

		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: <u>0019109</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																									
Facility Name: <u>The Lutheran Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> 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.																																																																																									
Address: <u>6901 North Galena Rd</u> <u>Peoria</u> <u>61614</u>																																																																																											
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Telephone Number: <u>314-968-9313</u> Fax # <u>314-968-5590</u>																																																																																											
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Paul Ogier</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Chief Financial Officer</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u></td><td></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>2/25/07</u></td><td colspan="2" rowspan="4"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)3</u></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Kevin Wellen</u></td><td colspan="2">Telephone Number: <u>314-925-4446</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Paul Ogier</u>		Paid Preparer	(Title) <u>Chief Financial Officer</u>		(Signed) _____	(Date) _____	(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>		(Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u>				(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>		Date of Initial License for Current Owners: <u>2/25/07</u>		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		Type of Ownership:		<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____			IRS Exemption Code <u>501(c)3</u>		In the event there are further questions about this report, please contact:				Name: <u>Kevin Wellen</u>		Telephone Number: <u>314-925-4446</u>		Email Address: _____			
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#	0019109	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ 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 6/1/1976

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 109 and days of care provided

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X
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CASH*

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

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

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

	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	1,269	18,516	6,044	25,829	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,269	18,516	6,044	25,829	14

77.52%

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	407,511	22,040	25,055	454,606		454,606	(1,090)	453,516			1
2	Food Purchase		171,459		171,459		171,459	(170)	171,289			2
3	Housekeeping	145,580	28,748	3,410	177,738		177,738		177,738			3
4	Laundry	34,959	10,634	3,705	49,298		49,298		49,298			4
5	Heat and Other Utilities			157,887	157,887		157,887		157,887			5
6	Maintenance	132,974	35,845	175,847	344,666	(1,266)	343,400	(44,244)	299,156			6
7	Other (specify):*											7
8	TOTAL General Services	721,024	268,726	365,904	1,355,654	(1,266)	1,354,388	(45,504)	1,308,884			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,290,887	99,242	464,366	2,854,495	(1,666)	2,852,829		2,852,829			10
10a	Therapy			750,762	750,762		750,762		750,762			10a
11	Activities	189,369	9,058	18,041	216,468	(460)	216,008		216,008			11
12	Social Services	55,928	891	3,378	60,197		60,197		60,197			12
13	CNA Training											13
14	Program Transportation	12,909	2,257	3,274	18,440		18,440	(17,519)	921			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,549,093	111,448	1,245,821	3,906,362	(2,126)	3,904,236	(17,519)	3,886,717			16
	C. General Administration											
17	Administrative	71,343			71,343		71,343		71,343			17
18	Directors Fees											18
19	Professional Services			609,627	609,627		609,627	75,979	685,606			19
20	Dues, Fees, Subscriptions & Promotions			32,428	32,428	4,372	36,800	(1,479)	35,321			20
21	Clerical & General Office Expenses	509,090	21,959	599,294	1,130,343	(4,372)	1,125,971	(333,362)	792,609			21
22	Employee Benefits & Payroll Taxes			767,446	767,446		767,446	(18,414)	749,032			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,966	18,966		18,966		18,966			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,724	67,724		67,724		67,724			26
27	Other (specify):* Marketing	53,892	9,571	6,803	70,266		70,266	(70,266)				27
28	TOTAL General Administration	634,325	31,530	2,102,288	2,768,143		2,768,143	(347,542)	2,420,601			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,904,442	411,704	3,714,013	8,030,159	(3,392)	8,026,767	(410,565)	7,616,202			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 The Lutheran Home #0019109 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			532,955	532,955		532,955	(129,638)	403,317			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			275,058	275,058		275,058	(81,929)	193,129			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					3,392	3,392		3,392			35
36	Other (specify):*											36
37	TOTAL Ownership			808,013	808,013	3,392	811,405	(211,567)	599,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,363	59,771	306,134		306,134		306,134			39
40	Barber and Beauty Shops			17,333	17,333		17,333	(17,333)				40
41	Coffee and Gift Shops			17,068	17,068		17,068		17,068			41
42	Provider Participation Fee			174,369	174,369		174,369		174,369			42
43	Other (specify):*	1,946,583	907,208	7,737,368	10,591,159		10,591,159	(10,591,159)				43
44	TOTAL Special Cost Centers	1,946,583	1,153,571	8,005,909	11,106,063		11,106,063	(10,608,492)	497,571			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,851,025	1,565,275	12,527,935	19,944,235		19,944,235	(11,230,624)	8,713,611			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	(1,090)	1		4
5	Telephone, TV & Radio in Resident Rooms	(44,079)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(154,173)	30		9
10	Interest and Other Investment Income	(49,728)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,486)	21		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	(12,500)	19		18
19	Entertainment	(170)	2		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(242,532)	21		24
25	Fund Raising, Advertising and Promotional	(70,266)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,735,073)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,312,097)		\$	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)	81,473	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 81,473		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (11,230,624)		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	Beauty Shop Income	\$ (17,333)	40	1
2	Transportation Income	(17,519)	14	2
3	Miscellaneous Income	(1,972)	21	3
4	Interest on Past Due Accounts	(660)	32	4
5	Maintenance Services Income	(165)	6	5
6	IL and AL Expenses	(10,591,159)	43	6
7	Finance and Late Fees	(86,372)	21	7
8	Employee Benefits	(18,414)	22	8
9	Public Relations Expense	(1,479)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,735,073)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Lutheran Home# 0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	(1,090)	0	0	0	0	0	0	0	0	0	0	(1,090)	1
2	Food Purchase	(170)	0	0	0	0	0	0	0	0	0	0	(170)	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	(44,244)	0	0	0	0	0	0	0	0	0	0	(44,244)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(45,504)	0	0	0	0	0	0	0	0	0	0	(45,504)	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	(17,519)	0	0	0	0	0	0	0	0	0	0	(17,519)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(17,519)	0	0	0	0	0	0	0	0	0	0	(17,519)	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	(12,500)	88,479	0	0	0	0	0	0	0	0	0	75,979	19
20	Fees, Subscriptions & Promotions	(1,479)	0	0	0	0	0	0	0	0	0	0	(1,479)	20
21	Clerical & General Office Expenses	(333,362)	0	0	0	0	0	0	0	0	0	0	(333,362)	21
22	Employee Benefits & Payroll Taxes	(18,414)	0	0	0	0	0	0	0	0	0	0	(18,414)	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):*	(70,266)	0	0	0	0	0	0	0	0	0	0	(70,266)	27
28	TOTAL General Administration	(436,021)	88,479	0	0	0	0	0	0	0	0	0	(347,542)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(499,044)	88,479	0	0	0	0	0	0	0	0	0	(410,565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(154,173)	24,535	0	0	0	0	0	0	0	0	0	(129,638)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50,388)	(31,541)	0	0	0	0	0	0	0	0	0	(81,929)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(204,561)	(7,006)	0	0	0	0	0	0	0	0	0	(211,567)	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	(17,333)	0	0	0	0	0	0	0	0	0	0	(17,333)	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):*	(10,591,159)	0	0	0	0	0	0	0	0	0	0	(10,591,159)	43
44	TOTAL Special Cost Centers	(10,608,492)	0	0	0	0	0	0	0	0	0	0	(10,608,492)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(11,312,097)	81,473	0	0	0	0	0	0	0	0	0	(11,230,624)	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
See Board Listing at PG6-Supp		Lutheran Convalescent Home	Webster, MO	Lutheran Senior Servi	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO			
		Breeze Park	St. Charles, MO			
		Heisinger Lutheran Home	Jefferson City, MO			
		Lenori Woods	Columbia, MO			
		Meridian Village Care Center	Glen Carbon, IL			
		Meramec Bluffs	St. Louis, MO			

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

☐ YES

☐ NO

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

1		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	19	Management Fee	\$ 539,824	Lutheran Senior Services	100.00%	\$ 628,303	\$ 88,479	1
2	V	30	Management Fee		Lutheran Senior Services	100.00%	24,535	24,535	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(31,541)	(31,541)	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			\$ 539,824			\$ 621,297	\$ * 81,473	14

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

Facility Name & ID Number

The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Richard J. Bagy Jr.	BOD	Concordia Village Care Center	Springfield, IL				1
2	Lee H. Bodendieck	BOD	REACH West County	Creve Coeur, MO				2
3	Diane R. Drollinger	BOD	St. Joseph Bluffs	Jefferson City, MO				3
4	Karl A. Dunajcik	BOD						4
5	Jeffrey L. Dunn	BOD						5
6	Scott M. Hartwig	BOD						6
7	John A. Komlos	BOD						7
8	John R. Kotovsky	BOD						8
9	Dr. F. Matt Kuhlmann	BOD						9
10	Harry Mueller	BOD						10
11	Kathleen T. Mueller	BOD						11
12	Olson, Gary	BOD						12
13	William F. Roth	BOD						13
14	Rev. Dr. Scott K. Seidler	BOD						14
15	Rev. William T. Simmons	BOD						15
16	Sherri C. Strand	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 2/31/2016

(314-968-5590

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	IL Finance Authority -						\$				\$	1		
2	2006 Bonds		X	Campus Expansion	Various	7/16/2006	5,750,142	4,756,489	2/1/2037	5.0000	199,223	2		
3	2016A Bonds		X	Campus Expansion	Various	2/1/2016	9,325,282	9,193,712	2/1/2046	5.0000	81,369	3		
4	Bond Costs			Amoritized Bond Costs							(5,534)	4		
5	Interest Income										(81,929)	5		
	Working Capital													
6												6		
7												7		
8												8		
9	TOTAL Facility Related						\$	15,075,424	\$	13,950,201		\$	193,129	9
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$	15,075,424	\$	13,950,201		\$	193,129	15

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

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

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

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.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	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.				\$	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 The Lutheran Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0019109

CONTACT PERSON REGARDING THIS REPORT Paul Ogier

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

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.

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.

A. Square Feet: 32,000

B. General Construction Type: Exterior Masonry Frame Wood

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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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).

Lutheran Hillside Village operates 39 assisted living units, 20 assisted living memory care units, 126 independent living apartments, and 48 patio homes and villas

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 807,882

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4,451

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	Facility	35,725	1976	\$ 149,068	1
2	Facility	28,611	1985	180,000	2
3	TOTALS	64,336		\$ 329,068	3

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1		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	85			1976	\$ 1,676,061	\$	40	\$		\$ 1,676,061	4
5				1985	481,567	13,733	40	13,733		450,107	5
6				1986	698,529	17,466	40	17,466		537,006	6
7											7
8											8
	Improvement Type**										
9	Various			1976	58,237		20			58,237	9
10	Various			1978	4,465		20			4,465	10
11	Various			1979	149		20			149	11
12	Various			1980	470		20			470	12
13	Various			1982	403		20			403	13
14	Various			1983	1,717		20			1,717	14
15	Various			1984	2,946		20			2,946	15
16	Various			1985	3,290		20			3,290	16
17	Various			1986	5,335		20			5,335	17
18	Various			1987	18,303		20			18,303	18
19	Various			1988	66,182	1,756	VARIOUS	1,756		61,575	19
20	Various			1990	134,732	3,305	VARIOUS	3,305		92,774	20
21	Various			1991	40,069	1,091	VARIOUS	1,091		29,308	21
22	Various			1992	890	29	VARIOUS	29		739	22
23	Various			1993	748		20			748	23
24	Various			1994	5,993	193	VARIOUS	193		4,530	24
25	Various			1995	36,256		VARIOUS			36,256	25
26	Various			1996	43,073	1,174	VARIOUS	1,174		31,718	26
27	Various			1997	32,988	522	VARIOUS	522		22,629	27
28	Various			1998	13,903	209	VARIOUS	209		13,866	28
29	Various			1999	122,497	405	VARIOUS	405		117,814	29
30	Various			2000	63,646	2,719	VARIOUS	2,719		52,406	30
31	Various			2001	190,577	2,255	VARIOUS	2,255		170,296	31
32	Various			2002	1,912,111	57,217	VARIOUS	57,217		858,259	32
33	Various			2003	319,328	16,337	VARIOUS	16,337		228,720	33
34	Various			2004	220,824	10,173	VARIOUS	10,173		123,602	34
35	Various			2005	57,276	2,864	VARIOUS	2,864		34,366	35
36	Various			2006	8,909	297	VARIOUS	297		3,267	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 The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	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 Various	2007	\$ 474,844	\$ 23,742	VARIOUS	\$ 23,742	\$	\$ 221,521	37
38 Various	2008	378,947	20,230	VARIOUS	20,230		213,026	38
39 Various	2009	399,349	26,624	VARIOUS	26,624		199,717	39
40 WALL PROTECTOR	2010	74	5	15	5		32	40
41 OPTIMUS SETUP-CABLES&CONNECTORS	2010	1,274	85	15	85		552	41
42 WIRING,CABLE,DATA LINE-OPTIMUS EMR	2010	2,957	197	15	197		1,281	42
43 OPTIMUS SETUP-CABLES&ELECTRICAL LINES	2010	1,915	128	15	128		830	43
44 FLOORING,CARPET-DINING RM	2010	150	21	7	21		139	44
45 DEMOLITION-OLD CARE CENTER LINK	2011	3,676	245	15	245		1,307	45
46 FLOORING, CARPET	2011	821	117	7	117		684	46
47 FLOORING, CARPET	2011	3,093	442	7	442		2,577	47
48 FLOORING, CARPET-#5	2011	1,316	188	7	188		1,065	48
49 FIREPLACE INSERT, DIMPLEX 39"	2011	2,356	157	15	157		890	49
50 FLOORING, BINDING CARPET	2011	212	30	7	30		172	50
51 FLOORING,CERAMIC TILE-PUBLIC BATHRMS	2011	1,502	100	15	100		567	51
52 SURVEY,ASBESTOS/LEAD-AREA, OLD REC CENTE	2011	2,190	146	15	146		815	52
53 FIXTURE,PRE RINSE SPRAY VALVE	2011	74	5	15	5		28	53
54 VANITY,-BATHROOM	2011	227	15	15	15		84	54
55 MIRROR,WALL&HOLDERS-BATHROOM	2011	104	7	15	7		39	55
56 CERAMIC TILE&LIGHTING,MIRRORS-BATHRMS	2011	414	28	15	28		154	56
57 FLOORING, CERAMIC PUBLIC-BATHROOMS	2011	1,500	100	15	100		550	57
58 THERAPY & PUBLIC BATHROOMS-DRYWALL,CARPT	2011	12,388	826	15	826		4,542	58
59 PLUMBING,FIXTURE-THERAPY&PUBLIC BATHROOM	2011	3,381	225	15	225		1,240	59
60 FLOORING, CARPET BASE/RUG	2011	421	60	7	60		326	60
61 FLOORING, CARPET-COMMON AREAS	2011	9,767	1,395	7	1,395		7,558	61
62 FLOORING,VINYL-NEW THERAPY RM	2011	5,267	752	7	752		4,076	62
63 FLOORING,CARPET-HC HALLWAY	2011	3,203	458	7	458		2,440	63
64 ELECTRICAL WK-DEMO OF REC CENTER	2011	735	49	15	49		261	64
65 CONDENSING UNIT, 15 TON, AWNING	2011	21,380	1,425	15	1,425		7,602	65
66 FLOORING, CERAMIC TILE-THERAPY HALLWAY	2011	499	33	15	33		178	66
67 FLOORING, CARPET-THERAPY HALLWAY	2011	173	25	7	25		132	67
68 FLOORING,CARPET-PUBLIC AREA	2011	164	23	7	23		125	68
69								69
70 TOTAL (lines 4 thru 69)		\$ 7,555,847	\$ 209,628		\$ 209,628	\$	\$ 5,315,872	70

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	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		\$ 7,555,847	\$ 209,628		\$ 209,628	\$	\$ 5,315,872	1
2	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	124	7	124		659	2
3	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	124	7	124		659	3
4	FLOORING, CARPET-HALLWAY, THERAPY	2011	1,511	216	7	216		1,151	4
5	SECURITY, ACCESS CONTROL ON DOOR-THERAPY	2011	3,000	200	15	200		1,067	5
6	FLOORING,CARPET BASEBOARD-HC PULIC AREA	2011	196	28	7	28		149	6
7	FLOORING, CARPET & VINYL-#CLOVER CT COMM	2011	3,251	464	7	464		2,477	7
8	FLOORING, CARPET-DOGWOOD CT	2011	3,368	481	7	481		2,566	8
9	INTERIOR CONSULTANTING FEES-NURSES STATI	2011	6,750	450	15	450		2,363	9
10	GLASS, COMMERCIAL-NURSES STATIONS	2011	43	3	15	3		15	10
11	FLOORING, CARPET & VINYL-NURSES STATION	2011	18,570	2,653	7	2,653		13,927	11
12	PLUMBING-NURSES STATION OFFICE	2011	474	32	15	32		166	12
13	CABINETS-NURSES STATION	2011	29,646	1,976	15	1,976		10,376	13
14	PHONES,WIRING, CABLES RELOCATED-NURSE ST	2011	836	56	15	56		293	14
15	FIREPLACE-NURSES STATION/LOBBY	2011	7,880	525	15	525		2,758	15
16	RECEPTION STATION/AREA-NURSES STATION	2011	4,950	330	15	330		1,732	16
17	ELECTRICAL UPGRADES-NURSES STATION	2011	310	21	15	21		109	17
18	FLOORING, CARPET INSTALLED, COMMON AREAS	2011	2,383	340	7	340		1,759	18
19	FLOORING, CARPET-#ACON WAY-COMMON AREA	2011	6,750	964	7	964		4,982	19
20	PLUMBING, DRAIN RADIATOR LINES	2011	428	29	15	29		147	20
21	FLOORING, CARPET BASE	2011	590	98	5	98		590	21
22	DEMOLITION OF CORRIDOR LINK	2011	7,303	487	15	487		2,515	22
23	FLOORING, CERAMIC TILE	2011	1,114	74	15	74		378	23
24	ROOFING, MAIN BUILDING	2012	40,400	2,020	20	2,020		9,427	24
25	ASBESTOS MONITORING-INSIDE BLDG	2012	550	37	15	37		162	25
26	EMERGENCY CALL SYSTEM, WIRELESS	2012	185,913	12,394	15	12,394		61,971	26
27	GRANITE-FIREPLACE	2012	792	53	15	53		264	27
28	FLOORING, CARPET-CC	2012	196	39	5	39		196	28
29	FLOORING, CARPET BASE-#CC	2012	47	9	5	9		47	29
30	SCONE GLASS-EMERGENCY CALL SYSTEM	2012	463	31	15	31		154	30
31	FLOORING, TRANSITION STRIPS-ACTIVITY	2012	267	18	15	18		86	31
32	LOCK,MORTOSE-OFFICE DOOR-LAVENDER LANE	2012	414	28	15	28		133	32
33	WALLCABINECUBBY AREAS	2012	3,118	208	15	208		1,005	33
34	TOTAL (lines 1 thru 33)		\$ 7,889,090	\$ 234,140		\$ 234,140	\$	\$ 5,440,155	34

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	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		\$ 7,889,090	\$ 234,140		\$ 234,140	\$	\$ 5,440,155	1
2	CABINETS-CNA CUBBY AREAS	2012	2,260	151	15	151		716	2
3	CABINETS-CUBBY AREA	2012	1,747	116	15	116		544	3
4	CABINETS, CUBBY AREAS-CNA	2012	6,310	421	15	421		1,963	4
5	WATER & SEWER LINES CAPPED OF	2012	2,303	154	15	154		691	5
6	ELECTRICAL PANEL REMOVED-CC	2012	1,245	83	15	83		367	6
7	ELECTRICAL DEMO-OLD RET HM	2012	255	17	15	17		72	7
8	ELECTRICAL WORK-DISHWASHER-EMANUAL	2012	922	61	15	61		256	8
9	HOT WATER MIXING VALVE&CIRC PUMP UPGRADE	2013	4,500	300	15	300		1,175	9
10	TILES, CERAMIC-PANTRY	2013	379	25	15	25		99	10
11	TILE, CERAMIC-WALL OR FL	2013	122	8	15	8		32	11
12	CABINETRY/SHELVING	2013	666	44	15	44		174	12
13	REMODEL-DEMO-EMMANUE KITCHEN	2013	1,569	105	15	105		401	13
14	REMODEL-CARPENTRY-EMMANUAL KITCHEN	2013	14,378	959	15	959		3,674	14
15	REMODEL-CABINETS&CTR TOPS-EMMANUEL KITCH	2013	3,137	209	15	209		802	15
16	REMODEL,ELECTRICAL-EMMANUAL KITCHEN	2013	1,307	87	15	87		334	16
17	REMODEL,PLUMBING&FIXTURES-EMMANUAL KITCH	2013	2,353	157	15	157		601	17
18	REMODEL, PAINTING-EMMANUAL KITCHEN	2013	2,091	299	7	299		1,145	18
19	FLOORING, REMODEL-EMMANUAL KITCHEN	2013	1,307	187	7	187		716	19
20	PANTRY DOOR SECURITY, ACCESS-EMANUAL	2013	1,244	83	15	83		318	20
21	CERAMIC TILE-WALL/FLOOR-EMANUAL PL PANTR	2013	416	28	15	28		109	21
22	FLOORING,CARPET-#1 EMANUEL	2013	243	49	5	49		174	22
23	ELECTRICAL-ADDITIONAL POWER	2013	3,350	223	15	223		800	23
24	CABINETS- CC-COFFEEBAR	2013	1,150	77	15	77		268	24
25	LIGHTING FIXTURES	2013	996	66	15	66		216	25
26	LIGHTING FIXTURES	2013	318	21	15	21		69	26
27	LIGHTING- CARE CENTER	2013	5,858	391	15	391		1,302	27
28	FLOORING, CARPET & VINYL-HALLWAYS	2013	705	141	5	141		529	28
29	FLOORING-CARPET- EP 1	2013	125	25	5	25		88	29
30	FLOORING-CARPET	2013	60	12	5	12		42	30
31	FLOORING- CARPET- EVERGREEN DINING	2014	8,319	1,188	7	1,188		3,466	31
32	FLOORING- VINYL- EVERGREEN DINING	2014	1,107	158	7	158		461	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,959,832	\$ 239,985		\$ 239,985	\$	\$ 5,461,759	34

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,959,832	\$ 239,985		\$ 239,985	\$	\$ 5,461,759	1
2	EVERGREEN DINING 1/2 WALL	2014	2,680	179	15	179		506	2
3	ELECTRICAL- FOOD PREP- EVERGREEN DINING	2014	3,502	233	15	233		662	3
4	FLOORING- CARPET- EVERGREEN DINING	2014	2,826	404	7	404		1,144	4
5	LIGHT FIXTURE- HEAT LAMP (2)	2014	749	50	15	50		141	5
6	LIGHT FIXTURE- HEAT LAMP (2)	2014	569	38	15	38		107	6
7	HAND SINK - EVERGREEN DINING	2014	703	47	15	47		133	7
8	FLOORING- COVE BASE- EVERGREEN DINING	2014	525	75	7	75		213	8
9	FLOORING- COVE BASE- EVERGREEN DINING	2014	158	23	7	23		64	9
10	Sink for evergreen	2014	1,251	83	15	83		229	10
11	Carpet for evergreen	2014	358	51	7	51		140	11
12	FLOORING - CARPET BP3	2014	471	94	5	94		235	12
13	FLOORING-CARPETING #C7	2014	303	61	5	61		131	13
14	FLOORING-CARPETING #C7	2014	150	10	15	10		22	14
15	ROOM FINISHES	2014	52	3	15	3		7	15
16	SARA 3000 W/SCALE W/O SIDE GRP	2014	5,193	1	15	1		405	16
17	SARA 3000 SLING-LARGE	2014	224	1	15	1		18	17
18	FURNISH 8 TOWEL BARS AND TOILET PAPER HOLDERS	2014	730	1	15	1		4,168	18
19	LOCKSETS FOR BATHROOM DOORS IN SNF	2014	937	1	15	1		52	19
20	DEMOLISH AND REFURBISH 8 BATHROOMS IN SNF	2014	53,500	62	15	62		130	20
21	- remove tile on walls, light fixtures, wallpaper, flooring								21
22	and toilets								22
23	- add storage unit above toilet, mirrors, grab bars								23
24	- patch and paint entire bathrooms, add tile accent on walls								24
25	- new vinyl flooring, updates faucets and drains								25
26	WOOD FLOORING-CHERRY SUNROOM	2015	1,008	67	15	67		123	26
27	THERAPY SHOWER WALLBOARD, CERAMIC	2016	990	66	15	66		66	27
28	Dining area replace window	2016	1,900	84	15	84		84	28
29	COPPER/FIBER CABLE E.H.R. NTRWK PROJ	2016	39,170	1,088	15	1,088		1,088	29
30	FINANCE CHRG REPLACE COMPRESSOR	2016	136	2	15	2		2	30
31	REPLACE HEAT EXC EVERGREEN PANTRY	2016	2,810	31	15	31		31	31
32	WANDER GUARD ALARM REACH	2016	3,388	56	15	56		56	32
33	WANDER GUARD ALARM REACH	2016	1,922	32	15	32		32	33
34	TOTAL (lines 1 thru 33)		\$ 8,086,037	\$ 242,829		\$ 242,829	\$	\$ 5,471,749	34

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	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		\$ 8,086,037	\$ 242,829		\$ 242,829	\$	\$ 5,471,749	1
2	45 Interior Signs	2016	3,111	35	15	35		35	2
3	147 Interior Signs	2016	8,379	93	15	93		93	3
4	2 Interior Directional Signs	2016	180	2	15	2		2	4
5	Furnish/Install 46 Lock Cylinders	2016	10,923	121	15	121		121	5
6	10 Bed Sta w/Call Placed LED	2016	1,356	15	15	15		15	6
7	7-8' Call Cord for Bed Station	2016	185	2	15	2		2	7
8	3-10' Call Cord for Bed Station	2016	83	1	15	1		1	8
9	30 Pull Cord Stations	2016	3,501	39	15	39		39	9
10	28 Single Line White Phones	2016	322	4	15	4		4	10
11	Programmed 24 resident rooms	2016	689	8	15	8		8	11
12	10 Interior Signs	2016	176	2	15	2		2	12
13	Install IP DECT Cordless Phn	2016	2,525	28	15	28		28	13
14	8 Interior Signs	2016	132	1	15	1		1	14
15	Power for Touch Town Sys	2016	839	9	15	9		9	15
16	Power/Data Temp Concierge	2016	1,474	16	15	16		16	16
17	Labor/Install Storeroom Lock	2016	522	6	15	6		6	17
18	1 Set Cust Granite Counters	2016	2,350	26	15	26		26	18
19	New Addition REACH/PT/OT/ST - Flooring	2016	217,818	5,186	7	5,186		5,186	19
20	New Addition REACH/PT/OT/ST - Painting	2016	136,142	1,513	15	1,513		1,513	20
21	New Addition REACH/PT/OT/ST - Touch Up drywall & paint	2016	5,000	56	15	56		56	21
22	New Addition REACH/PT/OT/ST - Plumbing	2016	269,722	2,997	15	2,997		2,997	22
23	New Addition REACH/PT/OT/ST - HVAC	2016	438,883	4,876	15	4,876		4,876	23
24	New Addition REACH/PT/OT/ST - Electrical	2016	1,131,609	12,573	15	12,573		12,573	24
25	UPS COMPONENTS EHR NETWORK PROJ	2016	1,610	9	15	9		9	25
26	UPS COMPONENTS EHR NETWORK PROJ	2016	2,209	12	15	12		12	26
27	FIBER OPTIC CABLE QTY 25 *	2016	650	11	15	11		11	27
28	DATA DROPS IL BLDG	2016	12,284	136	15	136		136	28
29	Rounding		(5)						29
30									30
31	HO Capital Allocation			24,535		24,535			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,338,708	\$ 295,142		\$ 295,142	\$	\$ 5,499,526	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	\$ 339,026	\$ 43,782	\$ 43,782	\$		\$ 219,285	71
72	Current Year Purchases	1,038,097	63,405	63,405			63,405	72
73	Fully Depreciated Assets	1,405,916	988	988			1,405,916	73
74								74
75	TOTALS	\$ 2,783,039	\$ 108,175	\$ 108,175	\$		\$ 1,688,606	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	Care Center	Car	2000	\$ 10,630	\$	\$	\$	8	\$ 10,630
77	Care Center	Vehicle Wheelchair Conversion	2007	16,029				5	16,029
78									78
79									79
80	TOTALS			\$ 26,659	\$	\$	\$		\$ 26,659

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)			\$	13,477,474
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	403,317
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	403,317
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)			\$	7,214,791

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	Non Care Combined Assets	\$ 79,955,720	\$ 2,764,798	\$ 33,123,431
87	Non Care Land	40,000		
88				
89				
90				
91	TOTALS	\$ 79,995,720	\$ 2,764,798	\$ 33,123,431

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 829,324
93		
94		
95		\$ 829,324

* 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: \$ 3,392 Description: Maintenance, Nursing & Activities
- (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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

* 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	V10A-3	hrs	\$ 328,728	4,120	\$	\$	4,120	\$ 328,728	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs	100,711	1,433			1,433	100,711	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs	320,506	4,587			4,587	320,506	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				185,289		185,289	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Other (See WTB Detail)			60,588			61,074		121,662	13
14	TOTAL			\$ 810,533	10,140	\$	\$ 246,363	10,140	\$ 1,056,896	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	\$ (3,863,126)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (343,799))	1,239,403		3
4	Supply Inventory (priced at)	49,873		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	70,723		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	83,502		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (2,419,625)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,411,968		12
13	Land	369,068		13
14	Buildings, at Historical Cost	86,711,856		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,392,270		16
17	Accumulated Depreciation (book methods)	(40,338,222)		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): CIP	829,324		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,376,264	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 57,956,639	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 639,445	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	568,186		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,539		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	205,553		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,434,723	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,059,953		39
40	Mortgage Payable	52,417,660		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Entrance Fees Payable	28,822,828		43
44	Resident Deposits	424,807		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 82,725,248	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 84,159,971	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (26,203,332)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 57,956,639	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (23,626,301)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (23,626,301)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,577,030)	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) rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,577,031)	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)	\$ (26,203,332)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 7,570,346	1
2	Discounts and Allowances for all Levels	(1,939,493)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,630,853	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,899,731	6
7	Oxygen	10,720	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,910,451	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	17	12
13	Barber and Beauty Care	21,379	13
14	Non-Patient Meals	1,090	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	251,703	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,094	19
20	Radiology and X-Ray	11,939	20
21	Other Medical Services	112,096	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 410,318	23
	D. Non-Operating Revenue		
24	Contributions	351,593	24
25	Interest and Other Investment Income***	49,728	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 401,321	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	21,232	28
28a	IL and AL Revenue	8,993,030	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,014,262	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,367,205	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,355,654	31
32	Health Care	3,906,362	32
33	General Administration	2,768,143	33
	B. Capital Expense		
34	Ownership	808,013	34
	C. Ancillary Expense		
35	Special Cost Centers	10,931,694	35
36	Provider Participation Fee	174,369	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,944,235	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,577,030)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,577,030)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 315,370	44
45	Private Pay - Net Inpatient Revenue	4,652,361	45
46	Medicare - Net Inpatient Revenue	601,105	46
47	Other-(specify) <u>Benevolent Care</u>	(166,736)	47
48	Other-(specify) <u>Managed Care</u>	228,753	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,630,853	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	1,139	1,339	\$ 53,870	\$ 40.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,397	11,332	282,467	24.93	3
4	Licensed Practical Nurses	27,873	29,893	760,843	25.45	4
5	CNAs & Orderlies	72,832	81,389	1,176,407	14.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,378	9,738	202,278	20.77	10
11	Social Service Workers	2,091	2,091	55,928	26.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,509	32,221	407,511	12.65	15
16	Dishwashers					16
17	Maintenance Workers	6,127	6,548	132,974	20.31	17
18	Housekeepers	11,322	12,362	145,580	11.78	18
19	Laundry	2,924	3,332	34,959	10.49	19
20	Administrator	1,635	1,635	71,343	43.63	20
21	Assistant Administrator					21
22	Other Administrative	19,592	21,419	508,967	23.76	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,213	1,213	17,300	14.26	31
32	Other Health Care Marketing CC	2,091	2,091	54,015	25.83	32
33	Other(specify) IL and AL	158,784	177,605	1,946,583	10.96	33
34	TOTAL (lines 1 - 33)	356,907	394,208	\$ 5,851,025 *	\$ 14.84	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		\$		35
36	Medical Director	Monthly	6,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	848	5,639	V39-3	39
40	Physical Therapy Consultant	13	727	V10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	88	2,628	V11-3	44
45	Social Service Consultant				45
46	Other(specify) Human Resources	67	930	V21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,016	\$ 15,924		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Wade Cies	LHV Care Center Administrator		\$ 44,689	Workers' Compensation Insurance		\$ 44,835	IDPH License Fee	\$ 1,990	
Michelle Pollard	LHV Care Center Administrator		26,654	Unemployment Compensation Insurance		26,751	Advertising: Employee Recruitment	17,461	
				FICA Taxes		285,834	Health Care Worker Background Check		
				Employee Health Insurance		309,329	(Indicate # of checks performed 699)	4,372	
				Employee Meals			Patient Background Checks 150	1,500	
				Illinois Municipal Retirement Fund (IMRF)*			Publications	1,573	
				Disability Insurance		6,774	AAHA	1,299	
				Life Insurance		4,427	LSN Leading Age	3,968	
				Savings & Revenue Sharing		52,726	Other Memberships	2,694	
TOTAL (agree to Schedule V, line 17, col. 1)							Other Licenses	1,943	
(List each licensed administrator separately.)						\$ 71,343	Less: Public Relations Expense	(1,479)	
B. Administrative - Other							Non-allowable advertising	()	
Description				Amount			Yellow page advertising	()	
				\$			TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 35,321		
TOTAL (agree to Schedule V, line 17, col. 3)				\$					
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Lutheran Senior Services	Management Services		\$ 539,824			\$	Out-of-State Travel	\$	
CliftonLarsonAllen LLP	Accounting Services		6,307						
Sandberg Phoenix & Von Gontard	Legal Services		34,447						
IDPH	Fine		12,500				In-State Travel	10,842	
Myers Carden & Sax	Legal Services		7,181						
Goldfine & Bowles, PC	Legal Services		9,292						
Polsinelli PC	Legal Services		76						
							Seminar Expense	8,124	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)				\$ 609,627			TOTAL	\$ 18,966	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>LSN - \$3,968; AAHSA - \$1,299</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>No</u> <u>N/A</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>6.8</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>32,312</u> Line <u>39</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>174,369</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? 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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>1,090</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> <u>N/A</u> <u>100</u> <u>N/A</u> <u>N/A</u> <u>N/A</u> <u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>CliftonLarsonAllen LLP</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>