

		FOR BHF USE					

LL 1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051078			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																		
Facility Name: Concordia Village Care Ctr			I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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: 4101 West Iles Ave Springfield 62711 Number City Zip Code																																																					
County: Sangamon																																																					
Telephone Number: (217) 793-9429 Fax # (217) 793-1333																																																					
HFS ID Number:																																																					
Date of Initial License for Current Owners: 5/1/2012			Officer or Administrator of Provider																																																		
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 colspan="2">IRS Exemption Code 501(c)3</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2"></td></tr></table>			☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code 501(c)3		☐	Corporation	☐	Other			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other			Paid Preparer		
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		☐	Trust																																																		
		☐	Other																																																		
In the event there are further questions about this report, please contact: Name: Kevin Wellen, CPA Telephone Number: (314) 925-4446 Email Address:																																																					
			(Signed) _____ (Date) _____ (Type or Print Name) Chad Sneed (Title) Chief Financial Officer (Signed) _____ (Date) _____ (Print Name and Title) Kevin Wellen, CPA Director (Firm Name & Address) CliftonLarsonAllen LLP 600 Washington Ave. Suite 1800, St. Louis, MO 63101 (Telephone) (314) 925-4446 Fax # (314) 925-4350 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																		

Facility Name & ID Number Concordia Village Care Ctr

0051078 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	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	62	Skilled (SNF)	62	22,692	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	62	TOTALS	62	22,692	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	844	11,437	3,277	15,558	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	844	11,437	3,277	15,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.56%

D. How many bed reserve days during this year were paid by the Department?

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

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

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

X

NO

☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

X

NO

☐

I. On what date did you start providing long term care at this location?

Date started

5/1/2012

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

YES

X

Date

5/1/2012

NO

☐

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

YES

X

NO

☐

If YES, enter number

of beds certified

62

and days of care provided

2,162

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

NO

☐

Tax Year:

12/31/2020

Fiscal Year:

12/31/2020

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	1,677,258	102,359	38,560	1,818,177		1,818,177	(1,288,786)	529,391			1
2	Food Purchase		679,032		679,032		679,032	(487,220)	191,812			2
3	Housekeeping	419,630	110,439		530,069		530,069	(341,810)	188,259			3
4	Laundry	29,544	21,718	1,816	53,078		53,078		53,078			4
5	Heat and Other Utilities			788,489	788,489		788,489	(695,497)	92,992			5
6	Maintenance	434,927	160,785	547,521	1,143,233		1,143,233	(986,349)	156,884			6
7	Other (specify):*											7
8	TOTAL General Services	2,561,359	1,074,333	1,376,386	5,012,078		5,012,078	(3,799,662)	1,212,416			8
	B. Health Care and Programs											
9	Medical Director			30,900	30,900		30,900	(1,579)	29,321			9
10	Nursing and Medical Records	2,325,912	184,872	(1,667)	2,509,117		2,509,117		2,509,117			10
10a	Therapy			407,794	407,794		407,794		407,794			10a
11	Activities	281,977	4,930	10,143	297,050		297,050	(183,789)	113,261			11
12	Social Services	76,808			76,808		76,808		76,808			12
13	CNA Training											13
14	Program Transportation	41,615	7,404	5,448	54,467		54,467	(44,714)	9,753			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,726,312	197,206	452,618	3,376,136		3,376,136	(230,082)	3,146,054			16
	C. General Administration											
17	Administrative	117,446		459,208	576,654		576,654	16,417	593,071			17
18	Directors Fees											18
19	Professional Services			190,848	190,848		190,848	(139,432)	51,416			19
20	Dues, Fees, Subscriptions & Promotions			41,785	41,785	1,422	43,207	(16,274)	26,933			20
21	Clerical & General Office Expenses	380,095	35,183	475,896	891,174	(1,422)	889,752	(656,032)	233,720			21
22	Employee Benefits & Payroll Taxes			458,007	458,007		458,007		458,007			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,762	4,762		4,762	(2,168)	2,594			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,606	85,606		85,606		85,606			26
27	Other (specify):* Marketing	195,479	21,661	38,736	255,876		255,876	(255,876)				27
28	TOTAL General Administration	693,020	56,844	1,754,848	2,504,712		2,504,712	(1,053,365)	1,451,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,980,691	1,328,383	3,583,852	10,892,926		10,892,926	(5,083,109)	5,809,817			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			567,854	567,854		567,854	20,420	588,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			442,815	442,815		442,815	(102,357)	340,458			32
33	Real Estate Taxes			33,741	33,741		33,741		33,741			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,001	6,001		6,001	(4,521)	1,480			35
36	Other (specify):*											36
37	TOTAL Ownership			1,050,411	1,050,411		1,050,411	(86,458)	963,953			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		153,622	104,681	258,303		258,303		258,303			39
40	Barber and Beauty Shops			6,714	6,714		6,714	(6,714)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,793	114,793		114,793		114,793			42
43	Other (specify):* AL/IL	1,033,624	52,423	6,776,511	7,862,558		7,862,558	(7,862,558)				43
44	TOTAL Special Cost Centers	1,033,624	206,045	7,002,699	8,242,368		8,242,368	(7,869,272)	373,096			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,014,315	1,534,428	11,636,962	20,185,705		20,185,705	(13,038,839)	7,146,866			45

