FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

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: 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 10/01/2016 to 9/30/2017 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) 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 Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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	6,743	13,953	2,925	23,621	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,743	13,953	2,925	23,621	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.41%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2,920

Medicare Intermediary WPS GHA

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/2017 Fiscal Year: 9/30/2017

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

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/01/2016 **Ending:** 9/30/2017

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	286,134	24,089	6,778	317,001		317,001		317,001			1
2	Food Purchase		178,460		178,460		178,460	(25,452)	153,008			2
3	Housekeeping	84,620	16,041		100,661		100,661		100,661			3
4	Laundry	113,174	9,748		122,922		122,922		122,922			4
5	Heat and Other Utilities			123,180	123,180		123,180		123,180			5
6	Maintenance	98,068	11,856	24,245	134,169		134,169		134,169			6
7	Other (specify):*											7
8	**TOTAL General Services**	581,996	240,194	154,203	976,393		976,393	(25,452)	950,941			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,266,683	52,018	2,540	1,321,241		1,321,241		1,321,241			10
10a	Therapy	238,475	759		239,234		239,234		239,234			10a
11	Activities	179,566	1,885	11,038	192,489		192,489		192,489			11
12	Social Services	66,936	673	583	68,192		68,192		68,192			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,751,660	55,335	20,161	1,827,156		1,827,156		1,827,156			16
	C. General Administration											
17	Administrative	90,549			90,549		90,549		90,549			17
18	Directors Fees											18
19	Professional Services			51,422	51,422		51,422		51,422			19
20	Dues, Fees, Subscriptions & Promotions			40,648	40,648		40,648	(760)	39,888			20
21	Clerical & General Office Expenses	115,849	3,566	(894)	118,521		118,521	(6,440)	112,081			21
22	Employee Benefits & Payroll Taxes			642,948	642,948		642,948	(9,067)	633,881			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,407	2,407		2,407		2,407			24
25	Other Admin. Staff Transportation		4,139		4,139		4,139		4,139			25
26	Insurance-Prop.Liab.Malpractice			37,753	37,753		37,753		37,753			26
27	Other (specify):*											27
28	**TOTAL General Administration**	206,398	7,705	774,284	988,387		988,387	(16,267)	972,120			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,540,054	303,234	948,648	3,791,936		3,791,936	(41,719)	3,750,217			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: 10/01/2016 Ending: 9/30/2017

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			101,361	101,361	(5,185)	96,176		96,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8	8		8	(8)				32
33	Real Estate Taxes			485	485		485	(485)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,389	2,389		2,389		2,389			35
36	Other (specify):*											36
37	**TOTAL Ownership**			104,243	104,243	(5,185)	99,058	(493)	98,565			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			73,503	73,503		73,503		73,503			39
40	Barber and Beauty Shops			18,011	18,011		18,011		18,011			40
41	Coffee and Gift Shops			1,975	1,975		1,975		1,975			41
42	Provider Participation Fee			178,197	178,197		178,197		178,197			42
43	Other (specify):* NRCC-See Groupi	369,728	83,938	316,417	770,083	5,185	775,268	(775,268)				43
44	**TOTAL Special Cost Centers**	369,728	83,938	588,103	1,041,769	5,185	1,046,954	(775,268)	271,686			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,909,782	387,172	1,640,994	4,937,948		4,937,948	(817,480)	4,120,468			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: 10/01/2016 Ending: 9/30/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(25,452)	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	(8)	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	(5,155)	21		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	(760)	20		28
29	Other-Attach Schedule See PG5A for Detail	(786,105)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (817,480)		$	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))**	$ (817,480)		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

