

		FOR BHF USE					

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

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 Altamont 62411 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: ☒ VOLUNTARY,NON-PROFIT ☒ 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: Telephone Number: ()

Email Address:

Facility Name & ID Number Lutheran Care Center

0025023 Report Period Beginning: 10/1/2015 Ending: 9/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,136</u>	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	<u>96</u>	TOTALS	<u>96</u>	<u>35,136</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,141</u>	<u>12,859</u>	<u>2,720</u>	<u>23,720</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,141</u>	<u>12,859</u>	<u>2,720</u>	<u>23,720</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.51%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
DAYCARE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ 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 ☒ Date 10/01/1980 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 96 and days of care provided 2,720

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 9/30/2016 Fiscal Year: 9/30/2016

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/2015 Ending: 9/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	275,520	23,607	7,264	306,391		306,391		306,391			1
2	Food Purchase		172,164		172,164		172,164	(26,148)	146,016			2
3	Housekeeping	96,053	15,881		111,934		111,934		111,934			3
4	Laundry	98,704	12,036		110,740		110,740		110,740			4
5	Heat and Other Utilities			119,221	119,221		119,221		119,221			5
6	Maintenance	91,532	11,085	20,893	123,510		123,510		123,510			6
7	Other (specify):*											7
8	TOTAL General Services	561,809	234,773	147,378	943,960		943,960	(26,148)	917,812			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,183,434	44,790	2,598	1,230,822		1,230,822		1,230,822			10
10a	Therapy	186,709	215		186,924		186,924		186,924			10a
11	Activities	174,503	2,636	11,244	188,383		188,383		188,383			11
12	Social Services	60,101	507	576	61,184		61,184		61,184			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,604,747	48,148	20,418	1,673,313		1,673,313		1,673,313			16
	C. General Administration											
17	Administrative	88,800			88,800		88,800		88,800			17
18	Directors Fees											18
19	Professional Services			53,213	53,213		53,213		53,213			19
20	Dues, Fees, Subscriptions & Promotions			38,266	38,266		38,266	(1,711)	36,555			20
21	Clerical & General Office Expenses	128,041	3,283	158,524	289,848		289,848	(123,520)	166,328			21
22	Employee Benefits & Payroll Taxes			680,717	680,717		680,717	(7,848)	672,869			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,402	3,402		3,402		3,402			24
25	Other Admin. Staff Transportation		3,804		3,804		3,804		3,804			25
26	Insurance-Prop.Liab.Malpractice			41,376	41,376		41,376		41,376			26
27	Other (specify):*											27
28	TOTAL General Administration	216,841	7,087	975,498	1,199,426		1,199,426	(133,079)	1,066,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,383,397	290,008	1,143,294	3,816,699		3,816,699	(159,227)	3,657,472			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			138,929	138,929		138,929		138,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,012	1,012		1,012	(936)	76			32
33	Real Estate Taxes			461	461		461	(481)	(20)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			924	924		924		924			35
36	Other (specify):*											36
37	TOTAL Ownership			141,326	141,326		141,326	(1,417)	139,909			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			102,679	102,679		102,679		102,679			39
40	Barber and Beauty Shops			21,510	21,510		21,510		21,510			40
41	Coffee and Gift Shops			1,484	1,484		1,484		1,484			41
42	Provider Participation Fee			180,143	180,143		180,143		180,143			42
43	Other (specify):* NRCC-SEE GROU	360,052	85,431	319,439	764,922		764,922	(764,922)				43
44	TOTAL Special Cost Centers	360,052	85,431	625,255	1,070,738		1,070,738	(764,922)	305,816			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,743,449	375,439	1,909,875	5,028,763		5,028,763	(925,566)	4,103,197			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,148)	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	(936)	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	(122,185)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,711)	20		28
29	Other-Attach Schedule SEE PG5A FOR DETAIL	(774,586)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (925,566)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (925,566)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-care related salaries	\$ (360,052)	43	1
2	Non-care related supplies	(85,431)	43	2
3	Non-care related expenses	(319,439)	43	3
4	Offset Miscellaneous revenue against expense	(1,335)	21	4
5	OffsetUniform revenue against expense	(7,848)	22	5
6	Non-care related real estate taxes	(481)	33	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(774,586)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/1/2015