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

	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	(385)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,267)	5		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	(17,658)	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	(75,166)	21		24
25	Fund Raising, Advertising and Promotional	(255,876)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (363,352)		\$	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)	(47,334)		34
35	Other- Attach Schedule	(12,628,153)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,675,487)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (13,038,839)		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	Barber & Beauty Income (limited to expense)	\$ (6,714)	40	1
2	Interest on Past Due Accounts	(528)	32	2
3	Maintenance Services Income	(864)	6	3
4	AL and IL Direct Expenses	(7,862,558)	43	4
5	Non-SNF Dietary Costs	(1,288,786)	1	5
6	Non-SNF Food Purchases	(479,915)	2	6
7	Non-SNF Housekeeping	(341,810)	3	7
8	Non-SNF Utilities	(681,230)	5	8
9	Non-SNF Maintenance	(985,485)	6	9
10	Non-SNF Activities	(183,789)	11	10
11	Non-SNF Transportation	(44,714)	14	11
12	Non-SNF Professional Fees	(139,432)	19	12
13	Non-SNF Dues, Fees, Subscriptions, & Promotions	(16,274)	20	13
14	Non-SNF Clerical & Office Expense	(580,866)	21	14
15	Non-SNF Equipment Rental	(4,521)	35	15
16	Non-SNF Travel & Seminars	(2,168)	24	16
17	Liquor	(6,920)	2	17
18	Medical Director Reimbursement	(1,579)	9	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	(12,628,153)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concordia Village Care Ctr# 0051078

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	(1,288,786)	0	0	0	0	0	0	0	0	0	0	(1,288,786)	1
2	Food Purchase	(487,220)	0	0	0	0	0	0	0	0	0	0	(487,220)	2
3	Housekeeping	(341,810)	0	0	0	0	0	0	0	0	0	0	(341,810)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(695,497)	0	0	0	0	0	0	0	0	0	0	(695,497)	5
6	Maintenance	(986,349)	0	0	0	0	0	0	0	0	0	0	(986,349)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,799,662)	0	0	0	0	0	0	0	0	0	0	(3,799,662)	8
	B. Health Care and Programs													
9	Medical Director	(1,579)	0	0	0	0	0	0	0	0	0	0	(1,579)	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	(183,789)	0	0	0	0	0	0	0	0	0	0	(183,789)	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	(44,714)	0	0	0	0	0	0	0	0	0	0	(44,714)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(230,082)	0	0	0	0	0	0	0	0	0	0	(230,082)	16
	C. General Administration													
17	Administrative	0	16,417	0	0	0	0	0	0	0	0	0	16,417	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(139,432)	0	0	0	0	0	0	0	0	0	0	(139,432)	19
20	Fees, Subscriptions & Promotions	(16,274)	0	0	0	0	0	0	0	0	0	0	(16,274)	20
21	Clerical & General Office Expenses	(656,032)	0	0	0	0	0	0	0	0	0	0	(656,032)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,168)	0	0	0	0	0	0	0	0	0	0	(2,168)	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):*	(255,876)	0	0	0	0	0	0	0	0	0	0	(255,876)	27
28	TOTAL General Administration	(1,069,782)	16,417	0	0	0	0	0	0	0	0	0	(1,053,365)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,099,526)	16,417	0	0	0	0	0	0	0	0	0	(5,083,109)	29