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/01/2016

Ending: 9/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-care related salaries	$ (369,728)	43	1
2	Non-care related supplies	(83,938)	43	2
3	Non-care related expenses	(316,417)	43	3
4	Miscellaneous Income	(1,285)	21	4
5	Uniform Income	(9,067)	22	5
6	Non-care related real estate taxes	(485)	33	6
7	50% of Chapel Depreciation	(5,185)	43	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**	(786,105)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/01/2016 **Ending:** 9/30/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,452)	0	0	0	0	0	0	0	0	0	0	(25,452)	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**	(25,452)	0	0	0	0	0	0	0	0	0	0	(25,452)	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	(760)	0	0	0	0	0	0	0	0	0	0	(760)	20
21	Clerical & General Office Expenses	(6,440)	0	0	0	0	0	0	0	0	0	0	(6,440)	21
22	Employee Benefits & Payroll Taxes	(9,067)	0	0	0	0	0	0	0	0	0	0	(9,067)	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**	(16,267)	0	0	0	0	0	0	0	0	0	0	(16,267)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,719)	0	0	0	0	0	0	0	0	0	0	(41,719)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/01/2016 **Ending:** 9/30/2017

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	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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	32
33	Real Estate Taxes	(485)	0	0	0	0	0	0	0	0	0	0	(485)	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**	(493)	0	0	0	0	0	0	0	0	0	0	(493)	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):*	(775,268)	0	0	0	0	0	0	0	0	0	0	(775,268)	43
44	**TOTAL Special Cost Centers**	(775,268)	0	0	0	0	0	0	0	0	0	0	(775,268)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(817,480)	0	0	0	0	0	0	0	0	0	0	(817,480)	45

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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 ☐ 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: 10/01/2016 Ending: 9/30/2017

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2	Note: No members of the Board either provided services to the nursing home or 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: 10/01/2016 Ending:)/30/2017

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: 10/01/2016 Ending: 9/30/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National Bank		X	Line of Credit		1/23/2017	59,508		2/23/2018	0.0375	8	6
7												7
8												8
9	TOTAL Facility Related						$ 59,508	$			$ 8	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 59,508	$			$ 8	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/01/2016 **Ending:** 9/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	$	485	2
3. Under or (over) accrual (line 2 minus line 1).	$	485	3
4. Real Estate Tax accrual used for 2017 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.	$	485	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-02-016-021	Vacant Lot	$ 485.00	$
2.			$	$
3.	Facility is a not-for-profit entity, therefore is not subject to real estate tax.		$	$
4.	Non-care related real estate taxes		$	$
5.	have beeen removed from report at		$	$
6.	Sch V, Line 33, Col 7		$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 485.00	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 10/01/2016 Ending: 9/30/2017

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, 15 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: 10/01/2016 Ending: 9/30/2017

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	$ 879,500	$	25	$	$	$ 879,500	4
5			1980	1981	3,764		25			3,764	5
6			1980	1982	141,000		25			141,000	6
7				2014	213,250	5,331	40	5,331		14,660	7
8											8
	Improvement Type**										
9	Land Improvements			1980	30,660		25			30,660	9
10	Land Improvements			1986	4,143		25			4,143	10
11	Land Improvements			1997	5,308	266	20	266		5,338	11
12	Building Improvements			1981	3,486		5			3,486	12
13	Building Improvements			1982	6,720		20			6,720	13
14											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											21
22	Building Improvements			1989	16,262		10			16,262	22
23											23
24	Building Improvements			1989	28,510		20			28,510	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	Building Improvements			1993	86,395	2,623	Various	2,623		66,281	32
33	Sprinkler System			1994	37,479	938	40	938		21,788	33
34	Additional Patio Work			1994	1,725	42	40	42		999	34
35	Breakroom Wallpaper			1994	302	8	40	8		177	35
36	Admin Office Wallpaper			1994	381	10	40	10		223	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: 10/01/2016 Ending: 9/30/2017

