FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 10/1/19 to 9/30/20 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: 10/1/19 Ending: 9/30/20

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	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,599	13,143	1,988	20,730	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,599	13,143	1,988	20,730	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.00%

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 1,988

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: 9/30/20 Fiscal Year: 9/30/20

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	307,723	22,186	7,008	336,917		336,917		336,917			1
2	Food Purchase		184,198		184,198		184,198	(21,854)	162,344			2
3	Housekeeping	88,581	10,385		98,966		98,966		98,966			3
4	Laundry	118,322	7,135		125,457		125,457		125,457			4
5	Heat and Other Utilities			107,215	107,215		107,215		107,215			5
6	Maintenance	94,964	12,549	23,242	130,755		130,755		130,755			6
7	Other (specify):*											7
8	**TOTAL General Services**	609,590	236,453	137,465	983,508		983,508	(21,854)	961,654			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,355,503	33,795	107,807	1,497,105		1,497,105		1,497,105			10
10a	Therapy	184,912	87		184,999		184,999		184,999			10a
11	Activities	184,797	689	7,035	192,521		192,521		192,521			11
12	Social Services	75,782	168	194	76,144		76,144		76,144			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,800,994	34,739	121,036	1,956,769		1,956,769		1,956,769			16
	C. General Administration											
17	Administrative	103,750			103,750		103,750		103,750			17
18	Directors Fees											18
19	Professional Services			47,452	47,452		47,452		47,452			19
20	Dues, Fees, Subscriptions & Promotions			33,363	33,363		33,363	(593)	32,770			20
21	Clerical & General Office Expenses	136,608	2,942	132,321	271,871		271,871	(114,979)	156,892			21
22	Employee Benefits & Payroll Taxes			843,175	843,175		843,175	(9,433)	833,742			22
23	Inservice Training & Education											23
24	Travel and Seminar			861	861		861		861			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,237	64,237		64,237		64,237			26
27	Other (specify):*											27
28	**TOTAL General Administration**	240,358	2,942	1,121,409	1,364,709		1,364,709	(125,005)	1,239,704			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,650,942	274,134	1,379,910	4,304,986		4,304,986	(146,859)	4,158,127			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: 10/1/19 Ending: 9/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			144,285	144,285		144,285	(5,186)	139,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25	25		25	(25)				32
33	Real Estate Taxes			254	254		254	(254)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			994	994		994		994			35
36	Other (specify):*											36
37	**TOTAL Ownership**			145,558	145,558		145,558	(5,465)	140,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			52,135	52,135		52,135		52,135			39
40	Barber and Beauty Shops			9,340	9,340		9,340		9,340			40
41	Coffee and Gift Shops			2,146	2,146		2,146		2,146			41
42	Provider Participation Fee			166,245	166,245		166,245		166,245			42
43	Other (specify):*	399,064	82,553	336,931	818,548		818,548	(818,548)				43
44	**TOTAL Special Cost Centers**	399,064	82,553	566,797	1,048,414		1,048,414	(818,548)	229,866			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,050,006	356,687	2,092,265	5,498,958		5,498,958	(970,872)	4,528,086			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: 10/1/19 Ending: 9/30/20

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	(21,854)	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	(25)	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	(99,045)	21		24
25	Fund Raising, Advertising and Promotional	(7,771)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(593)	20		28
29	Other-Attach Schedule See PG5A	(841,584)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (970,872)		$	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))**	$ (970,872)		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: 10/1/19

Ending: 9/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-care related salaries	$ (399,064)	43	1
2	Non-care related supplies	(82,553)	43	2
3	Non-care related expenses	(336,931)	43	3
4	Miscellaneous Income	(8,163)	21	4
5	Uniform Income	(9,433)	22	5
6	Non-care related real estate taxes	(254)	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**	(841,584)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center **#** 0025023 **Report Period Beginning:** 10/1/19 **Ending:** 9/30/20

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	(21,854)	0	0	0	0	0	0	0	0	0	0	(21,854)	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**	(21,854)	0	0	0	0	0	0	0	0	0	0	(21,854)	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	(593)	0	0	0	0	0	0	0	0	0	0	(593)	20
21	Clerical & General Office Expenses	(114,979)	0	0	0	0	0	0	0	0	0	0	(114,979)	21
22	Employee Benefits & Payroll Taxes	(9,433)	0	0	0	0	0	0	0	0	0	0	(9,433)	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**	(125,005)	0	0	0	0	0	0	0	0	0	0	(125,005)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(146,859)	0	0	0	0	0	0	0	0	0	0	(146,859)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center **#** 0025023 **Report Period Beginning:** 10/1/19 **Ending:** 9/30/20