Ending:

9/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(26,148)	0	0	0	0	0	0	0	0	0	0	(26,148)	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	(26,148)	0	0	0	0	0	0	0	0	0	0	(26,148)	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	(1,711)	0	0	0	0	0	0	0	0	0	0	(1,711)	20
21	Clerical & General Office Expenses	(123,520)	0	0	0	0	0	0	0	0	0	0	(123,520)	21
22	Employee Benefits & Payroll Taxes	(7,848)	0	0	0	0	0	0	0	0	0	0	(7,848)	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	(133,079)	0	0	0	0	0	0	0	0	0	0	(133,079)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,227)	0	0	0	0	0	0	0	0	0	0	(159,227)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/2015 Ending: 9/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(936)	0	0	0	0	0	0	0	0	0	0	(936)	32
33	Real Estate Taxes	(481)	0	0	0	0	0	0	0	0	0	0	(481)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,417)	0	0	0	0	0	0	0	0	0	0	(1,417)	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):*	(764,922)	0	0	0	0	0	0	0	0	0	0	(764,922)	43
44	TOTAL Special Cost Centers	(764,922)	0	0	0	0	0	0	0	0	0	0	(764,922)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(925,566)	0	0	0	0	0	0	0	0	0	0	(925,566)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 10/1/2015 Ending: 9/30/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2	Note: No members of the Board provided services to the nursing home nor owned business entities that provided services to the nursing home										2
3	See attached list of Board of Directors										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/2015 Ending: 1/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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		2/23/2016	350,000		2/23/2017	0.0350	1,012	6	
7						12/01/09						7	
8												8	
9	TOTAL Facility Related						\$ 350,000	\$			\$ 1,012	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 350,000	\$			\$ 1,012	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 481	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 481	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 481	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	
		FOR BHF USE ONLY		
		13 FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14 PLUS APPEAL COST FROM LINE 5 \$		14
		15 LESS REFUND FROM LINE 6 \$		15
		16 AMOUNT TO USE FOR RATE CALCULATION \$		16

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

A. Square Feet: 25,884

B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity?

☒ (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?

☒ (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?
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	2	3	4	
	Use	Square Feet	Year Acquired	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

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XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96		1980	1969	\$ 879,500	\$	25	\$	\$	879,500	4
5			1980	1982	141,000		25			141,000	5
6			1980	1981	3,764		25			3,764	6
7			1980	1991	5,960		25			5,960	7
8				2014	213,250	5,331	40	5,331		9,329	8
	Improvement Type**										
9	Land Improvements			1980	30,660		25			30,660	9
10	Land Improvements			1986	4,143		25			4,143	10
11	Land Improvements			1997	5,308	266	20	266		5,072	11
12	Building Improvements			1981	3,486		5			3,486	12
13	Building Improvements			1982	6,720		20			6,720	13
14											14
15	Building Improvements			1985	940		10			940	15
16	Building Improvements			1985	2,512		20			2,512	16
17	Building Improvements			1986	955		10			955	17
18	Building Improvements			1986	1,949		20			1,949	18
19	Building Improvements			1987	2,150		10			2,150	19
20	Building Improvements			1987	1,023		20			1,023	20
21	Building Improvements			1988	1,500		10			1,500	21
22	Building Improvements			1989	16,262		10			16,262	22
23											23
24	Building Improvements			1989	28,510		20			28,510	24
25	Building Improvements			1990	6,315		5			6,315	25
26	Building Improvements			1990	20,381		10			20,381	26
27	Building Improvements			1990	10,176		15			10,176	27
28	Building Improvements			1990	1,656		20			1,656	28
29	Building Improvements			1991	6,000		10			6,000	29
30	Building Improvements			1992	7,122		7			7,122	30
31	Building Improvements			1992	4,345		10			4,345	31
32	Building Improvements			1993	86,395	2,623	Various	2,623		63,658	32
33	Sprinkler System			1994	37,479	938	40	938		20,850	33
34	Additional Patio Work			1994	1,725	42	40	42		957	34
35	Breakroom Wallpaper			1994	302	8	40	8		169	35
36	Admin Office Wallpaper			1994	381	10	40	10		213	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:

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Floor Tile	1994	\$ 683	\$ 17	40	\$ 17		\$ 380	37
38	Misc. Building Improvements	1994	1,408	35	40	35		783	38
39	Land Improvements- Sewer Line	1994	7,949	199	40	199		4,423	39
40	Land Imp. - Drainage Pipe	1994	860	22	40	22		479	40
41	Misc. Land Improvements	1994	1,279	31	40	31		710	41
42	Building Improvements	1995	7,987	200	40	200		4,343	42
43	Office Wallpaper	1995	2,087		10			2,087	43
44	Front Office Wallpaper	1995	825		10			825	44
45	Activity Office Counter Top	1995	2,292		10			2,292	45
46	Air Conditioner Unit	1996	8,400		10			8,400	46
47	Air Conditioner Unit	1996	940		10			940	47
48	Air Conditioner Unit	1996	560		10			560	48
49	Gas Line	1996	4,036		10			4,036	49
50	Fire Alarm System	1996	2,429		10			2,429	50
51	Building Improvements	1996	697		10			697	51
52	Electrical Wiring	1997	1,171		10			1,171	52
53	Electrical Wiring	1997	966		10			966	53
54	Cabinets and Counter Tops	1997	11,664		10			11,664	54
55	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Ro	1998	2,445	122	20	122		2,293	55
56	Plumbing, blinds, lighting (Remodeling-Medicare Rooms)	1998	1,221		10			1,221	56
57	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	7,701		10			7,701	57
58	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Room	1998	6,937		10			6,937	58
59	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Med	1998	3,543		10			3,543	59
60	Landscaping	1999	4,080	204	20	204		3,536	60
61	Closets (Remodeling-Medicare Rooms)	1999	1,474		10			1,474	61
62	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		2,775	62
63	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		6,180	63
64	Brick work (Laundry Expansion)	1999	4,554	228	20	228		3,965	64
65	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		2,346	65
66	Remodel Medicare Room	1999	652		5			652	66
67	Flooring	2002	6,306		10			6,306	67
68	Windows	2002	3,635		10			3,635	68
69	Roof Item #20	1997	178,417	8,921	20	8,921		169,495	69
70	TOTAL (lines 4 thru 69)		\$ 1,821,994	\$ 19,843		\$ 19,843	\$	\$ 1,556,521	70

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

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Report Period Beginning:

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,821,994	\$ 19,843		\$ 19,843	\$	\$ 1,556,521	1
2	Chapel - Updated to 6/30/07 Audit Findings	2002	220,826	5,186	40	5,186		86,867	2
3	Chapel - Windows- Updated to 6/30/07 Audit Findings	2002	13,270		10			13,270	3
4	Chapel - Sidewalk- Updated to 6/30/07 Audit Findings	2002	1,042		10			1,042	4
5	Chapel - Cabinets- Updated to 6/30/07 Audit Findings	2002	4,623		10			4,623	5
6	Chapel - Wiring- Updated to 6/30/07 Audit Findings	2002	2,554		10			2,554	6
7	Chapel - Landscaping- Updated to 6/30/07 Audit Findings	2002	3,140		10			3,140	7
8	Chapel - Screen	2002	858		10			858	8
9	Chapel - Cable- Updated to 6/30/07 Audit Findings	2002	3,977		10			3,977	9
10	Chapel - Door Guard- Updated to 6/30/07 Audit Findings	2002	2,478		10			2,478	10
11	Driveway & parking lot	2002	87,004	4,350	20	4,350		60,903	11
12	Plants/Rock/Stone	2003	853		10			853	12
13	Window replacement project	2003	14,285		10			14,285	13
14									14
15	Painting- hallways and west wing	2003	6,347		10			6,347	15
16	Painting- hallways	2003	2,230		10			2,230	16
17	Garage expansion	2004	15,214	761	20	761		9,318	17
18	Room painting and wall paper	2004	17,526		10			17,526	18
19	Painting building, trim & eaves	2004	1,978		10			1,978	19
20	Generator- Updated to 6/30/07 Audit findings (ALL)	2004	160,787		10			160,787	20
21	Window Coverings	2004	3,307		10			3,307	21
22	Wiring	2004	11,383	569	20	569		6,782	22
23	Physical Therapy Addition	2006	123,827	6,187	VARIOUS	6,187		65,083	23
24	Review fee to IDPH for Therapy Building Plans	2006	6,000	240	25	240		2,540	24
25	Architecture fees for Therapy Building	2006	26,205	1,048	25	1,048		11,093	25
26	Physical Therapy/Activity Room Addition	2006	294,126	15,172	VARIOUS	15,172		150,188	26
27	Bldg Improvements - Lobby	2008	74,733	4,983	15	4,983		39,817	27
28	Painting - Lobby	2008	2,115		5			2,115	28
29	Bldg Improvements - Lobby	2008	10,516	1,051	10	1,051		7,892	29
30	LI - Seal Concrete	2008	2,951		7			2,951	30
31	Kitchen	2008	57,030	4,290	VARIOUS	4,290		35,967	31
32	Curt Reardon- Installation of Lobby Flooring	2008	2,510		6			2,510	32
33	Roof Addition	2010	75,292	7,529	10	7,529		46,834	33
34	TOTAL (lines 1 thru 33)		\$ 3,070,981	\$ 71,209		\$ 71,209	\$	\$ 2,326,636	34

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

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Report Period Beginning:

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9/30/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,070,981	\$ 71,209		\$ 71,209	\$	\$ 2,326,636	1
2	<u>Sprinkler System</u>	2011	14,535	581		581		3,488	2
3	<u>Dining Room Renovation</u>	2011	86,826	6,013	VARIOUS	6,013		32,999	3
4	<u>Alarm System Door Transmitter 467</u>	2012	483	48	10	48		226	4
5	<u>Compressor 485</u>	2012	2,226	148	15	148		656	5
6	<u>Built In Nurses Desks</u>	2012	3,316	166	20	166		760	6
7	<u>Electrical Wiring - BR Remodel 449</u>	2012	834	83	10	83		396	7
8	<u>Electrical Wiring - Laundry 503</u>	2012	1,317	66	20	66		253	8
9	<u>Flooring - N&S Halls 457</u>	2012	7,059	353	20	353		1,618	9
10	<u>Flooring - Chapel Hall 495</u>	2012	4,068	814	5	814		3,119	10
11	<u>Flooring - DON Office 497</u>	2012	1,590	318	5	318		1,219	11
12	<u>Install Flooring - Chapel Hall</u>	2012	2,422	484	5	484		1,857	12
13	<u>Install Flooring - DON Office</u>	2012	379	76	5	76		290	13
14	<u>Sound System - Chapel 490</u>	2012	630	126	5	126		504	14
15	<u>Sprinkler System 455</u>	2012	6,580	263	25	263		1,250	15
16	<u>Sprinkler System 456</u>	2012	9,700	388	25	388		1,810	16
17	<u>Sprinkler System 462</u>	2012	11,667	583	20	583		2,625	17
18	<u>Copper Water Lines - Laundry 502</u>	2012	701	28	25	28		108	18
19	<u>Recover Aawning 2' X 6' X 53' W/Valance</u>	2013	4,000	800	5	800		2,733	19
20	<u>Counter Tops for Desks</u>	2013	908	91	10	91		265	20
21	<u>Gutters, Downspouts, & leaf guards</u>	2013	2,300	115	20	115		383	21
22	<u>Painting, Drywalling and Priming 504</u>	2013	1,400	140	10	140		525	22
23	<u>Sprinkler System 515</u>	2013	6,190	309	20	309		1,057	23
24	<u>LI - Design Services</u>	2013	1,865	186	10	186		544	24
25	<u>LI - Landscaping</u>	2013	8,341	834	10	834		2,502	25
26	<u>LI - Pergola</u>	2013	3,240	324	10	324		918	26
27	<u>LI - Sidewalk</u>	2013	19,669	1,967	10	1,967		5,901	27
28									28
29	<u>Fire Door Closer</u>	2014	1,850	123	10	123		329	29
30	<u>Patio Cover, Americana Sierra 40' X 10'</u>	2014	3,803	254	10	254		634	30
31	<u>LI - Scallop Picket Fence</u>	2014	5,548	555	10	555		1,387	31
32	<u>LI - Plants for Courtyard</u>	2014	540	54	10	54		131	32
33	<u>LI - Lights around sidewalks and courtyard</u>	2014	2,152	215	10	215		502	33
34	TOTAL (lines 1 thru 33)		\$ 3,287,120	\$ 87,714		\$ 87,714	\$	\$ 2,397,625	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:

10/1/2015

Ending:

9/30/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,287,120	\$ 87,714		\$ 87,714	\$	\$ 2,397,625	1
2	LI - Parking Lot Addition	2014	6,709	671	10	671		1,342	2
3	LI - Courtyard Drains, 4 concrete benches, seal patio	2014	10,904	1,090	10	1,090		2,181	3
4	LI - Beccue Bldrs - Parking Lot - The Gathering LI	2014	30,867	1,543	20	1,543		2,701	4
5	#1089 - Wrights - Flooring - The Gathering Bldg Impr	2014	13,673	684	20	684		1,196	5
6	#158 - Integrity Electric - Wiring - The Gathering Bldg Impr	2014	248	12	20	12		21	6
7	#402 - Jeff Shelton - Plumbing - The Gathering Bldg Impr	2014	2,700	135	20	135		236	7
8	Integrity Electric - The Gathering Bldg Impr	2014	1,017	51	20	51		89	8
9	Kemme's Heating & Air - The Gathering Bldg Impr	2014	7,350	368	20	368		644	9
10	Integrity Electric - The Gathering Bldg Impr	2014	10,680	534	20	534		935	10
11	Merz Heating Install - The Gathering Bldg Impr	2014	3,250	163	20	163		284	11
12	Shelton Plumbing - The Gathering Bldg Impr	2014	4,793	240	20	240		420	12
13	Hazlett Flooring - The Gathering Bldg Impr	2014	223	11	20	11		19	13
14	Hollar Design 50% - The Gathering - Tub Room	2014	3,203	214	15	214		410	14
15	Altamont Lumber - The Gathering - Tub Room	2014	547	36	15	36		69	15
16	Construction Supplies - The Gathering - Tub Room	2014	62	4	15	4		8	16
17	Tape and Finish - The Gathering - Tub Room	2014	450	30	15	30		58	17
18	Paint - The Gathering - Tub Room	2014	42	3	15	3		6	18
19	Prime and Paint - The Gathering - Tub Room	2014	173	12	15	12		23	19
20	Tile Install - The Gathering Tub Room	2014	3,313	221	15	221		423	20
21	Bathtub, Lift Trolley - The Gathering - Tub Room	2014	21,700	2,170	10	2,170		4,057	21
22	Electric Wiring - The Gathering - Tub Room	2014	1,156	77	15	77		148	22
23	Supplies - The Gathering - Tub Room	2014	23	2	15	2		3	23
24	Built Guard - The Gathering - Tub Room	2014	192	13	15	13		25	24
25	Install Cabinets - The Gathering - Tub Room	2014	415	27	15	27		52	25
26	R&H Plumbing - Vent Van - The Gathering - Tub Room	2014	763	51	15	51		98	26
27	R&H Plumbing - P Trap - The Gathering - Tub Room	2014	12	1	15	1		2	27
28	LI - Parking Lot Repairs	2015	3,000	600	5	600		750	28
29	LI - LCC Sign Out Front	2015	3,441	344	10	344		373	29
30	LI - Beccue Bldrs - Concrete - The Gathering	2015	4,358	436	10	436		763	30
31	LI - Alwerdts Gardens - Landscaping & Trees - The Gathering	2015	8,529	853	15	853		1,227	31
32	(77) Shutters, 14-14X47, 10-14X55, 2-14X51	2015	2,270	454	5	454		568	32
33	(10) Shutters 2-14X71, & 8-14X75	2015	624	125	5	125		156	33
34	TOTAL (lines 1 thru 33)		\$ 3,433,807	\$ 98,889		\$ 98,889	\$	\$ 2,416,912	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:

10/1/2015

Ending:

9/30/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,433,807	\$ 98,889		\$ 98,889	\$	\$ 2,416,912	1
2	Flooring, Wall Base, RMS 1 & 5	2015	4,425	885	5	885		1,327	2
3	Remodel Flooring 7	2015	2,328	233	10	233		233	3
4	Remodel Flooring 6	2016	2,328	194	10	194		194	4
5	Remodel Flooring 1	2015	2,328	233	10	233		310	5
6	Remodel Flooring 1	2016	2,328	78	10	78		78	6
7	Remodel Flooring 2	2015	2,329	233	10	233		272	7
8	Resident RM Remodel 7 & 11(Blinds, Paint, lighting, counter tops)	2015	5,651	565	10	565		565	8
9	Resident RM Remodel 6 & 8 (Blinds, Paint, lighting, counter tops)	2016	5,651	471	10	471		471	9
10	Resident RM Remodel 1 & 3 (Blinds, Paint, lighting, counter tops)	2015	5,651	565	10	565		659	10
11	Resident RM Remodel 2 & 4 (Blinds, Paint, lightening, counter top)	2015	5,651	565	10	565		753	11
12	Compressor On Dining Room	2016	1,118	47	10	47		47	12
13	Permastone Vinyl Tile	2016	1,023	68	10	68		68	13
14	Remodel Flooring 1	2016	2,328	116	10	116		116	14
15	Resident RM Remodel 1 & 15 (Blinds, Paint, lightening, counter tops)	2016	5,651	283	10	283		283	15
16	Resident RM Remodel 12 & 1 (Blinds, Paint, lightening, counter tops)	2016	5,651	188	10	188		188	16
17	Smokers Hut	2016	577	48	5	48		48	17
18	Rounding Variance		(3)						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,488,822	\$ 103,661		\$ 103,661	\$	\$ 2,422,524	34

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

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	\$ 330,560	\$ 30,018	\$ 30,018	\$	VARIOUS	\$ 165,958	71
72	Current Year Purchases	26,078	1,493	1,493		VARIOUS	1,493	72
73	Fully Depreciated Assets	538,135					538,135	73
74								74
75	TOTALS	\$ 894,773	\$ 31,511	\$ 31,511	\$		\$ 705,586	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	2011	\$ 39,825	\$	\$	\$	5	\$ 39,825
77	Facility Use	2011 Dodge Grand Caravan	2011	37,570	3,757	3,757		10	18,785
78	Facility Use	Chevy Lumina	2004	5,675				5	5,675
79									
80	TOTALS			\$ 83,070	\$ 3,757	\$ 3,757	\$		\$ 64,285

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	4,530,375
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	138,929
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	138,929
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,192,395

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	\$ 1,443,021	\$ 54,646	\$ 680,766
87	Lutheran Terrace	1,208,044	45,308	608,622
88	Child Enrichment Center	522,001	21,670	248,175
89	Chapel (50%)	252,767	8,185	118,809
90				
91	TOTALS	\$ 3,425,833	\$ 129,809	\$ 1,656,372

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

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:
- *

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: \$ 924
- Description: DISHWASHER - \$836; Nursing Equip \$88
- (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

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ 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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A1	12235 hrs	\$ 20,726		\$	\$	12,235	\$ 20,726	1
2	Licensed Speech and Language Development Therapist	10A1	127 hrs	6,669				127	6,669	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A1	606 hrs	159,314				606	159,314	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-2	# of prescrpts				83,313		83,313	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 186,709		\$	\$ 83,313	12,968	\$ 270,022	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 684,939	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,965)	583,711		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,327		6
7	Other Prepaid Expenses	18,808		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,350,785	\$	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	6,780,302		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,112,196		16
17	Accumulated Depreciation (book methods)	(4,848,767)		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 CIP)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,107,441	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,458,226	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 176,726	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,046		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,252		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	(132)		36
37	Resident Fund/Allowance/LOC	107,808		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 527,615	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Subscriber Deposits	587,205		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 587,205	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,114,820	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,343,406	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,458,226	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,361,743	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,361,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(18,337)	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)	\$ (18,337)	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)	\$ 3,343,406	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning: 10/1/2015

Ending: 9/30/2016

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,686,699	1
2	Discounts and Allowances for all Levels	(169,261)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,517,438	3
	B. Ancillary Revenue		
4	Day Care	293,593	4
5	Other Care for Outpatients		5
6	Therapy	265,898	6
7	Oxygen	10,162	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 569,653	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	4,299	12
13	Barber and Beauty Care	19,921	13
14	Non-Patient Meals	26,148	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	100,288	16
17	Sale of Drugs	124,921	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,353	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,170	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 327,100	23
	D. Non-Operating Revenue		
24	Contributions	97,877	24
25	Interest and Other Investment Income***	936	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98,813	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Non-reimbursable revenue (See grouping)</u>	488,239	28
28a	<u>Miscellaneous Revenue</u>	9,183	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 497,422	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,010,426	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	943,960	31
32	Health Care	1,673,313	32
33	General Administration	1,199,426	33
	B. Capital Expense		
34	Ownership	141,326	34
	C. Ancillary Expense		
35	Special Cost Centers	890,595	35
36	Provider Participation Fee	180,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,028,763	40
41	Income before Income Taxes (line 30 minus line 40)**	(18,337)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (18,337)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,048,873	44
45	Private Pay - Net Inpatient Revenue	1,906,213	45
46	Medicare - Net Inpatient Revenue	562,352	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,517,438	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,097	2,355	\$ 67,801	\$ 28.79	1
2	Assistant Director of Nursing	2,123	2,292	50,159	21.88	2
3	Registered Nurses	8,838	9,447	201,781	21.36	3
4	Licensed Practical Nurses	10,905	11,811	181,828	15.39	4
5	CNAs & Orderlies	55,037	59,333	586,570	9.89	5
6	CNA Trainees					6
7	Licensed Therapist	12,967	14,235	186,709	13.12	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	18,494	19,806	174,503	8.81	10
11	Social Service Workers	2,431	2,662	60,101	22.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,600	31,690	275,520	8.69	15
16	Dishwashers					16
17	Maintenance Workers	6,709	7,203	91,532	12.71	17
18	Housekeepers	10,091	10,756	96,053	8.93	18
19	Laundry	8,607	9,426	98,704	10.47	19
20	Administrator	2,091	2,262	88,800	39.26	20
21	Assistant Administrator					21
22	Other Administrative	10,653	11,524	128,041	11.11	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,096	2,282	20,934	9.17	31
32	Other Health Care Qual Assur/Care P	3,801	4,063	74,361	18.30	32
33	Other(specify) Villa/Daycare/Terri	36,354	39,341	360,052	9.15	33
34	TOTAL (lines 1 - 33)	222,894	240,488	\$ 2,743,449 *	\$ 11.41	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,126	V01-3	35
36	Medical Director	Monthly	6,000	V09-3	36
37	Medical Records Consultant	Monthly	2,000	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	540	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	576	V11-3	44
45	Social Service Consultant	Monthly	576	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,818		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number

Lutheran Care Center

0025023

Report Period Beginning:

10/1/2015

Ending:

9/30/2016

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

KAREN HILLE

Administrator

0

\$ 88,800

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 88,800

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Paylocity

Payroll

\$ 10,119

CliftonLarsonAllen, LLP

Audit/Cost Rpt/Tax

37,036

Technical Partners

Computer Maintenance

6,058

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 53,213

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 107,408

Unemployment Compensation Insurance

0

FICA Taxes

156,829

Employee Health Insurance

417,477

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Employee Benefits

(12,009)

Employee Uniform Exp

11,012

Revenue from Uniforms

(7,848)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 672,869

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

3,601

Health Care Worker Background Check

(Indicate # of checks performed 12)

192

Patient Background Checks

87

Dues and Licenses

31,892

Promotional Advertising

1,518

Newsletter Expense

193

Less: Public Relations Expense

()

Non-allowable advertising

(193)

Yellow page advertising

(1,518)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 36,555

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

855

Seminar Expense

2,547

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 3,402

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount. LIFE SERVICES NETWORK - \$5,399

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 11,717

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

x

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 180,143

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 benefit on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 26,148

(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

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