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	$	$ 397	37
38	Misc. Building Improvements	1994	1,408	35	40	35		818	38
39	Land Improvements- Sewer Line	1994	7,949	199	40	199		4,622	39
40	Land Imp. - Drainage Pipe	1994	860	22	40	22		501	40
41	Misc. Land Improvements	1994	1,279	31	40	31		741	41
42	Building Improvements	1995	7,987	200	40	200		4,543	42
43	Office Wallpaper	1995	2,087		10			2,087	43
44	Front Office Wallpaper	1995	825		10			825	44
45	Activity Office Counter Top	1995	2,292		10			2,292	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	4,036		10			4,036	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		2,415	55
56	Plumbing, blinds, lighting (Remodeling-Medicare Rooms)	1998	1,221		10			1,221	56
57	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	7,701		10			7,701	57
58	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Room	1998	6,937		10			6,937	58
59	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Mec	1998	3,543		10			3,543	59
60	Landscaping	1999	4,080	204	20	204		3,740	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		2,933	62
63	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		6,533	63
64	Brick work (Laundry Expansion)	1999	4,554	228	20	228		4,193	64
65	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		2,481	65
66	Remodel Medicare Room	1999	652		5			652	66
67	Flooring	2002	6,306		10			6,306	67
68	Windows	2002	3,635		10			3,635	68
69	Roof Item #20	1997	178,417	8,922	20	8,922		178,417	69
70	TOTAL (lines 4 thru 69)		$ 1,814,534	$ 19,844		$ 19,844	$	$ 1,568,905	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: 10/01/2016 Ending: 9/30/2017

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		$ 1,814,534	$ 19,844		$ 19,844	$	$ 1,568,905	1
2	Chapel - Updated to 6/30/07 Audit Findings	2002	207,672	5,186	40	5,186		78,899	2
3	Chapel - Windows- Updated to 6/30/07 Audit Findings	2002	13,270		10			13,270	3
4	Chapel - Sidewalk- Updated to 6/30/07 Audit Findings	2002	1,042		10			1,042	4
5	Chapel - Cabinets- Updated to 6/30/07 Audit Findings	2002	4,623		10			4,623	5
6	Chapel - Wiring- Updated to 6/30/07 Audit Findings	2002	2,554		10			2,554	6
7	Chapel - Landscaping- Updated to 6/30/07 Audit Findings	2002	3,140		10			3,140	7
8	Chapel - Screen	2002	858		10			858	8
9	Chapel - Cable- Updated to 6/30/07 Audit Findings	2002	3,977		10			3,977	9
10	Chapel - 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	20	4,350		65,253	11
12	Plants/Rock/Stone	2003	853		10			853	12
13	Window replacement project	2003	14,285		10			14,285	13
14									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		10,079	17
18	Room painting and wall paper	2004	17,526		10			17,526	18
19	Painting building, trim & eaves	2004	1,978		10			1,978	19
20	Generator- Updated to 6/30/07 Audit findings (ALL)	2004	160,787		10			160,787	20
21	wiring	2004	11,383	569	20	569		7,351	21
22	Building Improvements 2006	2006	450,158	1,441	Various	1,441		236,891	22
23									23
24									24
25									25
26									26
27	Bldg Improvements - Lobby	2008	74,733	4,983	15	4,983		44,800	27
28	Painting - Lobby	2008	2,115		5			2,115	28
29	Bldg Improvements - Lobby	2008	10,516	1,051	10	1,051		8,943	29
30	LI - Seal Concrete	2008	2,951		7			2,951	30
31	Kitchen	2008	57,030	4,290	VARIOUS	4,290		40,257	31
32	Curt Reardon- Installation of Lobby Flooring	2008	2,510		6			2,510	32
33	Roof Addition	2010	75,292	7,529	10	7,529		54,363	33
34	TOTAL (lines 1 thru 33)		$ 3,047,060	$ 50,004		$ 50,004	$	$ 2,359,265	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: 10/01/2016 Ending: 9/30/2017

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		$ 3,047,060	$ 50,004		$ 50,004	$	$ 2,359,265	1
2									2
3	Dining Room Renovation	2011	86,826	6,013	VARIOUS	6,013		39,012	3
4	Alarm System Door Transmitter 467	2012	483	48	10	48		274	4
5	Compressor 485	2012	2,226	148	15	148		804	5
6	Built In Nurses Desks	2012	3,316	166	20	166		926	6
7	Electrical Wiring - BR Remodel 449	2012	834	83	10	83		479	7
8	Electrical Wiring - Laundry 503	2012	1,317	66	20	66		319	8
9	Flooring - N&S Halls 457	2012	7,059	353	20	353		1,971	9
10	Flooring - Chapel Hall 495	2012	4,068	814	5	814		3,933	10
11	Flooring - DON Office 497	2012	1,590	318	5	318		1,537	11
12	Install Flooring - Chapel Hall	2012	2,422	484	5	484		2,341	12
13	Install Flooring - DON Office	2012	379	76	5	76		366	13
14	Sound System - Chapel 490	2012	630	126	5	126		630	14
15	Sprinkler System 455	2012	6,580	263	25	263		1,513	15
16	Sprinkler System 456	2012	9,700	388	25	388		2,198	16
17	Sprinkler System 462	2012	11,667	583	20	583		3,208	17
18	Copper Water Lines - Laundry 502	2012	701	28	25	28		136	18
19	Recover Aewning 2' X 6' X 53' W/Valance	2013	4,000	800	5	800		3,533	19
20	Counter Tops for Desks	2013	908	91	10	91		356	20
21	Gutters, Downspouts, & leaf guards	2013	2,300	115	20	115		498	21
22	Painting, Drywalling and Priming 504	2013	1,400	140	10	140		665	22
23	Sprinkler System 515	2013	6,190	309	20	309		1,366	23
24	LI - Design Services	2013	1,865	186	10	186		730	24
25	LI - Landscaping	2013	8,341	834	10	834		3,336	25
26	LI - Pergola	2013	3,240	324	10	324		1,242	26
27	LI - Sidewalk	2013	19,669	1,967	10	1,967		7,868	27
28									28
29	Fire Door Closer	2014	1,850	123	10	123		452	29
30	Patio Cover, Americana Sierra 40' X 10'	2014	3,803	254	10	254		888	30
31	LI - Scallop Picket Fence	2014	5,548	555	10	555		1,942	31
32	LI - Plants for Courtyard	2014	540	54	10	54		185	32
33	LI - Lights around sidewalks and courtyard	2014	2,152	215	10	215		717	33
34	TOTAL (lines 1 thru 33)		$ 3,248,664	$ 65,928		$ 65,928	$	$ 2,442,690	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: 10/01/2016 Ending: 9/30/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,248,664	$ 65,928		$ 65,928	$	$ 2,442,690	1
2	LI - Parking Lot Addition	2014	6,709	671	10	671		2,013	2
3	LI - Courtyard Drains, 4 concrete benches, seal patio	2014	10,904	1,090	10	1,090		3,271	3
4	LI - Beccue Bldrs - Parking Lot - The Gathering LI	2014	30,867	1,543	20	1,543		4,244	4
5	#1089 - Wrights - Flooring - The Gathering Bldg Impr	2014	13,673	684	20	684		1,880	5
6	#158 - Integrity Electric - Wiring - The Gathering Bldg Impr	2014	248	12	20	12		33	6
7	#402 - Jeff Shelton - Plumbing - The Gathering Bldg Impr	2014	2,700	135	20	135		371	7
8	Integrity Electric - The Gathering Bldg Impr	2014	1,017	51	20	51		140	8
9	Kemme's Heating & Air - The Gathering Bldg Imrp	2014	7,350	368	20	368		1,012	9
10	Integrity Electric - The Gathering Bldg Impr	2014	10,680	534	20	534		1,469	10
11	Merz Heating Install - The Gathering Bldg Impr	2014	3,250	163	20	163		447	11
12	Shelton Plumbing - The Gathering Bldg Impr	2014	4,793	240	20	240		660	12
13	Hazlett Flooring - The Gathering Bldg Impr	2014	223	11	20	11		30	13
14	Hollar Design 50% - Tub Room	2014	3,203	214	15	214		624	14
15	Altamont Lumber - Tub Room	2014	547	36	15	36		105	15
16	Construction Supplies - Tub Room	2014	62	4	15	4		12	16
17	Tape and Finish - Tub Room	2014	450	30	15	30		88	17
18	Paint - Tub Room	2014	42	3	15	3		9	18
19	Prime and Paint - Tub Room	2014	173	12	15	12		35	19
20	Tile Install - Tub Room	2014	3,313	221	15	221		644	20
21	Bathtub, Lift Trolley - Tub Room	2014	21,700	2,170	10	2,170		6,227	21
22	Electric Wiring - Tub Room	2014	1,156	77	15	77		225	22
23	Supplies - Tub Room	2014	23	2	15	2		5	23
24	Built Guard - Tub Room	2014	192	13	15	13		38	24
25	Install Cabinets - Tub Room	2014	415	27	15	27		79	25
26	R&H Plumbing - Vent Van - Tub Room	2014	763	51	15	51		149	26
27	R&H Plumbing - P Trap - Tub Room	2014	12	1	15	1		3	27
28	LI - Parking Lot Repairs	2015	3,000	600	5	600		1,350	28
29	LI - LCC Sign Out Front	2015	3,441	344	10	344		717	29
30	LI - Beccue Bldrs - Concrete - The Gathering	2015	4,358	436	10	436		1,199	30
31	LI - Alwerdts Gardens - Landscaping & Trees - The Gathering	2015	8,529	853	15	853		2,080	31
32	(77) Shutters, 14-14X47, 10-14X55, 2-14X51	2015	2,270	454	5	454		1,022	32
33	(10) Shutters 2-14X71, & 8-14X75	2015	624	125	5	125		281	33
34	TOTAL (lines 1 thru 33)		$ 3,395,351	$ 77,103		$ 77,103	$	$ 2,473,152	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: 10/01/2016 Ending: 9/30/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,395,351	$ 77,103		$ 77,103	$	$ 2,473,152	1
2	Flooring, Wall Base, RMS 1 & 5	2015	4,425	885	5	885		2,212	2
3	Remodel Flooring 7	2015	2,328	233	10	233		466	3
4	Remodel Flooring 6	2016	2,328	233	10	233		427	4
5	Remodel Flooring 1	2015	2,328	233	10	233		543	5
6	Remodel Flooring 1	2016	2,328	233	10	233		311	6
7	Remodel Flooring 2	2015	2,329	233	10	233		505	7
8	Resident RM Remodel 7 & 11(Blinds, Paint, lighting, counter tops	2015	5,651	565	10	565		1,130	8
9	Resident RM Remodel 6 & 8 (Blinds, Paint, lighting, counter tops)	2016	5,651	565	10	565		1,036	9
10	Resident RM Remodel 1 & 3 (Blinds, Paint, lighting, counter tops)	2015	5,651	565	10	565		1,224	10
11	Resident RM Remodel 2 & 4 (Blinds, Paint, lightening, counter top	2015	5,651	565	10	565		1,318	11
12	Compressor On Dining Room	2016	1,118	112	10	112		159	12
13	Permastone Vinyl Tile	2016	1,023	102	10	102		170	13
14	Remodel Flooring 1	2016	2,328	233	10	233		349	14
15	Resident RM Remodel 1 & 15 (Blinds, Paint, lightening, counter to	2016	5,651	565	10	565		848	15
16	Resident RM Remodel 12 & 1 (Blinds, Paint, lightening, counter to	2016	5,651	565	10	565		753	16
17	Smokers Hut	2016	577	115	5	115		163	17
18	A/C, CONDENSR M#24ABB360A340, COIL M#FB4CNP060	2017	4,875	163	10	163		163	18
19	FLOOR MOUNTED SVC SINK 27X20-1/2	2017	728	55	10	55		55	19
20	HOT DAWG HANGING HEATER M#HD75AS-011-FBAN	2017	1,641	109	10	109		109	20
21	LG BOULDER, W/ENGRAVING-GILBERT	2017	573	14	10	14		14	21
22	SPRINKLER SYSTEM, DINING ROOM	2017	13,750	1,031	10	1,031		1,031	22
23	STANDARD PENDENT SPRINKLERS,halls&dining room	2017	1,053	70	15	70		70	23
24	WALK IN FREEZER IN GARAGE 12'X10'X7'6" 2-1/2HP	2017	15,177	253	10	253		253	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,488,166	$ 84,800		$ 84,800	$	$ 2,486,461	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: 10/01/2016 Ending: 9/30/2017