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

	Capital Expense	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)	
	D. Ownership													
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	(25)	0	0	0	0	0	0	0	0	0	0	(25)	32
33	Real Estate Taxes	(254)	0	0	0	0	0	0	0	0	0	0	(254)	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**	(5,465)	0	0	0	0	0	0	0	0	0	0	(5,465)	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):*	(818,548)	0	0	0	0	0	0	0	0	0	0	(818,548)	43
44	**TOTAL Special Cost Centers**	(818,548)	0	0	0	0	0	0	0	0	0	0	(818,548)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(970,872)	0	0	0	0	0	0	0	0	0	0	(970,872)	45

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

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: 10/1/19 Ending: 9/30/20

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: 10/1/19 Ending: 9/30/20

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: 10/1/19 Ending: 9/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National Bank		x	Line of Credit		2/25/19			2/23/2020	5.2500	25	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 25	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 25	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: 10/1/19 Ending: 9/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 254	2
3. Under or (over) accrual (line 2 minus line 1).		$ 254	3
4. Real Estate Tax accrual used for 2020 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.		$ 254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-02-016-021	Vacant Lot	$ 254.00	$
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	$ 254.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 10/1/19 Ending: 9/30/20

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: 10/1/19 Ending: 9/30/20

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		30,653	7
8				2002	239,614	5,186	40	5,186		126,399	8
	Improvement Type**										
9	Land Improvements			1980	30,660					30,660	9
10	Land Improvements			1994	10,088	252	40	252		6,621	10
11	Land Improvements			1997	5,308		20			5,308	11
12	Land Improvements			1999	4,080		20			4,080	12
13	Land Improvements			2002	87,004	4,350	20	4,350		78,304	13
14	Land Improvements			2007	1,250	63	20	63		818	14
15	Land Improvements			2008	2,951					2,951	15
16	Land Improvements			2013	33,116	3,312	10	3,312		23,111	16
17	Land Improvements			2014	25,852	2,585	10	2,585		15,877	17
18	PARKING LOT REPAIRS, ROUTE, CLEAN & REFILL JOINTS			2015	3,000	600	5	600		3,150	18
19	4'x6' LCC SIGN OUT FRONT, 2 SM SIGNS			2015	3,441	344	10	344		1,749	19
20	SMOKERS HUT			2016	577	115	5	115		509	20
21	LG BOULDER, W/ENGRAVING-GILBERT			2017	573	57	10	57		186	21
22	Plants -Trimming			2018	845					845	22
23	Plants Landscaping			2018	1,276					1,276	23
24	WOOD BRIGDE BY GARAGE			2019	885	44	10	44		88	24
25	BARK, PREEN			2019	780	91	5	91		182	25
26	COURTYARD ROCK BED			2019	650	43	5	43		86	26
27	LANDSCAPING			2019	1,557	285	5	285		570	27
28	PLANTS, MULCH			2019	1,000	50	5	50		100	28
29	Building Improvements			1986	2,904					2,904	29
30	Building Improvements			1987	3,173					3,173	30
31	Building Improvements			1989	44,772					44,772	31
32	Building Improvements			1990	38,528					38,528	32
33	Building Improvements			1991	6,000					6,000	33
34	Building Improvements			1992	11,467					11,467	34
35	Building Improvements			1993	86,395	2,623	30	2,623		74,151	35
36	Building Improvements			1994	41,978	1,050	40	1,050		27,550	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: 10/1/19 Ending: 9/30/20

