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0025023

CONTACT PERSON REGARDING THIS REPORT Karen Hille

TELEPHONE (618) 483-6136 FAX #: (618) 483-5607

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.	09-02-016-021	Vacant Lot	$ 224.00	$
2.			$	$
3.	Facility is a not for profit entity therefore not subject to real estate taxes.		$	$
4.	Non-care related real estate taxes		$	$
5.	have been removed from report		$	$
6.	Sch V, Line 33, Col 7.		$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 224.00	$

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? X YES _____ NO

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

C. **Tax Bills**

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,884 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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. [X] (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).

Luther Villas - Independent Living 7 units- 7,700 square feet
Luther Terrace - Independent Living 16 units - 13,688 square feet
Child Enrichment Center - Day Care 4,219 square feet

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Resident Care	239,085	1980	$ 35,000	1
2	Resident Care	197,415	1987	28,900	2
3	TOTALS	436,500		$ 63,900	3

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	96		1980	1969	$ 867,500	$	25	$	$	$ 867,500	4
5			1980	1969	12,000		25			12,000	5
6			1980	1974	141,000		25			141,000	6
7			1980	1969	10,000		25			10,000	7
8			1980	1977	1,000		25			1,000	8
	Improvement Type**										
9	Therapy Room			1981	3,764		25			3,764	9
10	Land Improvements			1980	28,500		25			28,500	10
11	Land Improvements			1986	2,000		25	34	34	2,000	11
12	Land Improvements			1987	2,143		25	19	19	2,143	12
13	Land Improvements			1991	491	20	25	16	(4)	491	13
14	Building Improvements			1981	3,486		5			3,486	14
15	Building Improvements			1982	6,557		20			6,557	15
16	Building Improvements			1982	163		10			163	16
17	Building Improvements			1985	940		10			940	17
18	Building Improvements			1985	2,512		20			2,512	18
19	Building Improvements			1986	955		10			955	19
20	Building Improvements			1986	1,949		20			1,949	20
21	Building Improvements			1987	2,150		10			2,150	21
22	Building Improvements			1987	1,023		20			1,023	22
23	Building Improvements			1988	1,500		10			1,500	23
24	Building Improvements			1989	16,021		10			16,021	24
25	Building Improvements			1989	241		15			241	25
26	Building Improvements			1989	14,979		20			14,979	26
27	Building Improvements			1990	6,315		5			6,315	27
28	Building Improvements			1990	20,381		10			20,381	28
29	Building Improvements			1990	10,176		15			10,176	29
30	Building Improvements			1990	1,656		20			1,656	30
31	Building Improvements			1991	6,000		10			6,000	31
32	Building Improvements			1992	7,122		7			7,122	32
33	Building Improvements			1992	4,345		10			4,345	33
34	Misc Flooring/ Wallpaper			1993	3,762		5			3,762	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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	Dining Room	1993	$ 82,632	$ 2,623	31.5	$ 2,623	$	$ 49,511	37
38	Sprinkler System	1994	31,932	798	40	798		14,538	38
39	Additional Patio Work	1994	1,725	43	40	43		781	39
40	Dining Room Floor	1994	2,788	70	40	70		1,271	40
41	Breakroom Wallpaper	1994	302	8	40	8		145	41
42	Admin Office Wallpaper	1994	381	10	40	10		180	42
43	Lobby Wall Covering	1994	2,759	69	40	69		1,254	43
44	Floor Tile	1994	683	17	40	17		309	44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		636	45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		3,631	46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		384	47
48	Misc. Land Improvements	1994	1,279	32	40	32		584	48
49	Building Improvements	1995	7,804	195	40	195		3,452	49
50	Carpet for Lobby	1995	1,465		10			1,465	50
51	Office Wallpaper	1995	622		10			622	51
52	Front Office Wallpaper	1995	825		10			825	52
53	Activity Office Counter Top	1995	1,575		10			1,575	53
54	Flooring North Hall	1996	717		10			717	54
55	Air Conditioner Unit	1996	8,400		10			8,400	55
56	Air Conditioner Unit	1996	940		10			940	56
57	Air Conditioner Unit	1996	560		10			560	57
58	Gas Line	1996	947		10			947	58
59	Flooring Halls	1995	1,822		10			1,822	59
60	Flooring Halls	1994	1,267		10			1,267	60
61	Fire Alarm System	1996	2,429		10			2,429	61
62	Building Improvements	1996	697		10			697	62
63	Parking lot improvements	1997	1,500	75	20	75		1,163	63
64	Parking lot improvements	1997	2,510		10			2,510	64
65	Electrical wiring	1997	1,171		10			1,171	65
66	5 ton air conditioner unit	1997	5,330		10			5,330	66
67	Front entrance awning	1997	2,867		10			2,867	67
68	Electrical wiring	1997	966		10			966	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,359,743	$ 4,215		$ 4,264	$ 49	$ 1,293,580	70