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	$ 273,683	$ 2,346	$ 2,346	$	VARIOUS	$ 96,003	71
72	Current Year Purchases	60,369	4,536	4,536		VARIOUS	4,536	72
73	Fully Depreciated Assets	598,594	497	497		VARIOUS	598,594	73
74								74
75	TOTALS	$ 932,646	$ 7,379	$ 7,379	$		$ 699,133	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 Van-Wht/Grn	2001	$ 39,825	$	$	$	5	$ 39,825	76
77	Facility Use	Chevy Lumina	2004	5,675				5	5,675	77
78	Facility Use	2011 Dodge Grand Caravan	2012	37,570	3,757	3,757		10	22,542	78
79	Facility Use	2000 Mercedes-Benz	2017	1,200	240	240		5	240	79
80	TOTALS			$ 84,270	$ 3,997	$ 3,997	$		$ 68,282	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,568,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,176	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 96,176	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)	$ 3,253,876	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	$ 1,493,666	$ 56,407	$ 715,950	86
87	Lutheran Terrace	1,214,750	47,166	635,746	87
88	Child Enrichment Center	523,655	21,618	265,497	88
89	Chapel (50%)	239,614	5,185	110,841	89
90					90
91	TOTALS	$ 3,471,685	$ 130,376	$ 1,728,034	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 2,389 Description: Dishwasher $886, Nursing Equipment $1,503
(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: 10/01/2016 Ending: 9/30/2017

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 Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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	10A-1	1,584	hrs	$ 53,138		$	$	1,584	$ 53,138	1
2	Licensed Speech and Language Development Therapist	10A-1	148	hrs	7,851				148	7,851	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A-1, 10A-2	12,905	hrs	175,175			759	12,905	175,934	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-3		# of prescrpts				58,600		58,600	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Respiratory Therapist	10A-1	94.75		2,311				95	2,311	12
13	Other (specify):										13
14	TOTAL				$ 238,475		$	$ 59,359	14,732	$ 297,834	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:** 10/01/2016 **Ending:** 9/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/2017 **(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	$ 913,657	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,672)	516,817		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,074		6
7	Other Prepaid Expenses	22,469		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,465,017	$	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	6,807,706		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,169,061		16
17	Accumulated Depreciation (book methods)	(4,981,910)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,058,567	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,523,584	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,126	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	246,063		30
31	Accrued Taxes Payable (excluding real estate taxes)	(689)		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 Liabilities	4,395		36
37	Resident Fund/Allowance/LOC	29,052		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 380,862	$	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	Subscriber Deposits	607,390		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 607,390	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 988,252	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,535,332	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,523,584	$	48

***(See instructions.)**

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,343,406	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,343,406	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	191,926	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)**	$ 191,926	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)**	$ 3,535,332	24 *