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 Improvements	1995	$ 12,474	$ 200	40	$ 200	$	$ 9,629	37
38	Building Improvement	1996	17,779					17,779	38
39	Building Improvement	1997	192,219					192,219	39
40	Building Improvement	1998	21,846					21,846	40
41	Building Improvement	1999	19,607					19,140	41
42	Building Improvement	2002	9,941					9,941	42
43	Building Improvement	2003	22,862					22,862	43
44	Building Improvement	2004	46,101	1,330	various	1,330		40,925	44
45	Building Improvement	2006	137,899	6,444	25	6,444		91,988	45
46	Building Improvement	2007	288,024	13,599	10	13,599		200,083	46
47	Building Improvement	2008	136,387	6,395	various	6,395		110,440	47
48	Building Improvement	2009	10,517		10			9,995	48
49	Building Improvement	2010	75,292	5,871	10	5,871		75,292	49
50	Building Improvement	2011	81,826	4,631	various	4,631		50,457	50
51	Building Improvement	2012	52,970	2,127	various	2,127		27,297	51
52	Building Improvement	2013	14,799	655	various	655		8,852	52
53	Building Improvement	2014	5,653	377	various	377		2,471	53
54	FLOORING, WALL BASE, RMS 1&5	2015	4,425	885	5	885		5,310	54
55	RES RM REMOD-FLOORING 1&3	2015	2,328	233	10	233		1,281	55
56	RESIDENT RM REMODEL 1&3	2015	5,651	565	10	565		5,065	56
57	(77) SHUTTERS, 14-14X47,10-14X55,2-14X51,51-14X59	2015	2,270	454	5	454		3,483	57
58	(10) SHUTTERS, 2-14X71 & 8-14X75	2015	624	125	5	125		655	58
59	RES RM REMOD-FLOORING 2&4	2015	2,328	233	10	233		1,203	59
60	RESIDENT RM REMODEL 2&4	2015	5,651	565	10	565		2,920	60
61	RES RM REMOD-FLOORING 7&11	2015	2,328	233	10	233		1,164	61
62	RESIDENT RM REMODEL 7&11	2015	5,651	565	10	565		2,825	62
63	RES RM REMOD-FLOORING 6&8	2015	2,328	233	10	233		1,125	63
64	RESIDENT RM REMODEL 6&8	2015	5,651	565	10	565		2,731	64
65	Permastone Luxury Vinyl Tile NAPMR482-Earth	2016	1,023	102	10	102		477	65
66	RES RM REMOD-FLOORING 15&17	2016	2,328	233	10	233		1,048	66
67	RESIDENT RM REMODEL 15&17	2016	5,651	565	10	565		2,543	67
68	COMPRESSOR ON A/C	2016	1,118	112	10	112		494	68
69	RES RM REMOD-FLOORING 12&14	2016	2,328	233	10	233		1,009	69
70	TOTAL (lines 4 thru 69)		$ 3,125,118	$ 73,911		$ 73,911	$	$ 2,510,883	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: 10/1/19 Ending: 9/30/20

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		$ 3,125,118	$ 73,911		$ 73,911	$	$ 2,510,883	1
2	RESIDENT RM REMODEL 12&14	2016	5,651	565	10	565		2,449	2
3	STANDARD PENDENT SPRINKLERS,halls&dining room	2016	1,053	70	15	70		281	3
4	SPRINKLER SYSTEM, DINING ROOM	2017	13,750	1,375	10	1,375		5,156	4
5	FLOOR MOUNTED SVC SINK 27X20-1/2	2017	728	73	10	73		273	5
6	HOT DAWG HANGING HEATER M#HD75AS-011-FBAN	2017	1,641	164	10	164		601	6
7	A/C, CONDENSR M#24ABB360A340, COIL M#FB4CNP060	2017	4,875	488	10	488		1,626	7
8	WALK IN FREEZER IN GARAGE 12'X10'X7'6" 2-1/2HP	2017	15,177	1,518	10	1,518		4,806	8
9	2 A/C units in dining room	2018	15,375	1,538	10	1,538		3,717	9
10	Circ pump for hot water supply	2018	557	56	10	56		144	10
11	Door security project -B	2018	242	24	10	24		54	11
12	Security Doors	2018	14,140	1,414	10	1,414		3,181	12
13	Walk in fridge	2018	41,610	4,161	10	4,161		10,403	13
14	10x7 white garage door	2017	1,098	220	5	220		641	14
15	Kitcehn Wall divider project	2018	160	16	10	16		44	15
16	Kitcehn Wall divider project	2017	1,979	198	10	198		561	16
17									17
18									18
19	B&G cric pump SSf-22, 10335	2018	965	193	5	193		482	19
20	DOOR CLOSERS, SENTRONIC	2019	1,091	36	10	36		72	20
21	PLMBNG PARTS TO BLD HO	2019	546	36	10	36		72	21
22	HO WATER PUMP EXPANSION	2019	620	62	10	62		124	22
23	HOOKUPS FOR NEW WASH/D	2019	1,130	28	10	28		56	23
24	LI - Alwerdts Gardens - Landscaping & Trees - The Gathering	2014	8,529	853	10	853		4,639	24
25	LI - Beccue Bldrs - Parking Lot - The Gathering	2014	30,867	1,543	20	1,543		8,873	25
26	LI - Beccue Bldrs - Concrete - The Gathering	2014	4,358	436	10	436		2,507	26
27	Wrights - Flooring - The Gathering	2014	13,896	695	15	695		3,995	27
28	Electric Wiring - The Gathering	2014	11,945	597	20	597		3,433	28
29	Plumbing - The Gathering	2014	7,493	375	20	375		2,156	29
30	Heating & Air - The Gathering	2014	10,600	531	20	531		3,052	30
31	Tub Room - Construction, Paint, Tile Install, Wiring, Cabinets	2014	10,351	691	15	691		4,089	31
32	Tub Room - Bathtub & lift Trolley	2014	21,700	2,170	10	2,170		12,737	32
33	Generator	2014	160,787					160,787	33
34	TOTAL (lines 1 thru 33)		$ 3,528,030	$ 94,038		$ 94,038	$	$ 2,751,896	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: 10/1/19 Ending: 9/30/20

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		$ 3,528,030	$ 94,038		$ 94,038	$	$ 2,751,896	1
2									2
3									3
4	Exit Door Touchpads	2020	1,054	88	5	88		88	4
5	Shed Shelving	2020	1,154	58	5	58		58	5
6	Flooring (lamenant) - The Gathering	2020	10,210	2,042	5	2,042		2,042	6
7									7
8									8
9	Resident Room Remodel #19 & 20 (All 1 asset in legder)								9
10	Vinyl Plank flooring	2018	215	22	10	22		57	10
11	Welded Steel for Heat Registers	2018	92	9	10	9		23	11
12	Remove Wallpaper, paint & painting	2018	851	85	10	85		220	12
13	Ceiling lights, vanity, outlets, wall plates, switches	2018	862	86	10	86		223	13
14	2 windown valances & blinds	2018	989	99	10	99		255	14
15	Resident Room Remodel #19 & 20 (All 1 asset in legder)								15
16	Labor to install vinyl square tiles	2018	1,240	124	10	124		320	16
17									17
18	Resident Room Remodel #27 (all 1 asset in ledge)								18
19	Vinyl Square tiles & labor to install	2020	2,335	175	10	175		175	19
20	Ceiling lights, outlets, plates, & wall plates	2020	67	5	10	5		5	20
21	Drywall repair, paint, & painting	2020	637	48	10	48		48	21
22									22
23	Dirty Utility Room Remodel (All 1 asset in ledger)								23
24	Circulation Pump & fittings for hot water system	2020	835	56	10	56		56	24
25	Floor mounted sink, faucets, caulking, cooper fittings	2020	1,635	109	10	109		109	25
26	Drywall repair, replace trim, paint, & painting, gaskets, caulk	2020	1,223	81	10	81		81	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,551,429	$ 97,125		$ 97,125	$	$ 2,755,656	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: 10/1/19 Ending: 9/30/20

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	$ 403,046	$ 34,557	$ 34,557	$	VARIOUS	$ 159,780	71
72	Current Year Purchases	33,906	2,220	2,220		VARIOUS	2,220	72
73	Fully Depreciated Assets	574,181				VARIOUS	574,181	73
74								74
75	TOTALS	$ 1,011,133	$ 36,777	$ 36,777	$		$ 736,181	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	2011 DODGE GRAND CARAVAI	2011	37,570	3,757	3,757		10	33,813	77
78	Facility Use	2000 MERCEDES-BENZ, E32, G	2017	1,200	240	240		5	720	78
79	Facility Use	2006 Cadillac dts, gold 4d	2018	6,000	1,200	1,200		5	2,600	79
80	TOTALS			$ 84,595	$ 5,197	$ 5,197	$		$ 76,958	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)	$ 4,710,867	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 139,099	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,099	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)	$ 3,568,795	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	$ 1,537,166	$ 57,933	$ 892,321	86
87	Lutheran Terrace	1,240,078	38,796	753,708	87
88	Child Enrichment Center	534,560	22,786	332,593	88
89	Chapel (50%)	239,614	5,186	126,398	89
90					90
91	TOTALS	$ 3,551,418	$ 124,701	$ 2,105,020	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: 10/1/19 Ending: 9/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 994 Description: Dishwasher Lease
(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: 10/1/19 Ending: 9/30/20

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.

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	1322 hrs	$ 45,180		$	$	1,322	$ 45,180	1
2	Licensed Speech and Language Development Therapist	10A-1	81 hrs	4,779				81	4,779	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1, 10A-2	5042 hrs	134,466			87	5,042	134,553	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				35,060		35,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapist	10A-1	19	487				19	487	12
13	Other (specify): Lab & Xrays, Medicare	39-3					17,075		17,075	13
14	TOTAL			$ 184,912		$	$ 52,222	6,464	$ 237,134	14

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/20 (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	$ 1,966,202	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 128,724)	312,169		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,035		6
7	Other Prepaid Expenses	20,242		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,304,648	$	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	6,966,127		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,232,448		16
17	Accumulated Depreciation (book methods)	(5,673,814)		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)**	$ 2,588,471	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,893,119	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,713	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	276,787		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,219		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	See Schedule	1,954		36
37	See Schedule	40,739		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 426,327	$	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 Funds	622,300		43
44	Deferred Provider Relief Funds	474,974		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,097,274	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,523,601	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,369,518	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,893,119	$	48

***(See instructions.)**

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,152,898	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,152,898	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	216,620	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)**	$ 216,620	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)**	$ 3,369,518	24 *

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 3,397,715	1
2	Discounts and Allowances for all Levels	207,188	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,604,903	3
	B. Ancillary Revenue		
4	Day Care	300,390	4
5	Other Care for Outpatients		5
6	Therapy	220,761	6
7	Oxygen	21,695	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 542,846	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	3,427	12
13	Barber and Beauty Care	9,527	13
14	Non-Patient Meals	21,854	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	112,585	16
17	Sale of Drugs	52,450	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,007	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,140	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 244,990	23
	D. Non-Operating Revenue		
24	Contributions	90,414	24
25	Interest and Other Investment Income***	1,182	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 91,596	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	see grouping	457,222	28
28a	Miscellaneous income/COVID Relief Funds	774,021	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,231,243	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,715,578	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	983,508	31
32	Health Care	1,956,769	32
33	General Administration	1,364,709	33
	B. Capital Expense		
34	Ownership	145,558	34
	C. Ancillary Expense		
35	Special Cost Centers	1,048,414	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,498,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	216,620	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 216,620	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 838,153	44
45	Private Pay - Net Inpatient Revenue	2,190,464	45
46	Medicare - Net Inpatient Revenue	576,286	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,604,903	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 10/1/19 Ending: 9/30/20

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	2,101	2,101	$ 77,976	$ 37.11	1
2	Assistant Director of Nursing	2,157	2,157	56,936	26.40	2
3	Registered Nurses	12,999	12,999	356,816	27.45	3
4	Licensed Practical Nurses	4,022	4,022	86,004	21.38	4
5	CNAs & Orderlies	49,604	49,604	694,622	14.00	5
6	CNA Trainees					6
7	Licensed Therapist	6,463	6,463	184,912	28.61	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,879	3,879	57,219	14.75	9
10	Activity Assistants	11,468	11,468	127,578	11.12	10
11	Social Service Workers	2,350	2,350	75,782	32.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,689	25,689	307,723	11.98	15
16	Dishwashers					16
17	Maintenance Workers	6,205	6,205	94,964	15.30	17
18	Housekeepers	7,943	7,943	88,581	11.15	18
19	Laundry	8,525	8,525	118,322	13.88	19
20	Administrator	2,076	2,076	103,750	49.98	20
21	Assistant Administrator					21
22	Other Administrative	8,162	8,162	136,608	16.74	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					31
32	Other Health C: Qual Assur/Care	3,916	3,916	83,149	21.23	32
33	Other(specify) Villa/Daycare/Terr	34,825	34,825	399,064	11.46	33
34	TOTAL (lines 1 - 33)	192,384	192,384	$ 3,050,006 *	$ 15.85	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	96	$ 5,893	V01-3	35
36	Medical Director	Monthly	6,000	V09-3	36
37	Medical Records Consultant	Monthly	500	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		194	V11-3	44
45	Social Service Consultant		194	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	$ 13,321		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	2,955	106,767	10-3	52
53	TOTAL (lines 50 - 52)	2,955	$ 106,767		53

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0	$ 103,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,750

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
CliftonLarsonAllen, LLP	Audit/Cost Report/Tax	$ 36,492
Paylocity	Payroll	10,960
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 47,452

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,143
Unemployment Compensation Insurance	
FICA Taxes	189,174
Employee Health Insurance	558,560
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniform Expense	5,611
Other Employee Benefits	19,687
Uniform Income	(9,433)
TOTAL (agree to Schedule V, line 22, col.8)	$ 833,742

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	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Licenses	28,790
Promotional Advertising	460
Newsletter Expense	133
Less: Public Relations Expense	( )
Non-allowable advertising	(593)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,770

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
CPR Training	240
Administrator Testing	621
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 861

**See instructions.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/19 Ending: 9/30/20

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. **AAHSA (Leading Age) $1,611; ILASN $1,505**

(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. $ **3,760** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement?
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. $ **166,245**
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. $ **21,854**

(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: **CLA, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **No legal fee costs**
Attach invoices and a summary of services for all architect and appraisal fees.