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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0025023

Facility Name: Lutheran Care Center

Address: 702 West Cumberland (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: Karen Hille **Telephone Number:** (618) 483-6136
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 10/1/13 to 9/30/14 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) Karen Hille
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Steve Howell, Director
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis MO 63101
(Telephone) (314) 925-4497 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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	35,040	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	35,040	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	9,186	15,163	2,173	26,522	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,186	15,163	2,173	26,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.69%

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)
Daycare

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 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 2,173

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/14 Fiscal Year: 9/30/14

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,689	23,968	6,616	344,273		344,273		344,273			1
2	Food Purchase		206,612		206,612		206,612	(27,629)	178,983			2
3	Housekeeping	101,971	17,095		119,066		119,066		119,066			3
4	Laundry	100,278	13,339		113,617		113,617		113,617			4
5	Heat and Other Utilities			116,574	116,574		116,574		116,574			5
6	Maintenance	56,616	4,161	26,559	87,336		87,336		87,336			6
7	Other (specify):*											7
8	TOTAL General Services	572,554	265,175	149,749	987,478		987,478	(27,629)	959,849			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,190,510	96,673	2,920	1,290,103		1,290,103		1,290,103			10
10a	Therapy	176,302	203		176,505		176,505		176,505			10a
11	Activities	175,507	1,116	1,856	178,479		178,479		178,479			11
12	Social Services	57,946	416	584	58,946		58,946		58,946			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,600,265	98,408	10,860	1,709,533		1,709,533		1,709,533			16
	C. General Administration											
17	Administrative	83,486			83,486		83,486		83,486			17
18	Directors Fees											18
19	Professional Services			68,673	68,673		68,673		68,673			19
20	Dues, Fees, Subscriptions & Promotions			17,177	17,177		17,177	(2,764)	14,413			20
21	Clerical & General Office Expenses	128,255	4,423	57,531	190,209		190,209	(15,593)	174,616			21
22	Employee Benefits & Payroll Taxes			804,353	804,353		804,353	(7,690)	796,663			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,651	1,651		1,651		1,651			24
25	Other Admin. Staff Transportation		6,708		6,708		6,708		6,708			25
26	Insurance-Prop.Liab.Malpractice			46,380	46,380		46,380		46,380			26
27	Other (specify):*											27
28	TOTAL General Administration	211,741	11,131	995,765	1,218,637		1,218,637	(26,047)	1,192,590			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,384,560	374,714	1,156,374	3,915,648		3,915,648	(53,676)	3,861,972			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: 10/1/13 Ending: 9/30/14

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			135,926	135,926		135,926		135,926			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,903	4,903		4,903	(1,122)	3,781			32
33	Real Estate Taxes			218	218		218	(218)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,183	1,183		1,183		1,183			35
36	Other (specify):*											36
37	**TOTAL Ownership**			142,230	142,230		142,230	(1,340)	140,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			20,086	20,086		20,086		20,086			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,280	200,280		200,280		200,280			42
43	Other (specify):*	362,587	82,747	339,233	784,567		784,567	(784,567)				43
44	**TOTAL Special Cost Centers**	362,587	82,747	559,599	1,004,933		1,004,933	(784,567)	220,366			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,747,147	457,461	1,858,203	5,062,811		5,062,811	(839,583)	4,223,228			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: 10/1/13 Ending: 9/30/14

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	(27,629)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,122)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(2,764)	20		28
29	Other-Attach Schedule	(808,068)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (839,583)		$	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))**	$ (839,583)		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

STATE OF ILLINOIS **Page 5A**

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/1/13

Ending: 9/30/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-care related salaries	$ (362,587)	43	1
2	Non-care related supplies	(82,747)	43	2
3	Non-care related expenses	(339,233)	43	3
4	Offset Miscellaneous revenue against expense	(15,593)	21	4
5	OffsetUniform revenue against expense	(7,690)	22	5
6	Non-care related real estate taxes	(218)	33	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				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**	(808,068)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center **#** 0025023 **Report Period Beginning:** 10/1/13 **Ending:** 9/30/14

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	(27,629)	0	0	0	0	0	0	0	0	0	0	(27,629)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(27,629)	0	0	0	0	0	0	0	0	0	0	(27,629)	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	20
21	Clerical & General Office Expenses	(15,593)	0	0	0	0	0	0	0	0	0	0	(15,593)	21
22	Employee Benefits & Payroll Taxes	(7,690)	0	0	0	0	0	0	0	0	0	0	(7,690)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,047)	0	0	0	0	0	0	0	0	0	0	(26,047)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(53,676)	0	0	0	0	0	0	0	0	0	0	(53,676)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center **#** 0025023 **Report Period Beginning:** 10/1/13 **Ending:** 9/30/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	32
33	Real Estate Taxes	(218)	0	0	0	0	0	0	0	0	0	0	(218)	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**	(1,340)	0	0	0	0	0	0	0	0	0	0	(1,340)	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	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(784,567)	0	0	0	0	0	0	0	0	0	0	(784,567)	43
44	**TOTAL Special Cost Centers**	(784,567)	0	0	0	0	0	0	0	0	0	0	(784,567)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(839,583)	0	0	0	0	0	0	0	0	0	0	(839,583)	45

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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						

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			$			$	$	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: 10/1/13 Ending: 9/30/14

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2	Note: No members of the Board provided services to the nursing home nor owned business entities that provided services to the nursing home										2
3	See attached list of Board of Directors										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: 10/1/13 Ending: 9/30/14

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										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: 10/1/13 Ending: 9/30/14

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National Bank		X	Line of Credit		8/25/14	211,536	189,644	8/25/15	0.0325	4,664	6
7	LSN		X	Amort int for wk comp	$4,002.00	12/01/09	139,719		12/1/13	0.0200	239	7
8												8
9	**TOTAL Facility Related**				$4,002.00		$ 351,255	$ 189,644			$ 4,903	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 351,255	$ 189,644			$ 4,903	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:** 10/1/13 **Ending:** 9/30/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 218	2
3. Under or (over) accrual (line 2 minus line 1).		$ 218	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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.		$ 218	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	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 or
Sch V, Line 33, Col 7.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-02-016-021	Vacant Lot	$ 218.00	$
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	$ 218.00	$

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,884 B. General Construction Type: Exterior Brick Frame Steel 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).

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:
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	Resident Care	239,085	1980	$ 35,000	1
2	Resident Care	197,415	1987	28,710	2
3	TOTALS	436,500		$ 63,710	3

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	Land Improvements			1980	28,500		25				9
10	Land Improvements			1986	2,000		25			2,000	10
11	Land Improvements			1991	491	20	25	20		458	11
12	Building Improvements			1981	3,485		5			3,485	12
13	Building Improvements			1982	6,557		20			6,557	13
14	Building Improvements			1982	163		10			163	14
15	Building Improvements			1985	940		10			940	15
16	Building Improvements			1985	2,512		20			2,512	16
17	Building Improvements			1986	955		10			955	17
18	Building Improvements			1986	1,949		20			1,949	18
19	Building Improvements			1987	2,150		10			2,150	19
20	Building Improvements			1987	1,023		20			1,023	20
21	Building Improvements			1988	1,500		10			1,500	21
22	Building Improvements			1989	16,021		10			16,021	22
23	Building Improvements			1989	241		15			241	23
24	Building Improvements			1989	14,979		20			14,979	24
25	Building Improvements			1990	6,315		5			6,315	25
26	Building Improvements			1990	20,381		10			20,381	26
27	Building Improvements			1990	10,176		15			10,176	27
28	Building Improvements			1990	1,656		20			1,656	28
29	Building Improvements			1991	6,000		10			6,000	29
30	Building Improvements			1992	7,122		7			7,122	30
31	Building Improvements			1992	4,345		10			4,345	31
32	Misc. Flooring/ Wallpaper			1993	3,762		5			3,762	32
33	Sprinkler System			1994	31,932	799	40	799		16,167	33
34	Additional Patio Work			1994	1,725	42	40	42		873	34
35	Breakroom Wallpaper			1994	302	8	40	8		153	35
36	Admin Office Wallpaper			1994	381	10	40	10		193	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: 10/1/13 Ending: 9/30/14

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	Floor Tile	1994	$ 683	$ 17	40	$ 17	$	$ 346	37
38	Misc. Building Improvements	1994	1,408	35	40	35		713	38
39	Land Improvements- Sewer Line	1994	7,949	199	40	199		4,025	39
40	Land Imp. - Drainage Pipe	1994	860	22	40	22		435	40
41	Misc. Land Improvements	1994	1,279	32	40	32		648	41
42	Building Improvements	1995	7,804	195	40	195		3,854	42
43	Office Wallpaper	1995	622		10			622	43
44	Front Office Wallpaper	1995	825		10			825	44
45	Activity Office Counter Top	1995	1,575		10			1,575	45
46	Air Conditioner Unit	1996	8,400		10			8,400	46
47	Air Conditioner Unit	1996	940		10			940	47
48	Air Conditioner Unit	1996	560		10			560	48
49	Gas Line	1996	947		10			947	49
50	Fire Alarm System	1996	2,429		10			2,429	50
51	Building Improvements	1996	697		10			697	51
52	Electrical Wiring	1997	1,171		10			1,171	52
53	Electrical Wiring	1997	966		10			966	53
54	Cabinets and Counter Tops	1997	11,664		10			11,664	54
55	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Ro	1998	2,445	122	20	122		2,048	55
56	Plumbing, blinds, lighting (Remodeling-Medicare Rooms)	1998	1,220		10			1,220	56
57	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	834		10			834	57
58	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Room	1998	3,548		10			3,548	58
59	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Med	1998	3,543		10			3,543	59
60	Landscaping	1999	4,080	204	20	204		3,128	60
61	Closets (Remodeling-Medicare Rooms)	1999	1,474		10			1,474	61
62	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		2,459	62
63	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		5,474	63
64	Brick work (Laundry Expansion)	1999	4,553	228	20	228		3,509	64
65	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		2,076	65
66	Air conditioner improvements	1999	677		5			677	66
67	Flooring	2002	6,306		10			6,306	67
68	Windows	2002	3,635		10			3,635	68
69	Seed for Lawn	2001	425	21	20	21		273	69
70	TOTAL (lines 4 thru 69)		$ 1,305,509	$ 2,600		$ 2,600	$	$ 1,244,597	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: 10/1/13 Ending: 9/30/14

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		$ 1,305,509	$ 2,600		$ 2,600	$	$ 1,244,597	1
2	Chapel- Updated to 6/30/07 Audit Findings	2002	187,539	4,810	40	4,810		70,142	2
3	Windows- Updated to 6/30/07 Audit Findings	2002	13,270		10			13,270	3
4	Sidewalk- Updated to 6/30/07 Audit Findings	2002	1,042		10			1,042	4
5	Cabinets- Updated to 6/30/07 Audit Findings	2002	4,623		10			4,623	5
6	Wiring- Updated to 6/30/07 Audit Findings	2002	1,299		10			1,299	6
7	Landscaping- Updated to 6/30/07 Audit Findings	2002	3,140		10			3,140	7
8	Screen	2002	1,716		10			1,716	8
9	Cable- Updated to 6/30/07 Audit Findings	2002	3,977		10			3,977	9
10	Door Guard- Updated to 6/30/07 Audit Findings	2002	2,478		10			2,478	10
11	Driveway & parking lot	2002	87,004	4,350	10	4,350		52,203	11
12	Plants/Rock/Stone	2003	853		10			853	12
13	Window replacement project	2003	14,285		10			14,285	13
14	Laundry replacement	2002	1,983		10			1,983	14
15	Painting- hallways and west wing	2003	6,347		10			6,347	15
16	Painting- hallways	2003	2,230		10			2,230	16
17	Garage expansion	2004	15,214	761	20	761		7,797	17
18	Room painting and wall paper	2004	17,526	1,023	10	1,023		17,526	18
19	Painting building, trim & eaves	2004	1,978	182	10	182		1,978	19
20	Generator- Updated to 6/30/07 Audit findings	2004	101,836	10,184	10	10,184		101,836	20
21	Paint	2004	371	38	10	38		371	21
22	Window Coverings	2004	3,307	331	10	331		3,307	22
23	Wiring	2004	11,383	569	20	569		5,644	23
24	GARAGE EXPANSION 49	2005	373	19	20	19		180	24
25	WINDOW TINT	2005	255	26	10	26		247	25
26	LANDSCAPING-ROCKS	2005	116	11	10	11		105	26
27	Review fee to IDPH for Therapy Building Plans	2006	6,000	240	25	240		2,060	27
28	Architecture fees for Therapy Building	2006	26,205	1,048	25	1,048		8,997	28
29	Physical Therapy/Activity Room Addition	2007	294,126	15,172	VARIOUS	15,172		119,844	29
30	Seal Concrete	2008	2,951	422	7	422		2,670	30
31	Kitchen	2008	57,030	4,290	VARIOUS	4,290		27,386	31
32	Curt Reardon- Installation of Lobby Flooring	2009	2,510	251	6	251		1,381	32
33	Roof Addition	2010	75,292	7,529	10	7,529		31,776	33
34	TOTAL (lines 1 thru 33)		$ 2,253,768	$ 53,856		$ 53,856	$	$ 1,757,290	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: 10/1/13 Ending: 9/30/14

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		$ 2,253,768	$ 53,856		$ 53,856	$	$ 1,757,290	1
2	Air Conditioner- South Hall	2010	7,200	288	10	288		1,152	2
3	Sprinkler System	2011	14,535		25				3
4	Dining Room Renovation								4
5	- Flooring, molding, counter tops	2011	22,589		15				5
6	- Painting	2011	2,539		5				6
7	- Electrical Work	2011	1,989		20				7
8	- Cabinets, counter tops, molding, piping, cabling & phone lines	2011	25,856		10				8
9	- Painting, plexiglass	2011	5,315		10				9
10	- Electrical Work	2011	3,919		10				10
11	Sprinklers	2011	5,000		15				11
12	Heat/ AC in Heart to Heart department	2011	2,615		10				12
13	Resident Hallway Flooring - North and South Halls	2012	20,375		20				13
14	Resident Hallway Sprinkler System- North and South Halls	2012	27,947		40				14
15	Fan Coil - Chapel Offices (Capitalized from Repairs)	2012	1,634		10				15
16	Flooring - Chapel Hall and DON office	2012	4,040		10				16
17	Sprinkler Protection, Dry Pendent & Air Compressor in Cooler, #5	2013	6,190		24				17
18	Boiler Installation: North & South Wings, #516	2013	15,500		20				18
19	Awning - Front of LCC Entrance, #517	2013	4,000		5				19
20	Replace Hall Lights: Remove and Install New Fixtures to Wall	2013	3,183		10				20
21	Rock and Pea Gravel, #522	2013	75		5				21
22	A/C Unit, Activity, #524	2013	2,595		10				22
23	Gutters, #523	2013	2,300		20				23
24	LCC Building Flooring, Painting, Wiring, #489,490,495,497-499,50	2013	9,243		10				24
25	FIRE DOOR CLOSER	2014	1,850	82	15	82		82	25
26	GUTTERS OUTSIDE OF ANNEX	2014	350	6	20	6		6	26
27	PATIO COVER, AMERICANA SIERRA 40'X10'	2014	3,803	127	15	127		127	27
28	PRO FIT 3 TOILET, WHITE	2014	149	22	5	22		22	28
29	SCALLOP PICKET FENCE	2014	5,548	277	10	277		277	29
30	PLANTS FOR COURTYARD	2014	540	23	10	23		23	30
31	LIGHTS AROUND SIDEWALKS-CRTYRD	2014	2,152	72	10	72		72	31
32									32
33	Tie to FS		(3)	88		88		(2)	33
34	TOTAL (lines 1 thru 33)		$ 2,456,796	$ 54,841		$ 54,841	$	$ 1,759,049	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: 10/1/13 Ending: 9/30/14

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		$ 2,456,796	$ 54,841		$ 54,841	$	$ 1,759,049	1
2	1980 Building (Adjustment)	1980	(1,276)					(1,276)	2
3	1980 Improvements (Adjustment)	1980	2,160						3
4	1981 Improvements (Adjustment)	1981	1					1	4
5	1986 Improvements (Adjustment)	1986	2,143					2,143	5
6	1989 Improvements (Adjustment)	1989	13,531					13,531	6
7	1994 Improvements (Adjustment)	1994	5,547	139		139		2,808	7
8	1995 Improvements (Adjustment)	1995	183	5		5		90	8
9	1996 Improvements (Adjustment)	1996	3,089					3,089	9
10	1997 Improvements (Adjustment)	1997	1					1	10
11	1998 Improvements (Adjustment)	1998	10,747					10,747	11
12	1999 Improvements (Adjustment)	1999	53					53	12
13	2002 Improvements (Adjustment)	2002	31,445	376		376		4,512	13
14	2004 Improvements (Adjustment)	2004	58,952	4,554		4,554		58,952	14
15	2006 Improvements (Adjustment)	2006	124,033	6,197		6,197		52,793	15
16	2008 Improvements (Adjustment)	2008	79,358	5,053		5,053		34,477	16
17	2009 Improvements (Adjustment)	2009	8,007	801		801		4,407	17
18	2010 Improvements (Adjustment)	2010	7,335	293		293		1,173	18
19	MOVED PIPES FOR DINING ROOM REMODEL	2011	215	9	25	9		29	19
20	WINDOW TRIM & MATERIAL	2011	800	40	20	40		120	20
21	INSTALLED WINDOWS & TRIM	2011	1,312	66	20	66		197	21
22	CABINET INSTALLATION 199	2011	1,620	108	15	108		351	22
23	CABINETS 205	2011	28,200	1,880	15	1,880		5,953	23
24	CABINETS 234	2011	5,000	333	15	333		1,056	24
25	CABLE & PHONE LINES 206	2011	917	61	15	61		193	25
26	CEILING FAN 236	2011	95	9	10	9		30	26
27	DECORATING FOR DINING ROOM	2011	98	20	5	20		64	27
28	ELECTRICAL WIRIN-D.RM.204	2011	5,475	274	20	274		867	28
29	ELECTRICAL WIRING 227	2011	343	23	15	23		74	29
30	DINING ROOM FLOORING 195	2011	19,531	1,302	15	1,302		4,340	30
31	FLOORING-N&S HALLS 442	2011	10,000	500	20	500		1,500	31
32	HEAT VENT 225	2011	96	100	10	100		31	32
33	PAINTING DINING RM 200	2011	7,618	1,524	5	1,524		4,952	33
34	TOTAL (lines 1 thru 33)		$ 2,883,425	$ 78,508		$ 78,508	$	$ 1,966,307	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: 10/1/13 Ending: 9/30/14

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 12E, Carried Forward		$ 2,883,425	$ 78,508		$ 78,508	$	$ 1,966,307	1
2	PAINTING 226	2011	256	26	10	26		83	2
3	PLEXIGLASS-DINING RM 203	2011	235	47	5	47		149	3
4	SINK & FAUCET 223	2011	754	50	15	50		163	4
5	SPRINKLER SYSTEM 197	2011	5,000	20	25	20		667	5
6	Remove 2011 amt from Capital Rate Adj (see 2011 assets above)	2011	(84,357)						6
7	ALARM SYSTEM DOOR TRANSMITTER 467	2012	483	48	10	48		129	7
8	COMPRESSOR 485	2012	2,226	148	15	148		359	8
9	BUILT IN NURSES DESKS	2012	3,316	166	20	166		428	9
10	DOOR CLOSER COMM DORMA	2012	138	9	15	9		22	10
11	DOOR CLOSER COMM DORMA	2012	138	9	15	9		22	11
12	ELECTRICAL WIRING-BR REMODEL 449	2012	834	83	10	83		229	12
13	ELECTRICAL WIRING-KITCHEN 489	2012	299	15	20	15		30	13
14	ELECTRICAL WIRING-LAUNDRY 503	2012	1,317	66	20	66		121	14
15	FLOORING-N&S HALLS 457	2012	7,059	353	20	353		912	15
16	FLOORING-CHAPEL HALL 495	2012	4,068	814	5	814		1,492	16
17	FLOORING-DON OFC 497	2012	1,590	318	5	318		583	17
18	INSTALL FLOORING-CHAPEL HALL	2012	2,043	409	5	409		749	18
19	INSTALL FLOORING-DON OFC	2012	379	76	5	76		139	19
20	PAINTING LABOR-LAUNDRY RM 472	2012	410	82	5	82		184	20
21	SOUND SYSTEM-CHAPEL 490	2012	630	126	5	126		252	21
22	SPRINKLER SYSTEM 455	2012	6,580	263	25	263		724	22
23	SPRINKLER SYSTEM 456	2012	9,700	388	25	388		1,035	23
24	SPRINKLER SYSTEM 462	2012	11,667	583	20	583		1,458	24
25	COPPER WATER LINES-LAUNDRY 502	2012	701	28	25	28		51	25
26	BENCH W/STORAGE-CHAPEL HALL	2012	245	16	15	16		30	26
27	CA-6 ROCK & PEA GRAVEL	2012	75	15	5	15		30	27
28	Remove 2012 amt from Capital Rate Adj (see 2012 assets above)	2012	(53,996)						28
29	RECOVER AWNING 2'X6'X53' W/VALANCE	2013	4,000	800	5	800		1,133	29
30	COUNTERTOPS FOR DESKS	2013	908	83	10	83		83	30
31	GUTTERS, DOWNSPOUT, LEAF GUARDS	2013	2,300	115	20	115		153	31
32	PAINTING, DRYWALLING, PRIMING 504	2013	1,400	140	10	140		245	32
33	SPRINKLER SYSTEM 515	2013	6,190	309	20	309		438	33
34	TOTAL (lines 1 thru 33)		$ 2,820,013	$ 84,113		$ 84,113	$	$ 1,978,400	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: 10/1/13 Ending: 9/30/14

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 12F, Carried Forward		$ 2,820,013	$ 84,113		$ 84,113	$	$ 1,978,400	1
2	DESIGN SERVICES	2013	1,865	171		171		171	2
3	LANDSCAPING	2013	8,341	834		834		834	3
4	PERGOLA	2013	3,240	270		270		270	4
5	PLUMBING PARTS	2013	265	11		11		11	5
6	PLUMBING PARTS	2013	465	19		19		19	6
7	SIDEWALK, 4" THICK, 6' WIDE	2013	19,669	1,967		1,967		1,967	7
8	Remove 2013 amt from Capital Rate Adj (see 2013 assets above)	2013	(43,086)						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,810,772	$ 87,385		$ 87,385	$	$ 1,981,672	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: 10/1/13 Ending: 9/30/14

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	$ 253,481	$ 24,271	$ 24,271	$	5-25	$ 107,091	71
72	Current Year Purchases	25,216	1,608	1,608		5-25	1,608	72
73	Fully Depreciated Assets	578,086					576,501	73
74	Tie to FS	9,600	1,869	1,869			2,134	74
75	TOTALS	$ 866,383	$ 27,748	$ 27,748	$		$ 687,334	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	3,757	3,757		10	11,271	77
78	Facility Use	Chevy Lumina	2004	5,675				5	5,675	78
79										79
80	TOTALS			$ 83,070	$ 3,757	$ 3,757	$		$ 56,771	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)	$ 3,823,935	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 118,890	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,890	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)	$ 2,725,777	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	Lutheran Villas	$ 1,172,963	$ 50,539	$ 573,544	86
87	Lutheran Terrace	1,196,892	43,071	519,582	87
88	Child Enrichment Center	521,285	22,588	204,455	88
89	Chapel (50%)	253,612	5,227	109,059	89
90					90
91	TOTALS	$ 3,144,752	$ 121,425	$ 1,406,640	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Lutheran Villas	$ 235,919	92
93	CIP - LCC	227,155	93
94			94
95		$ 463,074	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: 10/1/13 Ending: 9/30/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 1,183 Description: EQUIPMENT RENTAL - $360 , DISHWASHER - $823
    (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 Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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.

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

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: 10/1/13 Ending: 9/30/14

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	10A1	335.07	hrs	$ 10,917		$	$	335	$ 10,917	1
2	Licensed Speech and Language Development Therapist	10A1	117.64	hrs	5,825				118	5,825	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A1	7417.64	hrs	159,560				7,418	159,560	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	10-2		# of prescrpts				46,605		46,605	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				$ 176,302		$	$ 46,605	7,870	$ 222,907	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.

STATE OF ILLINOIS

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/14 (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	$ 477,981	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,000)	670,453		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,083		6
7	Other Prepaid Expenses	19,526		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,187,043	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710		13
14	Buildings, at Historical Cost	6,115,800		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,057,716		16
17	Accumulated Depreciation (book methods)	(4,345,443)		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):	463,074		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,354,857	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,541,900	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,055	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,296		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,386		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Payroll Liabiltiies	7,204		36
37	Other Accrued Expenses	193,885		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 582,741	$	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	Other LT Liabilties	719,877		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 719,877	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,302,618	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,239,282	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,541,900	$	48

***(See instructions.)**

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,118,197	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,118,197	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	121,085	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)**	$ 121,085	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)**	$ 3,239,282	24 *

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	$ 3,695,963	1
2	Discounts and Allowances for all Levels	(61,440)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,634,523	3
	B. Ancillary Revenue		
4	Day Care	275,007	4
5	Other Care for Outpatients		5
6	Therapy	236,685	6
7	Oxygen	13,568	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 525,260	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	390	12
13	Barber and Beauty Care	22,726	13
14	Non-Patient Meals	30,103	14
15	Telephone, Television and Radio	124	15
16	Rental of Facility Space	416,738	16
17	Sale of Drugs	71,377	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,570	19
20	Radiology and X-Ray		20
21	Other Medical Services	34,977	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 590,005	23
	D. Non-Operating Revenue		
24	Contributions	305,129	24
25	Interest and Other Investment Income***	7,743	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 312,872	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	40,577	28
28a	Endowment Income	80,659	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 121,236	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,183,896	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	987,478	31
32	Health Care	1,709,533	32
33	General Administration	1,218,637	33
	B. Capital Expense		
34	Ownership	142,230	34
	C. Ancillary Expense		
35	Special Cost Centers	804,653	35
36	Provider Participation Fee	200,280	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,062,811	40
41	**Income before Income Taxes (line 30 minus line 40)****	121,085	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 121,085	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,087,133	44
45	Private Pay - Net Inpatient Revenue	2,082,652	45
46	Medicare - Net Inpatient Revenue	464,738	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,634,523	49

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

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

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	1,933	2,170	$ 67,220	$ 30.98	1
2	Assistant Director of Nursing	2,010	2,170	53,810	24.80	2
3	Registered Nurses	8,066	8,622	190,745	22.12	3
4	Licensed Practical Nurses	12,055	13,058	208,421	15.96	4
5	CNAs & Orderlies	54,383	58,630	618,590	10.55	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	7,870	8,640	176,302	20.41	7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,852	2,117	32,864	15.52	9
10	Activity Assistants	14,065	15,062	142,643	9.47	10
11	Social Service Workers	2,302	2,522	57,946	22.97	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	3,692	4,048	62,878	15.53	13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	24,858	26,614	250,811	9.42	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	3,350	3,597	56,616	15.74	17
18	Housekeepers	10,316	10,996	101,971	9.27	18
19	Laundry	8,703	9,531	100,278	10.52	19
20	Administrator	1,928	2,086	83,486	40.03	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	2,105	2,344	56,226	23.98	23
24	Clerical	5,600	6,024	72,029	11.96	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	4,159	4,530	51,724	11.42	31
32	Other Health Care(specify)	-	-	-		32
33	Other(specify) Villa/Daycare/Terr	33,953	36,743	362,586	9.87	33
34	TOTAL (lines 1 - 33)	203,201	219,505	$ 2,747,147 *	$ 12.52	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	Monthly	$ 6,436	1-3	35
36	Medical Director	Monthly	5,500	9-3	36
37	Medical Records Consultant	Monthly	2,380	10-3	37
38	Nurse Consultant				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	Monthly	584	11-3	44
45	Social Service Consultant	Monthly	584	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,024		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0	$ 83,486
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,486

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
TruPay	Payroll Services	$ 8,161
CliftonLarsonAllen LLP	Accounting Services	51,983
Technical Partners	Computer Maintenance	8,529
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 68,673

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,213
Unemployment Compensation Insurance	4,436
FICA Taxes	171,867
Employee Health Insurance	506,749
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	20,806
Employee Uniform Exp	8,282
Revenue from Uniforms	(7,690)
TOTAL (agree to Schedule V, line 22, col.8)	$ 796,663

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,641
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Licenses	12,772
Promotional Advertising	2,629
Newsletter Expense	135
Less: Public Relations Expense	( )
Non-allowable advertising	(135)
Yellow page advertising	(2,629)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,413

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,651
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,651

**See instructions.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/13 Ending: 9/30/14

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 - $5,447**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,323** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **200,280**
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. $ **27,629**

(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? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.