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	
1	Totals from Page 12A, Carried Forward		$ 1,359,743	$ 4,215		$ 4,264	$ 49	$ 1,293,580	1
2	New administrative offices	1997	77,471	2,905	40	2,905		34,453	2
3	Dietary refrigeration system	1997	18,095		10			18,095	3
4	Cabinets & counter tops	1997	11,664		10			11,664	4
5	Roof	1998	178,417	8,921	20	8,921		129,354	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms)	1998	2,445	122	20	122		1,770	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms)	1998	384		10			384	7
8	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	834		10			834	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Rooms)	1998	3,548		10			3,548	9
10	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Medicare R	1998	2,576		10			2,576	10
11	Parking lot improvements	1998	1,298		10			1,298	11
12									12
13	Building Improvements - per 1994 audit	1981	1,140		10			1,140	13
14	Building Improvements - per 1994 audit	1982	2,159		10			2,159	14
15	Building Improvements - per 1994 audit	1984	1,677		10			1,677	15
16									16
17	Landscaping	1999	4,080	204	20	204		2,754	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295		10			295	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196		10			196	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474		10			1,474	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms)	1999	652		10			652	21
22	Cove base (Medicare room remodeling)	1999	77		10			77	22
23	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		2,132	23
24	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		4,766	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		3,067	25
26	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		1,824	26
27	Air Conditioner Improvements	1999	677		5			677	27
28	Wallcoverings, hand rails, chair rails (Remodeling - Medicare Rooms)	2000	1,684		10			1,684	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056		10			2,056	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59		10			59	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853		10			8,853	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59		10			59	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,699,093	$ 17,240		$ 17,289	$ 49	$ 1,533,157	34

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	
1	Totals from Page 12B, Carried Forward		$ 1,699,093	$ 17,240		$ 17,289	$ 49	$ 1,533,157	1
2	Sidewalk	2000	2,300	115	20	115		1,438	2
3	Flooring	2002	6,306	364	10	364		6,306	3
4	Windows	2002	3,635	306	10	298	(8)	3,635	4
5	Seed for lawn	2001	425	21	20	22	1	425	5
6	Chapel	2002	414,840	10,371	40	10,371		104,575	6
7	Windows	2002	26,539	2,432	10	2,432		26,539	7
8	Sidewalk	2002	2,083	194	10	194		2,083	8
9	Cabinets	2002	9,246	925	10	925		9,327	9
10	Wiring	2002	5,107	465	10	465		5,107	10
11	Landscaping	2002	6,280	576	10	576		6,280	11
12	Screen	2002	1,716	154	10	154		1,716	12
13	Cable	2002	7,954	732	10	733	1	7,954	13
14	Door guard	2002	4,955	458	10	450	(8)	4,955	14
15									15
16	Driveway & parking lot	2002	87,004	8,700	10	8,700		82,650	16
17	Plants/Rocks/Stone	2003	853	85	10	85		808	17
18	Window replacement project	2003	14,285	1,429	10	1,429		13,575	18
19	Laundry replacement	2002	1,983	198	10	198		1,881	19
20	Painting - hallways & west wing	2003	6,347	635	10	635		6,032	20
21	Painting - hallways	2003	2,230	223	10	223		2,119	21
22	Paintings - hallways	2003	5,000	500	10	500		4,500	22
23	Counter tops & cabinets	2003	696		7			696	23
24									24
25	Garage Expansion	2004	15,214	761	20	761		6,468	25
26	Room Painting and Wallpaper	2004	17,526	1,753	10	1,753		14,887	26
27	Painting building, trim, & eves	2004	1,978	198	10	198		1,600	27
28	Generator	2004	160,787	16,078	10	16,078		129,965	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,504,382	$ 64,913		$ 64,948	$ 35	$ 1,978,678	34

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	
1	Totals from Page 12C, Carried Forward		$ 2,504,382	$ 64,913		$ 64,948	$ 35	$ 1,978,678	1
2	Paint	2004	371	37	10	37		293	2
3	Window Coverings	2004	3,307	331	10	331		2,620	3
4	Wiring	2004	11,383	569	20	569		4,457	4
5	Garage Expansion	2005	373	19	20	19		144	5
6	Window Tint	2005	510	51	10	51		387	6
7	Rocks	2005	116	12	10	12		85	7
8									8
9	Review fee to IDPH for Therapy Building Plans	2006	6,000	240	25	240		1,560	9
10	Architecture Fees for Therapy building	2006	26,205	1,048	25	1,048		6,812	10
11									11
12	Physical Therapy/Activity Room Addition	2007	365,881	18,294	20	18,294		100,649	12
13	Fire Sprinklers	2006	12,201	1,220	10	1,220		6,751	13
14	Gutters & Awnings	2007	4,840	484	10	484		2,646	14
15	Architecture Fees for Therapy building	2007	14,956	748	20	748		4,057	15
16	A/C Unit for Kitchen	2007	4,863	486	10	486		2,673	16
17	Cabinets	2007	4,741	474	10	474		2,627	17
18	Bath Tub w/ Lift	2007	16,560	1,656	10	1,656		8,763	18
19	Blinds/Wallpaper	2007	3,999	400	10	400		2,200	19
20									20
21	Seal Concrete	2008	2,951	422	7	422		1,899	21
22	Kitchen	2008	57,030	3,802	10-20	3,802		17,109	22
23									23
24	Therapy and heart to heart department addition-	2009	71,079	4,739	15	4,739		16,586	24
25	(plumbing, electrical,painting)								25
26	Curt Reardon - Installation	2009	2,510	502	5	502		920	26
27	Lobby - Paint/Furniture	2009	5,768	667	15	667		1,629	27
28									28
29	Roof Addition	2010	75,292	3,764	20	3,764		9,410	29
30									30
31	Air conditioner	2010	7,200	720	10	720		978	31
32	Sprinkler system	2011	14,535	581	25	581		1,114	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,217,053	$ 106,179		$ 106,214	$ 35	$ 2,175,047	34

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	
1	Totals from Page 12D, Carried Forward		$ 3,217,053	$ 106,179		$ 106,214	$ 35	$ 2,175,047	1
2	Dining Room Renovation								2
3	- Flooring, cabinets, piping, cabling & phone lines	2011	50,483	3,360	15	3,360		3,867	3
4	- Painting, plexiglass	2011	7,853	1,571	5	1,571		1,829	4
5	- Electrical work	2011	5,475	274	20	274		297	5
6									6
7	Sprinklers	2011	5,000	333	15	333		416	7
8	Heat/AC in Heart to Heart department	2011	2,615	261	10	261		326	8
9									9
10	Flooring - North and South Hall	2011	10,000	458	20	458		458	10
11									11
12	Sprinkler System - Nursing Home	2012	6,580	219	20	219		219	12
13	Sprinkler System - Nursing Home	2012	9,700	283	20	283		283	13
14	Flooring - North and South Hall	2012	7,059	176	20	176		176	14
15	Nurses Desk-Built In - North and South Hall	2012	3,316	83	20	83		83	15
16	Sprinkler System - Nursing Home	2012	11,667	243	20	243		243	16
17	Fan Coil - Chapel Offices (Moved from Repairs)	2012	3,267	163	10	163		163	17
18									18
19									19
20	Reconcile to FS			(2,790)			2,790		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,340,068	$ 110,813		$ 113,638	$ 2,825	$ 2,183,407	34

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	$ 238,059	$ 31,529	$ 31,529	$	5-25	$ 179,047	71
72	Current Year Purchases	26,577	1,011	1,011		5-15	1,011	72
73	Fully Depreciated Assets	684,118					684,118	73
74								74
75	TOTALS	$ 948,754	$ 32,540	$ 32,540	$		$ 864,176	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 use	2001 Dodge E250 van	2001	$ 39,825	$	$	$	5	$ 39,825	76
77	Facility use	2011 Dodge Grand Caravan	2011	37,570	3,444	3,444		10	3,444	77
78	Facility use	Chevy Lumina	2004	5,675				5	5,675	78
79										79
80	TOTALS			$ 83,070	$ 3,444	$ 3,444	$		$ 48,944	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)	$ 4,435,792	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,797	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,622	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,825	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,096,527	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	Luther Villas & Luther Terrace	$ 2,195,556	$ 82,346	$ 797,755	86
87	Child Enrichment Center	524,317	23,120	64,635	87
88					88
89					89
90					90
91	TOTALS	$ 2,719,873	$ 105,466	$ 862,390	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Lutheran Villas	$ 7,000	92
93			93
94			94
95		$ 7,000	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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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:				$ N/A			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. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: $ 4,328 Description: Dishwasher lease - 833; Nursing Eqpt. - 3,495
    (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			$ N/A	$	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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

It is the policy of this facility to only hire certified nurses aides.

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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	39(1)	682 hrs	$ 16,686		$	$	682	$ 16,686	1
2	Licensed Speech and Language Development Therapist	39(1)	396 hrs	9,688				396	9,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(1,2)	6063 hrs	148,290			65	6,063	148,355	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				78,318		78,318	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			$ 174,664		$	$ 78,383	7,141	$ 253,047	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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/12 (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	$ 602,952	$ 602,952	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 29,172)	580,647	580,647	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,534	13,534	6
7	Other Prepaid Expenses	19,222	19,222	7
8	Accounts Receivable (owners or related parties)	1	1	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,216,356	$ 1,216,356	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	3,095,804	2,959,111	14
15	Leasehold Improvements, at Historical Cost	160,787	380,957	15
16	Equipment, at Historical Cost	1,040,267	1,031,824	16
17	Accumulated Depreciation (Book Method)	(2,945,036)	(3,096,527)	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 (spe CIP	7,000	7,000	22
23	Other(specify): Net F/A Villas, Terrace CEC	1,692,683	1,807,286	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,115,215	$ 3,153,551	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,331,571	$ 4,369,907	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 66,577	$ 66,577	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,885	226,885	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,618	64,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Payroll Liabilities	15,931	15,931	36
37	See Schedule 17A	3,927	3,927	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 380,853	$ 380,853	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Lutheran Villas-Endowment Fund	453,443	453,443	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 453,443	$ 453,443	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 834,296	$ 834,296	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,497,275	$ 3,535,611	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,331,571	$ 4,369,907	48

***(See instructions.)**

XV. BALANCE SHEET - Unrestricted Operating Fund.
Line 37

Description	Operating	After Consolidation
Resident allowances	60	60
Resident funds	3,866	3,866
Note Payable - Building Fund	1	1
	3,927	3,927

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,655,963	1
2	Restatements (describe):		2
3	**Adjustment subsequent to prior year cost report preparation**	(11,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,644,963	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(147,688)	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)**	$ (147,688)	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)**	$ 3,497,275	24 *

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	$ 3,453,585	1
2	Discounts and Allowances for all Levels	3,263	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,456,848	3
	B. Ancillary Revenue		
4	Day Care	267,249	4
5	Other Care for Outpatients		5
6	Therapy	236,627	6
7	Oxygen	11,822	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 515,698	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	21,834	13
14	Non-Patient Meals	30,593	14
15	Telephone, Television and Radio	76	15
16	Rental of Facility Space		16
17	Sale of Drugs	113,910	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,742	19
20	Radiology and X-Ray		20
21	Other Medical Services	43,517	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 234,672	23
	D. Non-Operating Revenue		
24	Contributions	103,109	24
25	Interest and Other Investment Income***	1,836	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104,945	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	516,369	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 516,369	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,828,532	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	985,796	31
32	Health Care	1,543,181	32
33	General Administration	1,040,244	33
	B. Capital Expense		
34	Ownership	156,192	34
	C. Ancillary Expense		
35	Special Cost Centers	1,029,571	35
36	Provider Participation Fee	221,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,976,220	40
41	**Income before Income Taxes (line 30 minus line 40)****	(147,688)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (147,688)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,027,694	44
45	Private Pay - Net Inpatient Revenue	1,855,726	45
46	Medicare - Net Inpatient Revenue	573,428	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,456,848	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No - NFP 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.**

Lutheran Care Center
Provider # 0025023
10/1/11-9/30/12

Schedule 19A

XVII. INCOME STATEMENT
E. Other Revenue
Line 28

Description	Amount
Personal Purchase Income	6,005
Employee Uniform Income	11,394
Miscellaneous Income	2,548
LV Rent Income	108,712
LV Endowment Income	78,389
LV Misc. Income	240
LT Rent Income	308,050
LT Employee Uniform Income	166
LT Misc. Income	855
CEC Employee Uniform Income	10
	516,369

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	1,744	1,968	$ 59,720	$ 30.35	1
2	Assistant Director of Nursing	1,796	1,964	46,706	23.78	2
3	Registered Nurses	4,615	4,863	109,432	22.50	3
4	Licensed Practical Nurses	15,486	16,750	264,035	15.76	4
5	CNAs & Orderlies	60,591	65,379	687,467	10.52	5
6	CNA Trainees					6
7	Licensed Therapist	3,614	3,902	95,443	24.46	7
8	Rehab/Therapy Aides	3,914	4,317	79,221	18.35	8
9	Activity Director	1,783	1,996	29,317	14.69	9
10	Activity Assistants	13,704	14,390	137,530	9.56	10
11	Social Service Workers	2,051	2,272	51,132	22.51	11
12	Dietician	1,675	1,884	31,845	16.90	12
13	Food Service Supervisor	1,584	1,752	21,903	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,934	24,949	258,627	10.37	15
16	Dishwashers					16
17	Maintenance Workers	2,586	2,802	48,607	17.35	17
18	Housekeepers	9,100	9,778	94,135	9.63	18
19	Laundry	8,507	9,440	103,637	10.98	19
20	Administrator	1,730	1,971	81,948	41.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,034	2,249	50,605	22.50	23
24	Clerical	5,068	5,596	69,523	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health CSee Pg 20A	5,271	5,844	86,706	14.84	32
33	Other(specify) See Pg 20A	30,329	32,589	329,280	10.10	33
34	TOTAL (lines 1 - 33)	200,116	216,655	$ 2,736,819 *	$ 12.63	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	135	$ 6,348	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	2,056	10(3)	37
38	Nurse Consultant	Monthly	404	10(3)	38
39	Pharmacist Consultant	Monthly	540	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	36	578	11(3)	44
45	Social Service Consultant	36	578	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	$ 16,504		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Lutheran Care Center
Provider #: 0025023
10/1/2011 to 9/30/2012 **Schedule 20A**

XVIII. A: STAFFING AND SALARY COSTS
Line 32: Other Health Care (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Care Plan Nurse	1,511	1,756	38,550	21.95
Quality Assurance Coordinator	1,486	1,694	24,386	14.40
Ward Clerk	2,274	2,394	23,770	9.93
	5,271	5,844	86,706	14.84

Line 33: Other (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Independent Living Facility	12,704	13,586	142,570	10.49
Child Enrichment Center	17,625	19,003	186,710	9.83
	30,329	32,589	329,280	10.10

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0	$ 81,948
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,948

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
Paymaster	Payroll Services	$ 7,406
McGladrey LLP	Accounting	50,738
Achieve	Computer Services	14,441
Taylor Law Offices	Legal	228
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 72,813

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,751
Unemployment Compensation Insurance	(18)
FICA Taxes	175,518
Employee Health Insurance	316,047
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	75
Other Employee Benefits	25,680
Employee Uniforms	982
TOTAL (agree to Schedule V, line 22, col.8)	$ 622,035

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	874
Health Care Worker Background Check	
(Indicate # of checks performed 77)	
Patient Background Checks	1,232
Life Services Network	3,110
MediaComm	767
Miscellaneous Dues & Subscriptions	3,907
Promotional Advertising	1,234
Newsletter Expense	157
Less: Public Relations Expense	(100)
Non-allowable advertising	(157)
Yellow page advertising	(1,234)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,790

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,422
Seminar Expense	2,187
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,609

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/11 Ending: 9/30/12

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			$		$	$	$	$	$	$	$	$	$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lutheran Care Center **#** 0025023 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $3,110**

(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? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,773** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **221,236**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **25,586**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **.03%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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: **McGladrey 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.