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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	$ 3,732,118	1
2	Discounts and Allowances for all Levels	(292,182)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,439,936	3
	B. Ancillary Revenue		
4	Day Care	296,433	4
5	Other Care for Outpatients		5
6	Therapy	573,775	6
7	Oxygen	19,917	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 890,125	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	8,304	12
13	Barber and Beauty Care	18,030	13
14	Non-Patient Meals	25,452	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	110,944	16
17	Sale of Drugs	87,884	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,880	19
20	Radiology and X-Ray	104	20
21	Other Medical Services	40,082	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 305,680	23
	D. Non-Operating Revenue		
24	Contributions	73,388	24
25	Interest and Other Investment Income***	871	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74,259	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-reimbursable revenues (see groupings)	430,444	28
28a	Miscellaneous income	(10,570)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 419,874	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,129,874	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	976,393	31
32	Health Care	1,827,156	32
33	General Administration	988,387	33
	B. Capital Expense		
34	Ownership	104,243	34
	C. Ancillary Expense		
35	Special Cost Centers	863,572	35
36	Provider Participation Fee	178,197	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,937,948	40
41	**Income before Income Taxes (line 30 minus line 40)****	191,926	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 191,926	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 899,572	44
45	Private Pay - Net Inpatient Revenue	1,876,156	45
46	Medicare - Net Inpatient Revenue	664,208	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,439,936	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: 10/01/2016 Ending: 9/30/2017

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	2,182	2,182	$ 73,959	$ 33.90	1
2	Assistant Director of Nursing	2,168	2,168	52,674	24.30	2
3	Registered Nurses	11,959	11,959	298,185	24.93	3
4	Licensed Practical Nurses	6,926	6,926	129,029	18.63	4
5	CNAs & Orderlies	50,890	50,890	610,695	12.00	5
6	CNA Trainees					6
7	Licensed Therapist	14,637	14,637	238,475	16.29	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	18,912	18,912	179,566	9.49	10
11	Social Service Workers	2,450	2,450	66,936	27.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,173	31,173	286,134	9.18	15
16	Dishwashers					16
17	Maintenance Workers	6,850	6,850	98,076	14.32	17
18	Housekeepers	8,724	8,724	84,620	9.70	18
19	Laundry	9,592	9,592	113,174	11.80	19
20	Administrator	2,086	2,086	90,549	43.41	20
21	Assistant Administrator					21
22	Other Administrative	9,895	9,895	115,849	11.71	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	2,321	2,321	23,804	10.26	31
32	Other Health C: Qual Assur/Care	3,913	3,913	78,337	20.02	32
33	Other(specify) Villa/Daycare/Terr	36,641	36,641	369,720	10.09	33
34	TOTAL (lines 1 - 33)	221,319	221,319	$ 2,909,782 *	$ 13.15	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	$ 6,157	V01-3	35
36	Medical Director	Monthly	6,000	V09-3	36
37	Medical Records Consultant	Monthly	2,000	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	540	V10-3	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	583	V11-3	44
45	Social Service Consultant	Monthly	583	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,863		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: 10/01/2016 Ending: 9/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0	$ 90,549
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,549

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Paylocity	Payroll	$ 10,032
CliftonLarsonAllen, LLP	Audit/Cost Report/Tax	39,454
Technical Partners	Computer Maintenance	1,936
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 51,422

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,073
Unemployment Compensation Insurance	
FICA Taxes	159,569
Employee Health Insurance	374,521
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	25,363
Employee Uniform Expense	7,422
Revenue from Uniforms	(9,067)
TOTAL (agree to Schedule V, line 22, col.8)	$ 633,881

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,829
Health Care Worker Background Check	
(Indicate # of checks performed 14)	213
Patient Background Checks 84	840
Dues and Licenses	37,006
Promotional Advertising	609
Newsletter Expense	151
Less: Public Relations Expense	( )
Non-allowable advertising	(151)
Yellow page advertising	(609)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,888

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	458
Seminar Expense	1,949
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,407

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2016 Ending: 9/30/2017

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 IL - $5,335**

(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. $ **10,890** 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. $ **178,197**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **25,452**

(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? **N/A**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees