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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0051078

Facility Name: Concordia Village Care Ctr

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

County: Sangamon

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

HFS ID Number:

Date of Initial License for Current Owners: 5/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kevin Wellen **Telephone Number:** 314-925-4446
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 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Paul Ogier
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 Fax # 314-925-4350

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	64	Skilled (SNF)	64	23,424	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	64	TOTALS	64	23,424	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	759	15,832	4,978	21,569	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	759	15,832	4,978	21,569	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.08%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 5/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 3,171

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	343,792	11,066	20,336	375,194	(470)	374,724		374,724			1
2	Food Purchase		99,667		99,667		99,667	(4,216)	95,451			2
3	Housekeeping	52,491	1,740	2,178	56,409		56,409		56,409			3
4	Laundry	6,860	15,591	3,764	26,215		26,215		26,215			4
5	Heat and Other Utilities			154,238	154,238		154,238		154,238			5
6	Maintenance	56,112	13,201	122,762	192,075	(20)	192,055	(34,222)	157,833			6
7	Other (specify):*											7
8	**TOTAL General Services**	459,255	141,265	303,278	903,798	(490)	903,308	(38,438)	864,870			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,871,358	152,744	203,871	2,227,973		2,227,973		2,227,973			10
10a	Therapy			724,658	724,658		724,658		724,658			10a
11	Activities	87,027	7,929	4,070	99,026		99,026	(63)	98,963			11
12	Social Services	17,386			17,386		17,386		17,386			12
13	CNA Training											13
14	Program Transportation	8,997	2,026	521	11,544		11,544	(506)	11,038			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,984,768	162,699	963,120	3,110,587		3,110,587	(569)	3,110,018			16
	C. General Administration											
17	Administrative	78,971			78,971		78,971		78,971			17
18	Directors Fees											18
19	Professional Services			506,380	506,380		506,380	71,468	577,848			19
20	Dues, Fees, Subscriptions & Promotions			58,515	58,515	3,928	62,443	(28,738)	33,705			20
21	Clerical & General Office Expenses	613,909	85,232	297,590	996,731	(4,015)	992,716	(168,789)	823,927			21
22	Employee Benefits & Payroll Taxes			736,082	736,082		736,082		736,082			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,074	20,074		20,074		20,074			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,419	46,419		46,419		46,419			26
27	Other (specify):* Marketing	68,233	8,760	2,490	79,483		79,483	(79,483)				27
28	**TOTAL General Administration**	761,113	93,992	1,667,550	2,522,655	(87)	2,522,568	(205,542)	2,317,026			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,205,136	397,956	2,933,948	6,537,040	(577)	6,536,463	(244,549)	6,291,914			29

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

Facility Name & ID Number Concordia Village Care Ctr #0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			639,293	639,293		639,293	(91,668)	547,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			499,734	499,734		499,734	(175,129)	324,605			32
33	Real Estate Taxes			26,146	26,146		26,146		26,146			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					577	577		577			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,165,173	1,165,173	577	1,165,750	(266,797)	898,953			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,849	43,612	265,461		265,461		265,461			39
40	Barber and Beauty Shops		37,810		37,810		37,810	(37,810)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,548	145,548		145,548		145,548			42
43	Other (specify):* IL and AL	1,867,034	982,082	8,972,279	11,821,395		11,821,395	(11,821,395)				43
44	**TOTAL Special Cost Centers**	1,867,034	1,241,741	9,161,439	12,270,214		12,270,214	(11,859,205)	411,009			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,072,170	1,639,697	13,260,560	19,972,427		19,972,427	(12,370,551)	7,601,876			45

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				4
5	Telephone, TV & Radio in Resident Rooms	(34,192)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(113,598)	30		9
10	Interest and Other Investment Income	(75,737)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(51,302)	21		13
14	Non-Care Related Interest	(251)	21		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	(28,738)	20		18
19	Entertainment	(1,905)	2		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	(117,078)	21		24
25	Fund Raising, Advertising and Promotional	(79,483)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PG5A	(11,865,720)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,368,004)		$	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)	(2,547)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,547)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,370,551)		37

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

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

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

Concordia Village Care Ctr

ID# 0051078

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Income	$ (37,810)	40	1
2	Transportation Income	(506)	14	2
3	Miscellaneous Income	(158)	21	3
4	Interest on Past Due Accounts	(2,758)	32	4
5	Maintenance Services Income	(30)	6	5
6	IL and AL Expenses	(11,821,395)	43	6
7	Gift Shop Supplies	(2,311)	2	7
8	Activities Income	(63)	11	8
9	Fine	(689)	19	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**	(11,865,720)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(4,216)	0	0	0	0	0	0	0	0	0	0	(4,216)	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	(34,222)	0	0	0	0	0	0	0	0	0	0	(34,222)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(38,438)	0	0	0	0	0	0	0	0	0	0	(38,438)	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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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	(506)	0	0	0	0	0	0	0	0	0	0	(506)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(569)	0	0	0	0	0	0	0	0	0	0	(569)	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	(689)	72,157	0	0	0	0	0	0	0	0	0	71,468	19
20	Fees, Subscriptions & Promotions	(28,738)	0	0	0	0	0	0	0	0	0	0	(28,738)	20
21	Clerical & General Office Expenses	(168,789)	0	0	0	0	0	0	0	0	0	0	(168,789)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(79,483)	0	0	0	0	0	0	0	0	0	0	(79,483)	27
28	**TOTAL General Administration**	(277,699)	72,157	0	0	0	0	0	0	0	0	0	(205,542)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(316,706)	72,157	0	0	0	0	0	0	0	0	0	(244,549)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concordia Village Care Ctr # 0051078 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(113,598)	21,930	0	0	0	0	0	0	0	0	0	(91,668)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(78,495)	(96,634)	0	0	0	0	0	0	0	0	0	(175,129)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(192,093)	(74,704)	0	0	0	0	0	0	0	0	0	(266,797)	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	(37,810)	0	0	0	0	0	0	0	0	0	0	(37,810)	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):*	(11,821,395)	0	0	0	0	0	0	0	0	0	0	(11,821,395)	43
44	**TOTAL Special Cost Centers**	(11,859,205)	0	0	0	0	0	0	0	0	0	0	(11,859,205)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,368,004)	(2,547)	0	0	0	0	0	0	0	0	0	(12,370,551)	45

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp		Lutheran Convalescent Home	Webster, MO	Lutheran Senior Servi	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO			
		Breeze Park	St. Charles, MO			
		Heisinger Lutheran Home	Jefferson City, MO			
		Lenoir Woods	Columbia, MO			
		Meridian Village Care Center	Glen Carbon, IL			
		Meramec Bluffs	St. Louis, MO			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fee - Operating	$ 489,446	Lutheran Senior Services	100.00%	$ 561,603	$ 72,157	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	21,930	21,930	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(96,634)	(96,634)	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			$ 489,446			$ 486,899	$ * (2,547)	14

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Richard J. Bagy Jr.	BOD	Lutheran Hillside Village	Peoria, IL				1
2	Lee H. Bodendieck	BOD	REACH West County	Creve Coeur, MO				2
3	Diane R. Drollinger	BOD	St. Joseph's Bluffs	Jefferson City, MO				3
4	Karl A. Dunajcik	BOD						4
5	Jeffrey L. Dunn	BOD						5
6	Scott M. Hartwig	BOD						6
7	John A. Komlos	BOD						7
8	John R. Kotovsky	BOD						8
9	Dr. F. Matt Kuhlmann	BOD						9
10	Harry Mueller	BOD						10
11	Kathleen T. Mueller	BOD						11
12	Olson, Gary	BOD						12
13	William F. Roth	BOD						13
14	Rev. Dr. Scott K. Seidler	BOD						14
15	Rev. William T. Simmons	BOD						15
16	Sherri C. Strand	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Home Office - Operating	Direct Costs	209,168,678	24	$ 15,705,573	$ 11,097,416	7,479,486	$ 561,602	1
2	30	Home Office - Capital	Direct Costs	209,168,678	24	613,297		7,479,486	21,930	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					$ 16,318,870	$ 11,097,416		$ 583,532	25

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Health and Educational Facilities Authority						$	$			$	1
2	2010 Bonds		X	Campus Expansion		10/13/2010	12,369,734	11,650,031	2042	various	499,734	2
3	Interest Income										(78,495)	3
4	HO Excess Interest Income										(96,634)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 12,369,734	$ 11,650,031			$ 324,605	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 12,369,734	$ 11,650,031			$ 324,605	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 Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	26,146	2
3. Under or (over) accrual (line 2 minus line 1).	$	26,146	3
4. Real Estate Tax accrual used for 2016 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.	$	26,146	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concordia Village Care Ctr COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051078