Summary B

12/31/2020

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 Serv	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO	In Home Services and	St. Louis, MO	HHA/Hospice
		Breeze Park	St. Charles, MO	Richmond Terrace	Richmond Heights, MO	AL
		Heisinger Lutheran Home	Jefferson City, MO	Provident Group	St. Louis, MO	Mgt Co
		Lenoir Woods	Columbia, MO	Affordable Housing	St. Louis, MO	Housing
		Meridian Village Care Center	Glen Carbon, IL	LSS Endowment Fund	St. Louis, MO	Foundation
		Meramec Bluffs	St. Louis, MO	Heisinger Hope Found	Jefferson City, MO	Foundation

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	17	Management Fee	\$ 459,208	Lutheran Senior Servies	100.00%	\$ 475,625	\$ 16,417	1
2	V	30	Management Fee		Lutheran Senior Servies	100.00%	20,420	20,420	2
3	V	32	HO Excess Interest Income		Lutheran Senior Servies	100.00%	(84,171)	(84,171)	3
4	V	1	Dietician	21,429	Lutheran Senior Servies	100.00%	21,429		4
5	V	10	Medical Records	5,291	Lutheran Senior Servies	100.00%	5,291		5
6	V	21	HR Recruitment	8,074	Lutheran Senior Servies	100.00%	8,074		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 494,002			\$ 446,668	\$ * (47,334)	14

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

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	Anderson, David	BOD	Lutheran Hillside Village	Peoria, IL				1
2	Anderson, Garry	BOD	St. Joseph's Bluffs	Jefferson City, MO				2
3	Bantle, Julie	BOD						3
4	Brown, Dan	BOD						4
5	Christell, Rev. Roy	BOD						5
6	Drollinger, Diane	BOD						6
7	Dunn, Jeffery	BOD						7
8	Komlos, John	BOD						8
9	Kuhlmann, Dr. F Mathew	BOD						9
10	Mueller, Harry	BOD						10
11	Scholl, Rev. Dr. Travis	BOD						11
12	Sombart, Lisa	BOD						12
13	Strand, Sherri	BOD						13
14	Tice, Paul	BOD						14
15	Toon, Norman	BOD						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

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

Facility Name & ID Number Concordia Village Care Ctr# 0051078

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Lutheran Senior Services

Street Address

1150 Hanley Industrial Court

City / State / Zip Code

St. Louis, MI 63144

Phone Number

(314)-968-9313

Fax Number

(314)-968-5590

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management - Operating	Direct Cost	249,622,883	24	\$ 15,938,951	\$ 12,041,987	7,448,817	\$ 475,623	1
2	30	Management - Capital	Direct Cost	249,622,883	24	684,299		7,448,817	20,420	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					\$ 16,623,250	\$ 12,041,987		\$ 496,043	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	Deferred Financing Costs						\$		\$			\$ (39,516)	1		
2	2019C Bonds		X	Campus Expansion		10/13/2010		12,369,734	10,124,160	2042	various	482,331	2		
3	Interest Income											(17,658)	3		
4	HO Excess Interest Income											(84,171)	4		
5	Interest on Past Due Accts											(528)	5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related						\$	12,369,734	\$	10,124,160			\$	340,458	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	12,369,734	\$	10,124,160			\$	340,458	15

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

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

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

FACILITY NAME	<u>Concordia Village Care Ctr</u>	COUNTY	<u>Sangamon</u>
---------------	-----------------------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	39,026	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.

(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).

Concordia Village operates 48 assistant living units, 178 independent living apartments, and 26 patio homes.

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:	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	Care Center	120,000	2010	\$ 77,462	1
2					2
3	TOTALS	120,000		\$ 77,462	3

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	64			2011	\$ 9,122,010	\$ 276,734	Various	\$ 276,734	\$	\$ 2,780,725	4
5				2020	2,331,796	85,524	Various	85,524		92,651	5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS REMOVED & FILLED IN - MAIN CORRIDOR/ABOVE EN			4/17/2012	3,064	204	15	204		1,787	9
10	PHONE SYSTEM UPGRADE+ 5 HANDSET - SNF CENTER (RECEPTIC			6/7/2012	3,201	213	15	213		1,832	10
11	FLOORING, VINYL-NURSES STATION			11/1/2012	3,919		5			3,919	11
12	EXAM TABLE, WELCH ALLEN EQUIP			3/31/2016	4,057	270	15	270		1,307	12
13	UPS FOR CU WIRING CLOSET			9/6/2016	842	56	15	56		243	13
14	FURN/INST VIKING DOOW SYSTEM - CC			10/19/2016	1,532	102	15	102		434	14
15	CARPET CARE CENTER W			12/31/2016	52,473	7,496	7	7,496		30,609	15
16	CARPET SPRING HILL WING			3/6/2017	20,117	2,874	7	2,874		11,016	16
17	CARPET - CARE CTR CORRIDORS			8/4/2017	41,903	5,986	7	5,986		20,453	17
18	KITCHEN REMODEL			7/26/2018	7,999	533	15	533		1,333	18
19	DOOR SECURITY SYSTEM (CARD ACCESS)			5/22/2019	8,668	578	15	578		963	19
20	DOOR SECURITY SYSTEM (CARD ACCESS) STAFF HAL			6/11/2019	10,460	697	15	697		1,104	20
21	FLOORING & TILE			12/13/2019	119,368	17,053	7	17,053		18,474	21
22	PAINT AND WALLCOVERING			12/13/2019	39,627	5,661	7	5,661		6,133	22
23	HVAC			12/13/2019	74,733	4,982	15	4,982		5,397	23
24	KITCHEN RENOVATION IN WEST WINGS			12/13/2019	107,653	7,177	15	7,177		7,775	24
25	DELAYED EGRES/WANDERGARD/SECURECARE			12/13/2019	528	35	15	35		38	25
26	GENERAL - INTERNAL SIGNAGE(55)			12/13/2019	3,430	229	15	229		248	26
27	FLOOR - LINOLEUM/SV/LVT			12/31/2019	26,110	5,222	5	5,222		5,657	27
28	PTAC/PTHP/VTAC			2/21/2020	2,161	198	15	198		198	28
29	PTAC/PTHP/VTAC			12/1/2020	2,161	12	15	12		12	29
30											30
31	HOME OFFICE ALLOCATION					20,420		20,420			31
32											32
33											33
34											34
35											35
36											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

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	N/A		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$11,987,812	\$442,256		\$442,256	\$	\$2,992,308	70

**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	\$ 993,499	\$ 132,762	\$ 132,762	\$		\$ 549,841	71
72	Current Year Purchases	76,403	9,518	9,518			9,518	72
73	Fully Depreciated Assets	914,859	208	208			914,859	73
74								74
75	TOTALS	\$ 1,984,761	\$ 142,488	\$ 142,488	\$		\$ 1,474,218	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 - SNF	VAN-W/C 2013 FORD E250 5+2 V	8/14/2013	\$ 42,355	\$ 3,530	\$ 3,530	\$	7	\$ 42,355	76
77										77
78										78
79										79
80	TOTALS			\$ 42,355	\$ 3,530	\$ 3,530	\$		\$ 42,355	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,092,390	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 588,274	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 588,274	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,508,881	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SNF - Laundry	\$ 1,757,817	\$ 51,447	\$ 524,379	86
87	SNF - Site Improvements - 2009	527,860	26,393	303,519	87
88	SNF - Building Improvements 2009	544,600	20,393	268,035	88
89	Independent Living	64,580,866	2,314,740	21,570,831	89
90	AL & AL Memory Care	11,841,765	391,388	4,334,210	90
91	TOTALS	\$ 79,252,908	\$ 2,804,361	\$ 27,000,974	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Memory Care	\$ 13,044	92
93	CIP - Apt Unit Renovation	96,590	93
94			94
95		\$ 109,634	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?

YES

NO
- If NO, see instructions.

		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

X

NO
16. Rental Amount for movable equipment: \$6,001Description: Maintenance Equip
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.

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	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	2,138	\$ 155,089	\$	2,138	\$ 155,089	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		912	63,561		912	63,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		2,642	189,144		2,642	189,144	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 prescripts				80,830		80,830	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	V39-2					72,792		72,792	12
13	Other (specify): <u>Lab, Xray, Hospital, Re</u>	V39-3,V10-3				104,681			104,681	13
14	TOTAL			\$	5,692	\$ 512,475	\$ 153,622	5,692	\$ 666,097	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	\$ 9,556,408	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	459,723		3
4	Supply Inventory (priced at)	50,015		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	96,690		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	94,657		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,257,493	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,126,732		13
14	Buildings, at Historical Cost	86,519,133		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,699,433		16
17	Accumulated Depreciation (book methods)	(31,509,855)		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	109,634		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 61,945,077	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 72,202,570	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 164,024	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	311,638		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,945		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	Current Portion of Long-Term Debt	1,069,139		36
37	Other Current Liabilities	1,669,342		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,222,088	\$	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	Due to Related Party	48,148,662		43
44	Other Liabilities	35,735,840		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 83,884,502	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 87,106,590	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (14,904,020)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 72,202,570	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,118,333)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,118,333)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(785,687)	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)	\$ (785,687)	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)	\$ (14,904,020)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 5,831,359	1
2	Discounts and Allowances for all Levels	(1,089,002)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,742,357	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,000,933	6
7	Oxygen	301	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,001,234	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		12
13	Barber and Beauty Care	8,331	13
14	Non-Patient Meals	385	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	123,114	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,489	19
20	Radiology and X-Ray	6,278	20
21	Other Medical Services	149,811	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 314,408	23
	D. Non-Operating Revenue		
24	Contributions	281,331	24
25	Interest and Other Investment Income***	17,658	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 298,989	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Revenue (See WTB)</u>	604,122	28
28a	<u>AL/IL Revenue</u>	12,438,908	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,043,030	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,400,018	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	5,012,078	31
32	Health Care	3,376,136	32
33	General Administration	2,504,712	33
	B. Capital Expense		
34	Ownership	1,050,411	34
	C. Ancillary Expense		
35	Special Cost Centers	8,127,575	35
36	Provider Participation Fee	114,793	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,185,705	40
41	Income before Income Taxes (line 30 minus line 40)**	(785,687)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (785,687)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 131,373	44
45	Private Pay - Net Inpatient Revenue	3,812,946	45
46	Medicare - Net Inpatient Revenue	503,963	46
47	Other-(specify) <u>Managed Care</u>	294,075	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,742,357	49

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

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

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

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

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	9,426	9,506	\$ 335,095	\$ 35.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,232	13,165	451,058	34.26	3
4	Licensed Practical Nurses	18,169	22,903	573,409	25.04	4
5	CNAs & Orderlies	51,703	57,203	921,113	16.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,411	13,850	281,977	20.36	10
11	Social Service Workers	3,150	3,150	76,808	24.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	107,527	114,675	1,677,258	14.63	15
16	Dishwashers					16
17	Maintenance Workers	18,433	20,308	434,927	21.42	17
18	Housekeepers	25,871	29,767	419,630	14.10	18
19	Laundry	1,949	2,208	29,544	13.38	19
20	Administrator	2,080	2,080	117,446	56.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,320	23,063	380,095	16.48	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	2,313	2,313	45,238	19.56	31
32	Other Health Care Transportation	2,697	2,947	41,615	14.12	32
33	Other(specify) AL/IL/Marketing	60,961	62,282	1,229,102	19.73	33
34	TOTAL (lines 1 - 33)	352,242	379,420	\$ 7,014,315 *	\$ 18.49	34

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	30,900	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	362	6,561	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	\$ 37,461		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

Leading Age, \$17,794

Yes

(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?

No

N/A

(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?

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

7

(6)

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

\$ 27,755

Line 39

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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
IDPH license number of this related party and the date the present owners took over.

NO

X

N/A

(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.

\$ 114,793

(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.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0

Yes

Indicate the amount. \$ 385

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

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.

No

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes

CliftonLarsonAllen

(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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes