FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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
  - [X] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code 501(c)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 10/1/17 to 9/30/18 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: 10/1/17 Ending: 9/30/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	4,936	11,724	3,091	19,751	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,936	11,724	3,091	19,751	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.37%

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 10/1/1980 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 3,091

Medicare Intermediary WPS GHA

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/18 Fiscal Year: 9/30/18

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	275,855	22,180	5,567	303,602		303,602		303,602			1
2	Food Purchase		164,559		164,559		164,559	(24,403)	140,156			2
3	Housekeeping	79,715	11,789		91,504		91,504		91,504			3
4	Laundry	108,524	6,691		115,215		115,215		115,215			4
5	Heat and Other Utilities			119,217	119,217		119,217		119,217			5
6	Maintenance	91,222	9,635	19,469	120,326		120,326		120,326			6
7	Other (specify):*											7
8	TOTAL General Services	555,316	214,854	144,253	914,423		914,423	(24,403)	890,020			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,184,382	44,836	11,892	1,241,110		1,241,110		1,241,110			10
10a	Therapy	246,916	512		247,428		247,428		247,428			10a
11	Activities	182,615	1,178	10,469	194,262		194,262		194,262			11
12	Social Services	64,404	624	600	65,628		65,628		65,628			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,678,317	47,150	28,961	1,754,428		1,754,428		1,754,428			16
	C. General Administration											
17	Administrative	93,361			93,361		93,361		93,361			17
18	Directors Fees											18
19	Professional Services			54,564	54,564		54,564		54,564			19
20	Dues, Fees, Subscriptions & Promotions			39,850	39,850		39,850	(632)	39,218			20
21	Clerical & General Office Expenses	136,524	3,423	189,131	329,078		329,078	(152,025)	177,053			21
22	Employee Benefits & Payroll Taxes			686,447	686,447		686,447	(12,656)	673,791			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,380	3,380		3,380		3,380			24
25	Other Admin. Staff Transportation		6,212		6,212		6,212		6,212			25
26	Insurance-Prop.Liab.Malpractice			37,742	37,742		37,742		37,742			26
27	Other (specify):*											27
28	TOTAL General Administration	229,885	9,635	1,011,114	1,250,634		1,250,634	(165,313)	1,085,321			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,463,518	271,639	1,184,328	3,919,485		3,919,485	(189,716)	3,729,769			29

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

Facility Name & ID Number Lutheran Care Center #0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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			137,653	137,653		137,653	(5,186)	132,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37	37		37	(37)				32
33	Real Estate Taxes			491	491		491	(491)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,585	1,585		1,585		1,585			35
36	Other (specify):*											36
37	**TOTAL Ownership**			139,766	139,766		139,766	(5,714)	134,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			96,625	96,625		96,625		96,625			39
40	Barber and Beauty Shops			13,486	13,486		13,486		13,486			40
41	Coffee and Gift Shops			1,487	1,487		1,487		1,487			41
42	Provider Participation Fee			153,179	153,179		153,179		153,179			42
43	Other (specify):* NRCC-See Groupi	369,370	80,771	329,495	779,636		779,636	(779,636)				43
44	**TOTAL Special Cost Centers**	369,370	80,771	594,272	1,044,413		1,044,413	(779,636)	264,777			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,832,888	352,410	1,918,366	5,103,664		5,103,664	(975,066)	4,128,598			45

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,403)	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	(37)	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	(140,819)	21		24
25	Fund Raising, Advertising and Promotional	(7,982)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(632)	20		28
29	Other-Attach Schedule See PG5A for Detail	(801,193)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (975,066)		$	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))**	$ (975,066)		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: 10/1/17

Ending: 9/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-care related salaries	$ (369,370)	43	1
2	Non-care related supplies	(80,771)	43	2
3	Non-care related expenses	(329,495)	43	3
4	Miscellaneous Income	(3,224)	21	4
5	Uniform Income	(12,656)	22	5
6	Non-care related real estate taxes	(491)	33	6
7	50% of Chapel Depreciation	(5,186)	30	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**	(801,193)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	(24,403)	0	0	0	0	0	0	0	0	0	0	(24,403)	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**	(24,403)	0	0	0	0	0	0	0	0	0	0	(24,403)	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	(632)	0	0	0	0	0	0	0	0	0	0	(632)	20
21	Clerical & General Office Expenses	(152,025)	0	0	0	0	0	0	0	0	0	0	(152,025)	21
22	Employee Benefits & Payroll Taxes	(12,656)	0	0	0	0	0	0	0	0	0	0	(12,656)	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**	(165,313)	0	0	0	0	0	0	0	0	0	0	(165,313)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(189,716)	0	0	0	0	0	0	0	0	0	0	(189,716)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/1/17 **Ending:** 9/30/18

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	(5,186)	0	0	0	0	0	0	0	0	0	0	(5,186)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37)	0	0	0	0	0	0	0	0	0	0	(37)	32
33	Real Estate Taxes	(491)	0	0	0	0	0	0	0	0	0	0	(491)	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**	(5,714)	0	0	0	0	0	0	0	0	0	0	(5,714)	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):*	(779,636)	0	0	0	0	0	0	0	0	0	0	(779,636)	43
44	**TOTAL Special Cost Centers**	(779,636)	0	0	0	0	0	0	0	0	0	0	(779,636)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(975,066)	0	0	0	0	0	0	0	0	0	0	(975,066)	45

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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
Not Applicable						

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: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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		2/26/18			2/23/19	4.0000	37	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 37	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 37	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: 10/1/17 Ending: 9/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)		$ 491	2
3. Under or (over) accrual (line 2 minus line 1).		$ 491	3
4. Real Estate Tax accrual used for 2018 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.		$ 491	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015		10
2016		11
2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-02-016-021	Vacant Lot	$ 491.00	$
2.	Facility is a not-for-profit entity, therefore is not subject to real estate tax.		$	$
3.	Non-care related real estate taxes		$	$
4.	have beeen removed from report at		$	$
5.	Sch V, Line 33, Col 7		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 491.00	$

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

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		19,991	7
8				2002	239,614	5,186	40	5,186		116,027	8
	Improvement Type**										
9	Land Improvements			1980	30,660					30,660	9
10	Land Improvements			1994	10,088	252	40	252		6,117	10
11	Land Improvements			1997	5,308	10	20	10		5,308	11
12	Land Improvements			1999	4,080	204	20	204		3,944	12
13	Land Improvements			2002	87,004	4,350	20	4,350		69,604	13
14	Land Improvements			2007	1,250	63	20	63		693	14
15	Land Improvements			2008	2,951					2,951	15
16	Land Improvements			2013	33,116	3,312	10	3,312		16,488	16
17	SCALLOP PICKET FENCE			2014	5,548	555	10	555		2,497	17
18	PLANTS FOR COURTYARD			2014	540	54	10	54		239	18
19	LIGHTS AROUND SIDEWALKS-CRTYRD			2014	2,152	215	10	215		932	19
20	PARKING LOT ADDITION BY CHAPEL			2014	6,709	671	10	671		2,684	20
21	CRTYD DRAINS, 4 CONCRETE BENCHES, SEAL PATIOS			2014	10,904	1,090	10	1,090		4,361	21
22	PARKING LOT REPAIRS, ROUTE, CLEAN & REFILL JOINTS			2015	3,000	600	5	600		1,950	22
23	4'x6' LCC SIGN OUT FRONT, 2 SM SIGNS			2015	3,441	344	10	344		1,061	23
24	SMOKERS HUT			2016	577	115	5	115		278	24
25	LG BOULDER, W/ENGRAVING-GILBERT			2017	573	57	10	57		71	25
26	Plants -Trimming			2018	845	423	1	423		423	26
27	Plants Landscaping			2018	1,276	532	1	532		532	27
28	Building Improvements			1986	2,904					2,904	28
29	Building Improvements			1987	3,173					3,173	29
30	Building Improvements			1989	44,772					44,772	30
31	Building Improvements			1990	38,528					38,528	31
32	Building Improvements			1991	6,000					6,000	32
33	Building Improvements			1992	11,467					11,467	33
34	Building Improvements			1993	86,395	2,623	30	2,623		68,905	34
35	Building Improvements			1994	41,978	1,050	40	1,050		25,451	35
36	Building Improvements			1995	12,474	200	40	200		4,743	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	Building Improvement	1996	$ 17,779	$		$	$	$ 17,779	37
38	Building Improvement	1997	192,219					192,219	38
39	Building Improvement	1998	21,846	30	10	30		21,846	39
40	Building Improvement	1999	19,607	874	10	874		19,140	40
41	Building Improvement	2002	9,941					9,941	41
42	Building Improvement	2003	22,862					22,862	42
43	Building Improvement	2004	46,101					46,101	43
44	Building Improvement	2006	137,899	6,444	25	6,444		79,099	44
45	Building Improvement	2007	288,024	13,599	10	13,599		172,885	45
46	Building Improvement	2008	136,387	8,241	various	8,241		97,922	46
47	Building Improvement	2009	10,517	1,052	10	1,052		9,995	47
48	Building Improvement	2010	75,292	7,529	10	7,529		61,892	48
49	Building Improvement	2011	81,826	4,631	various	4,631		41,195	49
50	Building Improvement	2012	52,970	2,409	various	2,409		23,043	50
51	Building Improvement	2013	14,799	1,122	various	1,122		7,541	51
52	FIRE DOOR CLOSER	2014	1,850	123	15	123		576	52
53	PATIO COVER, AMERICANA SIERRA 40'X10'	2014	3,803	254	15	254		1,141	53
54	FLOORING, WALL BASE, RMS 1&5	2015	4,425	885	5	885		3,097	54
55	RES RM REMOD-FLOORING 1&3	2015	2,328	233	10	233		776	55
56	RESIDENT RM REMODEL 1&3 (blinds, paint, lighting & counte	2015	5,651	565	10	565		1,884	56
57	(77) SHUTTERS, 14-14X47,10-14X55,2-14X51,51-14X59	2015	2,270	454	5	454		1,476	57
58	(10) SHUTTERS, 2-14X71 & 8-14X75	2015	624	125	5	125		406	58
59	RES RM REMOD-FLOORING 2&4	2015	2,328	233	10	233		737	59
60	RESIDENT RM REMODEL 2&4 (blinds, paint, lighting, & count	2015	5,651	565	10	565		1,789	60
61	RES RM REMOD-FLOORING 7&11	2015	2,328	233	10	233		698	61
62	RESIDENT RM REMODEL 7&11 (blinds, paint, lighting & coun	2015	5,651	565	10	565		1,695	62
63	RES RM REMOD-FLOORING 6&8	2015	2,328	233	10	233		660	63
64	RESIDENT RM REMODEL 6&8 (blinds, paint, lighting & counte	2015	5,651	565	10	565		1,601	64
65	Permastone Luxury Vinyl Tile NAPMR482-Earth	2016	1,023	102	10	102		273	65
66	RES RM REMOD-FLOORING 15&17	2016	2,328	233	10	233		582	66
67	RESIDENT RM REMODEL 15&17 (blinds, paint, lighting & cou	2016	5,651	565	10	565		1,413	67
68	COMPRESSOR ON A/C	2016	1,118	112	10	112		270	68
69	RES RM REMOD-FLOORING 12&14	2016	2,328	233	10	233		543	69
70	TOTAL (lines 4 thru 69)		$ 3,120,246	$ 79,445		$ 79,445	$	$ 2,360,095	70

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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		$ 3,120,246	$ 79,445		$ 79,445	$	$ 2,360,095	1
2	RESIDENT RM REMODEL 12&14 (blinds, paint, lighting & cou	2016	5,651	565	10	565		1,319	2
3	STANDARD PENDENT SPRINKLERS,halls&dining room	2016	1,053	70	10	70		140	3
4	SPRINKLER SYSTEM, DINING ROOM	2017	13,750	1,375	10	1,375		2,406	4
5	FLOOR MOUNTED SVC SINK 27X20-1/2	2017	728	73	10	73		127	5
6	HOT DAWG HANGING HEATER M#HD75AS-011-FBAN	2017	1,641	164	10	164		273	6
7	A/C, CONDENSR M#24ABB360A340, COIL M#FB4CNP060	2017	4,875	488	10	488		650	7
8	WALK IN FREEZER IN GARAGE 12'X10'X7'6" 2-1/2HP	2017	15,177	1,518	10	1,518		1,771	8
9	2 A/C units in dining room	2018	15,375	641	10	641		641	9
10	Circ pump for hot water supply	2018	557	32	10	32		32	10
11	Door security project -B	2018	242	6	10	6		6	11
12	Security Doors	2018	14,140	353	10	353		353	12
13	Walk in fridge	2018	41,610	2,081	10	2,081		2,081	13
14	10x7 white garage door	2017	1,098	201	5	201		201	14
15	Kitcehn Wall divider project	2018	160	12	10	12		12	15
16	Kitcehn Wall divider project	2017	1,979	165	10	165		165	16
17	Res room remodel 19 & 21 (blinds, paint, lighting & counter tops)	2018	3,009	176	10	176		176	17
18	Resident room remodel -F (blinds, paint, lighting & counter tops)	2018	1,240	72	10	72		72	18
19	B&G cric pump SSf-22, 10335	2018	965	96	5	96		96	19
20	Generator	2004	160,787		10			160,787	20
21									21
22	LI - Beccue Bldrs - Parking Lot - The Gathering	2014	30,867	1,543	20	1,543		5,787	22
23	LI - Beccue Bldrs - Concrete - The Gathering	2015	4,358	436	10	436		1,635	23
24	LI - Alwerdts Gardens - Landscaping & Trees - The Gathering	2015	8,529	853	15	853		2,933	24
25	Wrights - Flooring - The Gathering	2014	13,896	695	20	695		2,605	25
26	Electric Wiring - The Gathering	2014	11,945	597	20	597		2,239	26
27	Plumbing - Ther Gathering	2014	7,493	375	20	375		1,406	27
28	Heating & Air - The Gathering	2014	10,600	531	20	531		1,990	28
29	Tub Room - Construction, Paint, Tile Install, Wiring, Cabinets	2014	10,351	691	15	691		2,707	29
30	Tub Room - Bathtub & lift trolley	2014	21,700	2,170	10	2,170		8,397	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,524,022	$ 95,424		$ 95,424	$	$ 2,561,102	34

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	$ 339,274	$ 31,994	$ 31,994	$	VARIOUS	$ 112,876	71
72	Current Year Purchases	7,214	852	852		VARIOUS	852	72
73	Fully Depreciated Assets	615,457				VARIOUS	615,457	73
74								74
75	TOTALS	$ 961,945	$ 32,846	$ 32,846	$		$ 729,185	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	Multiple	Multiple	$ 45,500	$	$	$	5	$ 45,500	76
77	Facility Use	2011 Dodge Grand Caravan	2012	37,570	3,757	3,757		10	26,299	77
78	Facility Use	2000 Mercedes-Benz	2017	1,200	240	240		5	240	78
79	Facility Use	2006 Cadillac DTS	2018	6,000	200	200		5	200	79
80	TOTALS			$ 90,270	$ 4,197	$ 4,197	$		$ 72,239	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)	$ 4,639,947	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,467	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,467	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)	$ 3,362,526	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	$ 1,504,409	$ 59,475	$ 775,425	86
87	Lutheran Terrace	1,232,063	39,663	675,408	87
88	Child Enrichment Center	532,724	21,828	287,325	88
89	Chapel (50%)	239,614	5,186	116,027	89
90					90
91	TOTALS	$ 3,508,810	$ 126,152	$ 1,854,185	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: 10/1/17 Ending: 9/30/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 1,585 Description: Nursing Equipment $634, Dishwasher Lease 951
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

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	1610 hrs	$ 54,728		$	$	1,610	$ 54,728	1
2	Licensed Speech and Language Development Therapist	10A-1	146 hrs	6,516				146	6,516	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1, 10A-2	5393 hrs	183,341			512	5,393	183,853	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				77,711		77,711	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapist	10A-1	69	2,331				69	2,331	12
13	Other (specify): Lab & Xrays	39-3					18,914		18,914	13
14	TOTAL			$ 246,916		$	$ 97,137	7,218	$ 344,053	14

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

STATE OF ILLINOIS

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/18 (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	$ 455,012	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 136,336)	642,811		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,352		6
7	Other Prepaid Expenses	26,176		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,188,351	$	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	6,907,980		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,177,067		16
17	Accumulated Depreciation (book methods)	(5,216,711)		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)**	$ 2,932,046	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,120,397	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,609	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,364		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,448		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	4,827		36
37	Other Accrued Expenses	46,293		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 400,456	$	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	Endowment Fund - Villa	578,279		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 578,279	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 978,735	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,141,662	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,120,397	$	48

*(See instructions.)

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,535,332	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,535,332	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(393,670)	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)**	$ (393,670)	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)**	$ 3,141,662	24 *

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	$ 3,178,794	1
2	Discounts and Allowances for all Levels	(158,388)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,020,406	3
	B. Ancillary Revenue		
4	Day Care	294,093	4
5	Other Care for Outpatients		5
6	Therapy	521,791	6
7	Oxygen	21,775	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 837,659	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	(586)	12
13	Barber and Beauty Care	13,208	13
14	Non-Patient Meals	24,403	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	117,687	16
17	Sale of Drugs	116,631	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,970	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,695	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 323,008	23
	D. Non-Operating Revenue		
24	Contributions	72,354	24
25	Interest and Other Investment Income***	3,227	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 75,581	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see grouping	438,198	28
28a	Miscellaneous income	15,142	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 453,340	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,709,994	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	914,423	31
32	Health Care	1,754,428	32
33	General Administration	1,250,634	33
	B. Capital Expense		
34	Ownership	139,766	34
	C. Ancillary Expense		
35	Special Cost Centers	891,234	35
36	Provider Participation Fee	153,179	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,103,664	40
41	**Income before Income Taxes (line 30 minus line 40)****	(393,670)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (393,670)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 680,702	44
45	Private Pay - Net Inpatient Revenue	1,585,054	45
46	Medicare - Net Inpatient Revenue	754,650	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,020,406	49

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

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

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	1,888	2,113	$ 73,784	$ 34.92	1
2	Assistant Director of Nursing	1,950	2,134	52,806	24.75	2
3	Registered Nurses	9,636	10,536	263,110	24.97	3
4	Licensed Practical Nurses	7,758	8,445	155,263	18.39	4
5	CNAs & Orderlies	42,252	45,312	562,232	12.41	5
6	CNA Trainees					6
7	Licensed Therapist	9,507	10,327	246,916	23.91	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,862	2,078	36,591	17.61	9
10	Activity Assistants	13,739	14,579	146,024	10.02	10
11	Social Service Workers	1,907	2,207	64,404	29.18	11
12	Dietician					12
13	Food Service Supervisor	3,788	4,126	57,492	13.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,724	22,302	218,363	9.79	15
16	Dishwashers					16
17	Maintenance Workers	5,860	6,392	91,222	14.27	17
18	Housekeepers	7,316	8,023	79,715	9.94	18
19	Laundry	7,843	8,837	108,524	12.28	19
20	Administrator	1,790	2,094	93,361	44.59	20
21	Assistant Administrator					21
22	Other Administrative	5,969	6,812	113,644	16.68	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	2,000	2,080	22,880	11.00	31
32	Other Health C: Qual Assur/Care	3,506	3,806	77,187	20.28	32
33	Other(specify) Villa/Daycare/Ter	33,084	35,785	369,370	10.32	33
34	TOTAL (lines 1 - 33)	182,379	197,988	$ 2,832,888 *	$ 14.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,918	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	543	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	600	V11-3	44
45	Social Service Consultant	Monthly	600	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,661		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	519	9,349	10-3	52
53	TOTAL (lines 50 - 52)	519	$ 9,349		53

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0	$ 93,361
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,361

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	$ 10,215
CliftonLarsonAllen, LLP	Audit/Cost Report/Tax	40,751
Technical Partners	Computer Maintenance	3,598
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 54,564

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,817
Unemployment Compensation Insurance	
FICA Taxes	181,513
Employee Health Insurance	412,158
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniform Expense	14,174
Other Employee Benefits	(1,215)
Uniform Income	(12,656)
TOTAL (agree to Schedule V, line 22, col.8)	$ 673,791

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	272
(Indicate # of checks performed)	
Dues and Licenses	38,946
Promotional Advertising	486
Newsletter Expense	146
Less: Public Relations Expense	( )
Non-allowable advertising	(146)
Yellow page advertising	(486)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,218

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	265
Seminar Expense	3,115
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,380

**See instructions.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/17 Ending: 9/30/18

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? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,891** 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
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **153,179**
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. $ **24,403**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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