CONTACT PERSON REGARDING THIS REPORT Paul Ogier

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-02.0-451-001	Land 17.31 acres	$ 290,475.36	$ 26,146.00
2.	21-02.0-400-029	Land 6.95 acres	$ 8,710.52	$
3.	21-02.0-400-066	Land 4.62 acres	$ 6,008.24	$
4.	21-02.0-400-067	Land 3.94 acres	$ 5,123.98	$
5.	21-02.0-400-070	Land 4.67 acres	$ 6,073.24	$
6.	Various - see RE Tax bills	Land (various)	$ 21,793.44	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 338,184.78	$ 26,146.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Concordia Village operates 48 assisted living units, 178 independent living apartments, and 26 patio homes

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

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64			2011	$ 9,122,010	$ 319,825	various	$ 319,825	$	$ 1,585,813	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS REMOVED & FILLED IN - MAIN CORRIDOR/ABOVE EN			4/17/2012	3,064	204	15	204		970	9
10	PHONE SYSTEM UPGRADE+ 5 HANDSET - SNF CENTER (RECEPTI			6/7/2012	3,201	213	15	213		978	10
11	FLOORING, VINYL-NURSES STATION			11/1/2012	3,919	784	5	784		3,266	11
12	EXAM TABLE, WELCH ALLEN EQUIP			3/31/2016	4,057	225	15	225		225	12
13	UPS FOR CU WIRING CLOSET			9/6/2016	842	19	15	19		19	13
14	FURN/INST VIKING DOOW SYSTEM - CC			10/19/2016	1,532	26	15	26		26	14
15											15
16	HO Cost Report Allocation					21,930		21,930			16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 946,014	$ 135,504	$ 135,504	$		$ 658,308	71
72	Current Year Purchases	519,319	55,123	55,123			55,123	72
73	Fully Depreciated Assets	15,036	2,173	2,173			15,036	73
74								74
75	TOTALS	$ 1,480,369	$ 192,800	$ 192,800	$		$ 728,467	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE CARAVAN, 2000	9/29/2000	$ 20,792	$	$	$	5	$ 20,792	76
77	Facility	BUS, 12+2,2009 FORD E-SERIE	6/23/2009	50,940	3,639	3,639		7	50,940	77
78	Facility	TRUCK,PICKUP,'09 FORD F-2	7/13/2009	26,721	1,909	1,909		7	26,721	78
79	Facility	VAN-W/C 2013 FORD E250 5+2	8/14/2013	42,355	6,051	6,051		7	20,673	79
80	TOTALS			$ 140,808	$ 11,599	$ 11,599	$		$ 119,126	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,837,264	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 547,625	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 547,625	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)	$ 2,438,890	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SNF - Laundry	$ 1,840,846	$ 69,232	$ 346,160	86
87	SNF - Site Improvements - 2009	538,862	27,126	202,348	87
88	SNF - Building and Improvements - 2009	544,600	22,787	186,463	88
89	Indpendent Living	61,759,062	2,234,666	12,620,104	89
90	Assisted Living	8,906,310	381,777	2,905,502	90
91	TOTALS	$ 73,589,680	$ 2,735,588	$ 16,260,577	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 147,221	92
93			93
94			94
95		$ 147,221	95

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 577 Description: Dietary Equip, Maint Equip and Clerical
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	$	4,707	$ 312,800	$	4,707	$ 312,800	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,202	78,411		1,202	78,411	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		5,116	333,447		5,116	333,447	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				198,284		198,284	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Detail WTB					43,612	23,565		67,177	13
14	TOTAL			$	11,025	$ 768,270	$ 221,849	11,025	$ 990,119	14

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

Facility Name & ID Number Concordia Village Care Ctr **#** 0051078 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 26,060,975	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (173,127))	968,624		3
4	Supply Inventory (priced at)	42,285		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	62,709		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	215,555		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 27,350,148	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,126,732		13
14	Buildings, at Historical Cost	78,602,517		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,697,695		16
17	Accumulated Depreciation (book methods)	(18,699,467)		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 Deferred Mktg	619,977		22
23	Other(specify): CIP	147,221		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 66,494,675	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 93,844,823	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 133,793	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,896		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,935		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Workers' Compensation	12,466		36
37	Refund Clearing Account	(6,984)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 554,106	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,466,955		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to LSS - Related Party	70,121,284		43
44	Entrance Fees and Resident Deposits	34,679,967		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 106,268,206	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 106,822,312	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (12,977,490)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 93,844,822	$	48

***(See instructions.)**

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (12,060,315)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (12,060,315)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(917,175)	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)**	$ (917,175)	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)**	$ (12,977,490)	24 *

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

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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	$ 7,188,632	1
2	Discounts and Allowances for all Levels	(2,019,907)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,168,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,845,115	6
7	Oxygen	1,343	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,846,458	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	19	12
13	Barber and Beauty Care	40,874	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,609	17
18	Sale of Supplies to Non-Patients	17,348	18
19	Laboratory		19
20	Radiology and X-Ray	7,691	20
21	Other Medical Services	26,457	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 356,998	23
	D. Non-Operating Revenue		
24	Contributions	55,320	24
25	Interest and Other Investment Income***	75,737	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131,057	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	12,721	28
28a	IL and AL Revenue	11,539,293	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,552,014	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,055,252	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	903,798	31
32	Health Care	3,110,587	32
33	General Administration	2,522,655	33
	B. Capital Expense		
34	Ownership	1,165,173	34
	C. Ancillary Expense		
35	Special Cost Centers	12,124,666	35
36	Provider Participation Fee	145,548	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,972,427	40
41	**Income before Income Taxes (line 30 minus line 40)****	(917,175)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (917,175)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 184,067	44
45	Private Pay - Net Inpatient Revenue	4,439,966	45
46	Medicare - Net Inpatient Revenue	420,183	46
47	Other-(specify) Benevolent Care	(144,257)	47
48	Other-(specify) Managed Care	268,766	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,168,725	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.**

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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	1,352	1,492	$ 59,998	$ 40.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,637	8,050	235,276	29.23	3
4	Licensed Practical Nurses	22,127	25,458	633,242	24.87	4
5	CNAs & Orderlies	50,035	69,916	984,645	14.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	67	67	549	8.19	8
9	Activity Director					9
10	Activity Assistants	3,986	4,255	96,024	22.57	10
11	Social Service Workers	685	685	17,386	25.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,509	26,829	343,792	12.81	15
16	Dishwashers					16
17	Maintenance Workers	2,592	2,818	56,112	19.91	17
18	Housekeepers	616	4,731	52,491	11.10	18
19	Laundry	594	637	6,860	10.77	19
20	Administrator	2,080	2,080	78,971	37.97	20
21	Assistant Administrator					21
22	Other Administrative	23,829	24,303	512,997	21.11	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,114	1,114	17,645	15.84	31
32	Other Health C: Marketing CC	2,831	2,933	68,233	23.26	32
33	Other(specify) IL and AL	165,996	177,994	1,907,949	10.72	33
34	TOTAL (lines 1 - 33)	306,050	353,362	$ 5,072,170 *	$ 14.35	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		$		35
36	Medical Director	Monthly	30,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	813	5,218	V39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	250	V11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	821	$ 35,468		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Maaks	Care Center Administrator		$ 9,667
Janelle Clark	Care Center Administrator		69,304
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,971

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
Lutheran Senior Services	Management Services	$ 489,446
CliftonLarsonAllen LLP	Accounting Services	6,264
Littler Mendelson P.C.	Legal Services	9,922
Husch Blackwell	Legal Services	748
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 506,380

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,902
Unemployment Compensation Insurance	37,571
FICA Taxes	268,635
Employee Health Insurance	320,991
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	7,177
Life Insurance	3,898
Pension	4,193
Savings & Revenue Sharing	47,923
Tuition Reimbursement	209
Dental Insurance	17,583
TOTAL (agree to Schedule V, line 22, col.8)	$ 736,082

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,118
Advertising: Employee Recruitment	11,765
Health Care Worker Background Check	
(Indicate # of checks performed 694)	3,928
Patient Background Checks 225	2,250
Dues, Memberships & Licenses	9,092
IDPH Fine	28,738
Subscriptions & Publications	1,941
Other Licenses	3,611
Less: Public Relations Expense	(28,738)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,705

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,862
Seminar Expense	16,212
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,074

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. **Leading Age/LSC $3,395**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,814** Line **39**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **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. $ **145,548**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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? **100**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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