

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0005090

Facility Name: Lutheran Home for the Aged

Address: 800 West Oakton St Arlington Hgts 60004
Number City Zip Code

County: Cook

Telephone Number: (847) 368-7400 Fax # (847) 368-7302

HFS ID Number:

Date of Initial License for Current Owners: 8/1/1960

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Tracy Mitchell Telephone Number: (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2019 to 6/30/2020 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) Andrew Kazmierczak	
	(Title) Executive Director	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) Tracy Mitchell Partner	
	(Firm Name & Address) Bradley Associates 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225	
	(Telephone) (317) 237-5500	Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lutheran Home for the Aged

0005090 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>301</u>	Skilled (SNF)	<u>301</u>	<u>109,865</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,345</u>	3
4		Intermediate/DD			4
5	<u>22</u>	Sheltered Care (SC)	<u>22</u>	<u>8,030</u>	5
6		ICF/DD 16 or Less			6
7	<u>376</u>	TOTALS	<u>376</u>	<u>137,240</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,696</u>	<u>40,861</u>	<u>28,189</u>	<u>90,746</u>	8
9	SNF/PED					9
10	ICF	<u>4,885</u>	<u>8,090</u>		<u>12,975</u>	10
11	ICF/DD					11
12	SC		<u>4</u>		<u>4</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,581</u>	<u>48,955</u>	<u>28,189</u>	<u>103,725</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.58%

D. How many bed reserve days during this year were paid by the Department?
None (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)
Meals on Wheels, Adult Day Care, Out-Patient Therapy, Child Day Care

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 8/1/1953

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 301 and days of care provided 21,626

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lutheran Home for the Aged # 0005090 Report Period Beginning: 7/1/2019 Ending: 6/30/2020
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	1,949,706	171,302	47,174	2,168,182	35	2,168,217		2,168,217			1
2	Food Purchase		1,495,022		1,495,022	(282,196)	1,212,826	(383,902)	828,924			2
3	Housekeeping	1,082,534	106,218	44,422	1,233,174	(38,471)	1,194,703		1,194,703			3
4	Laundry	173,708	63,975	41,888	279,571		279,571		279,571			4
5	Heat and Other Utilities			1,108,894	1,108,894	(242,824)	866,070	(40,566)	825,504			5
6	Maintenance	843,779	73,395	598,805	1,515,979	(331,966)	1,184,013	(99,862)	1,084,151			6
7	Other (specify):*											7
8	TOTAL General Services	4,049,727	1,909,912	1,841,183	7,800,822	(895,422)	6,905,400	(524,330)	6,381,070			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	11,843,840	948,313	485,277	13,277,430	70	13,277,500	(640)	13,276,860			10
10a	Therapy		8,802	4,139,873	4,148,675		4,148,675		4,148,675			10a
11	Activities	578,418	12,976	70,804	662,198		662,198		662,198			11
12	Social Services	429,992	326	3,538	433,856		433,856		433,856			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	12,852,250	970,417	4,735,492	18,558,159	70	18,558,229	(640)	18,557,589			16
	C. General Administration											
17	Administrative	396,618			396,618	(100,731)	295,887		295,887			17
18	Directors Fees											18
19	Professional Services			2,834,275	2,834,275	(87,558)	2,746,717	(2,489,524)	257,193			19
20	Dues, Fees, Subscriptions & Promotions			68,665	68,665	(17,439)	51,226		51,226			20
21	Clerical & General Office Expenses	1,399,084	97,166	947,771	2,444,021	(620,719)	1,823,302	(300,728)	1,522,574			21
22	Employee Benefits & Payroll Taxes			4,195,848	4,195,848	(297,858)	3,897,990		3,897,990			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,983	17,983	(4,567)	13,416		13,416			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,112,465	1,112,465	(282,538)	829,927		829,927			26
27	Other (specify):*											27
28	TOTAL General Administration	1,795,702	97,166	9,177,007	11,069,875	(1,411,410)	9,658,465	(2,790,252)	6,868,213			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	18,697,679	2,977,495	15,753,682	37,428,856	(2,306,762)	35,122,094	(3,315,222)	31,806,872			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lutheran Home for the Aged #0005090 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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			4,080,411	4,080,411		4,080,411	(461,785)	3,618,626			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,622,909	4,622,909		4,622,909	(246,057)	4,376,852			32
33	Real Estate Taxes			25,276	25,276		25,276	(25,276)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			145,572	145,572		145,572		145,572			35
36	Other (specify):*											36
37	TOTAL Ownership			8,874,168	8,874,168		8,874,168	(733,118)	8,141,050			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		877,796	136,317	1,014,113	1	1,014,114		1,014,114			39
40	Barber and Beauty Shops			325	325		325	(325)				40
41	Coffee and Gift Shops		22,407		22,407		22,407	(22,407)				41
42	Provider Participation Fee			675,322	675,322		675,322		675,322			42
43	Other (specify):*	1,593,551	37,516	490,421	2,121,488	2,306,761	4,428,249	(4,428,249)				43
44	TOTAL Special Cost Centers	1,593,551	937,719	1,302,385	3,833,655	2,306,762	6,140,417	(4,450,981)	1,689,436			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	20,291,230	3,915,214	25,930,235	50,136,679		50,136,679	(8,499,321)	41,637,358			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(383,902)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(246,057)	32		10
11	Discounts, Allowances, Rebates & Refunds	(148,533)	21		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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,231,305)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,009,797)		\$	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	2	
		Amount	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)	(2,489,524)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,489,524)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (8,499,321)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			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	Marketing/Hearthstone Salary	\$ (1,593,551)	43	1
2	Marketing/Hearthstone Supplies	(37,516)	43	2
3	Marketing/Hearthstone Other	(2,797,182)	43	3
4	Misc. Income	(151,738)	21	4
5				5
6	Coffee and Gift Shop	(22,407)	41	6
7	Printing/Record Copies Income	(640)	10	7
8	Cellular Antenna Income	(40,566)	5	8
9	Royalty Income	(457)	21	9
10				10
11				11
12	Clinic Rent	(81,924)	6	12
13	LV Security	(17,938)	6	13
14	Barber and Beauty Shop	(325)	40	14
15				15
16	Non-Care Related Depreciation	(461,785)	30	16
17	Non-Care Real Estate Expense	(25,276)	33	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,231,305)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Home for the Aged# 0005090

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(383,902)	0	0	0	0	0	0	0	0	0	0	(383,902)	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	(40,566)	0	0	0	0	0	0	0	0	0	0	(40,566)	5
6	Maintenance	(99,862)	0	0	0	0	0	0	0	0	0	0	(99,862)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(524,330)	0	0	0	0	0	0	0	0	0	0	(524,330)	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	(640)	0	0	0	0	0	0	0	0	0	0	(640)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(640)	0	0	0	0	0	0	0	0	0	0	(640)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(2,489,524)	0	0	0	0	0	0	0	0	0	(2,489,524)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(300,728)	0	0	0	0	0	0	0	0	0	0	(300,728)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(300,728)	(2,489,524)	0	0	0	0	0	0	0	0	0	(2,790,252)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(825,698)	(2,489,524)	0	0	0	0	0	0	0	0	0	(3,315,222)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Home for the Aged # 0005090 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	(461,785)	0	0	0	0	0	0	0	0	0	0	(461,785)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(246,057)	0	0	0	0	0	0	0	0	0	0	(246,057)	32
33	Real Estate Taxes	(25,276)	0	0	0	0	0	0	0	0	0	0	(25,276)	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	(733,118)	0	0	0	0	0	0	0	0	0	0	(733,118)	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	(325)	0	0	0	0	0	0	0	0	0	0	(325)	40
41	Coffee and Gift Shops	(22,407)	0	0	0	0	0	0	0	0	0	0	(22,407)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,428,249)	0	0	0	0	0	0	0	0	0	0	(4,428,249)	43
44	TOTAL Special Cost Centers	(4,450,981)	0	0	0	0	0	0	0	0	0	0	(4,450,981)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,009,797)	(2,489,524)	0	0	0	0	0	0	0	0	0	(8,499,321)	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
Lutheran Life Ministries	100	Pleasant View Luther Home	Ottowa, IL	Lutheran Life Ministri	Arlington Heights, IL	Parent Holding Com
		Wittenberg Lutheran Village	Crown Point, IN	Lutheran Life Comuni	Arlington Heights, IL	Management Consul
		Arlington of Naples	Naples, FL	Lutheran Foundation	Arlington Heights, IL	Fundraising
		Luther Oaks	Bloomington, IL	Lutheran Community	Arlington Heights, IL	Support Services

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	Administrative Expenses	\$ 2,489,524	Lutheran Life Communities	0.00%	\$	\$ (2,489,524)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,489,524			\$	\$ * (2,489,524)	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	Sloan Bentley							1
2	Marie Carlson							2
3	Shareen Anderson							3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lutheran Home for the Aged # 0005090 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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									\$		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 Lutheran Home for the Aged# 0005090

Report Period Beginning:

7/1/2019Ending: 5/30/2020

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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	Revenue Bonds LHSA 2012		X	Skilled Beds Construction			\$ 98,500,000	\$	5/15/2046	Varies	\$ 2,063,868	1
2	Revenue Bonds 2019		X	Refinance Debt/Capital Imp			102,118,178	101,537,799	2049	Varies	2,515,787	2
3	Debt Swap		X					2,511,884				3
4	Debt Issuance Costs		X								(61,742)	4
5												5
	Working Capital											
6	Line of Credit (MIF)		X			7/1/15	5,000,000	3,952,710	7/1/20	3.8750	104,765	6
7	Interest on Capital Lease/Resident		X								231	7
8												8
9	TOTAL Facility Related						\$ 205,618,178	\$ 108,002,393			\$ 4,622,909	9
	B. Non-Facility Related*											
10												10
11	Investment Income										(246,057)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (246,057)	14
15	TOTALS (line 9+line14)						\$ 205,618,178	\$ 108,002,393			\$ 4,376,852	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	(10,666)	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.)			\$	26,454	2
3. Under or (over) accrual (line 2 minus line 1).			\$	37,120	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	(37,120)	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:		2015	21,566	8	
		2016	26,511	9	
		2017	28,425	10	
		2018	28,763	11	
		2019	26,454	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lutheran Home for the Aged COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005090

CONTACT PERSON REGARDING THIS REPORT Andrew Kazmierczak

TELEPHONE (847) 368-7400 FAX #: (847) 368-7302

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-19-400-002-0000</u>	<u>100% Non-Care Physician Building</u>	\$ <u>26,453.93</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>26,453.93</u></u>	\$ _____

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

474,744

B. General Construction Type:

Exterior Brick

Frame Steel/Precast

Number of Stories

3

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).

Lutheran Home and Services for the Aged, Inc. - Parent Corporation

Lutheran Community Services for the Aged, Inc. - Family Support Service

Lutheran Foundation for the Aged - Fundraising activites

Hearthstone Supportive Apartments - 100 beds, 82,125 square feet

Child Day Care - 7,468

Adult Day Care - 7,926 square feet

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	Patient Care	871,200	1922	\$ 20,000	1
2	Cemetary	43,560	1896	225	2
3	TOTALS	914,760		\$ 20,225	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	376		1953	1953	\$ 1,242,090	\$		\$	\$	\$	4
5			1962	1962	82,773						5
6			1966	1966	1,196,550						6
7			1973	1973	2,431,047						7
8			1978	1978	3,398,949						8
	Improvement Type**										
9	1976 Improvements			1976	10,801		20				9
10	1980 Improvements			1980	128,110		20				10
11	1981 Improvements			1981	1,686,911		20				11
12	1982 Improvements			1982	881,456		20				12
13	1983 Improvements			1983	733,983		20				13
14	1984 Improvements			1984	650,719		20				14
15	1985 Improvements			1985	335,901		20				15
16	1986 Improvements			1986	31,815		20				16
17	1987 Improvements			1987	36,747		20				17
18	1988 Improvements			1988	125,105		20				18
19	1989 Improvements			1989	5,271		20				19
20	1990 Improvements			1990	9,600		20				20
21	1991 Improvements			1991	65,975		20				21
22	1992 Improvements			1992	254,620		20				22
23	1993 Improvements			1993	60,706		20				23
24	1994 Improvements			1994	164,661		20				24
25	1995 Improvements			1995	40,474		20				25
26	1996 Improvements			1996	40,722		20				26
27	1997 Improvements			1997	20,182		20				27
28	1998 Improvements			1998	7,097,469		20				28
29	1999 Improvements			1999	3,328,341		20				29
30	2000 Improvements			2000	685,387		20				30
31	2001 Improvements			2001	4,120,711		20				31
32	2002 Improvements			2002	1,163,245		20				32
33	2003 Improvements			2003	1,077,127		20				33
34	2004 Improvements			2004	1,194,296		20				34
35	2005 Improvements			2005	707,268		20				35
36	2006 Improvements			2006	548,435		20				36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lutheran Home for the Aged

0005090

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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 2007 Improvements	2007	\$ 401,982	\$	20	\$	\$	\$	37
38 2008 Improvements	2008	280,548		20				38
39 2009 Improvements	2009	300,736		20				39
40 2010 Improvements	2010	144,550		20				40
41 2011 Improvements	2011	401,201		20				41
42 2012 Improvements	2012	407,537		20				42
43 2013 Improvements	2013	584,745		20				43
44 2014 Improvements	2014	25,918,534		20				44
45 Concrete Replacement and Doors	2015	4,635		20				45
46 Concrete on Employee Entrance	2015	8,150		20				46
47 Building Phase 2	2015	10,992,502		20				47
48 Close out Phase 3 Building	2016	13,416,085		20				48
49 Close out Series 2012 Bond	2016	19,851,176		20				49
50 Capitalize LHSA 2012 Bond	2017	563,961		20				50
51 Asphalt Concordia Lane Recon	2018	33,977		20				51
52 Bench - Victorian Bench 48'L w	2018	2,393		20				52
53 Olson Courtyard project renovation	2018	188,889		20				53
54 Flooring - Computer Room	2019	1,036		20				54
55 HVAC - Install 1 condenser coil	2019	16,854		20				55
56 Boiler Room - 2in ball valve ref	2019	2,600		20				56
57 Boiler - Boiler Repairs	2019	6,460		20				57
58 Boiler - Boiler Repairs	2019	2,860		20				58
59 Carpeting - Unit 312 carpet rep	2019	1,080		20				59
60 Carpeting - Unit 227 carpet rep	2019	1,080		20				60
61 Carpeting - Unit 236 carpet rep	2019	1,080		20				61
62 Carpeting - Hearthstone Stock	2019	9,600		20				62
63 Carpeting - Unit 210 carpet rep	2019	1,080		20				63
64 Fence - Install Fence and (2) V	2019	8,935		20				64
65 Carpet - Unit 106	2019	1,080		20				65
66 Carpet - Unit 303	2019	1,080		20				66
67 Doors - Doors & Partitions - Sti	2019	32,411		20				67
68 Security - Security System	2019	8,459		20				68
69 Flooring throughout facility	2019	6,000		20				69
70 TOTAL (lines 4 thru 69)		\$ 107,160,743	\$		\$	\$	\$	70

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

Facility Name & ID Number Lutheran Home for the Aged

0005090

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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	
1 Totals from Page 12A, Carried Forward		\$ 107,160,743	\$		\$	\$	\$	1
2 Carpet throughout facility	2019	21,652						2
3								3
4 Adjustment to building and improvements	2019	5,460,898						4
5								5
6								6
7 Financial Statement Depreciation			2,974,643		2,974,643		40,127,931	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 112,643,293	\$ 2,974,643		\$ 2,974,643	\$	\$ 40,127,931	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	\$ 4,630,382	\$ 587,935	\$ 587,935	\$	Var	\$ 2,670,969	71
72	Current Year Purchases	621,830	36,820	36,820		Var	36,820	72
73	Fully Depreciated Assets	13,806,488				Var	13,806,488	73
74								74
75	TOTALS	\$ 19,058,700	\$ 624,755	\$ 624,755	\$		\$ 16,514,277	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				\$ 784,372	\$ 19,228	\$ 19,228	\$	Var	\$ 708,325
77									
78									
79									
80	TOTALS			\$ 784,372	\$ 19,228	\$ 19,228	\$		\$ 708,325

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)			\$	132,506,590
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	3,618,626
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	3,618,626
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)			\$	57,350,533

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-Allowable	\$ 16,178,158	\$ 461,785	\$ 11,920,788
87				
88				
89				
90				
91	TOTALS	\$ 16,178,158	\$ 461,785	\$ 11,920,788

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$145,572 Description: See attachment (PG14A tab)
(Attach a schedule detailing the breakdown of movable equipment)
- ☒ YES☐ NO

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.

Lutheran Home for the Aged
Supplemental Schedule of Equipment Rental
6/30/2020

Line #	Description	Amount
35-3	Therapy Equipment	37,247
35-3	Nursing Equipment	<u>108,325</u>
		<u>145,572</u>

PG14, SCHEDULE XII, SECTION B

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

C. CONTRACTUAL INCOME

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)	\$			

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	10a-3	hrs	\$	27,223	\$ 1,463,586	\$	27,223	\$ 1,463,586	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,621	200,119		3,621	200,119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3, 10a-2	hrs		38,966	2,472,918	8,802	38,966	2,481,720	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				877,796		877,796	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray	39-3				125,576			125,576	12
13	Other (specify): Minor Equip & Transp	39-3				13,992			13,992	13
14	TOTAL			\$	69,810	\$ 4,276,191	\$ 886,598	69,810	\$ 5,162,789	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	\$ 7,665,119	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 955,219)	4,822,322		3
4	Supply Inventory (priced at)	147,499		4
5	Short-Term Investments	9,143,696		5
6	Prepaid Insurance	931,306		6
7	Other Prepaid Expenses	358,434		7
8	Accounts Receivable (owners or related parties)	30,003,042		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 53,071,418	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,225		13
14	Buildings, at Historical Cost	122,639,008		14
15	Leasehold Improvements, at Historical Cost	577,750		15
16	Equipment, at Historical Cost	25,447,765		16
17	Accumulated Depreciation (book methods)	(69,271,321)		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):	1,642,611		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 81,056,038	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 134,127,456	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,115,655	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	460,565		28
29	Short-Term Notes Payable	5,474,119		29
30	Accrued Salaries Payable	1,574,094		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,938		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,126		32
33	Accrued Interest Payable	700,562		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,834,722		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,254,781	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	102,528,274		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		2,292,853		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 104,821,127	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 116,075,908	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,051,548	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 134,127,456	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 33,791,780	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 33,791,780	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,787,567)	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) Transfer of Equity	(6,952,665)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (15,740,232)	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)	\$ 18,051,548	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lutheran Home for the Aged

0005090

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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	\$ 55,238,289	1
2	Discounts and Allowances for all Levels	(26,738,964)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 28,499,325	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,500,874	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 15,500,874	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	10,585	13
14	Non-Patient Meals	383,902	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,023,351	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,592	19
20	Radiology and X-Ray	37,729	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,532,159	23
	D. Non-Operating Revenue		
24	Contributions	68,569	24
25	Interest and Other Investment Income***	246,057	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 314,626	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	(12,561,266)	28
28a	Hearthstone Revenue	8,063,394	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,497,872)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 41,349,112	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	7,800,822	31
32	Health Care	18,558,159	32
33	General Administration	11,069,875	33
	B. Capital Expense		
34	Ownership	8,874,168	34
	C. Ancillary Expense		
35	Special Cost Centers	3,158,333	35
36	Provider Participation Fee	675,322	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 50,136,679	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,787,567)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,787,567)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,729,990	44
45	Private Pay - Net Inpatient Revenue	24,170,900	45
46	Medicare - Net Inpatient Revenue	1,442,647	46
47	Other-(specify) <u>HMO</u>	132,463	47
48	Other-(specify) <u>Other</u>	(1,976,675)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 28,499,325	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	3,761	3,960	\$ 216,623	\$ 54.70	1
2	Assistant Director of Nursing	17,569	18,487	638,545	34.54	2
3	Registered Nurses	112,560	123,079	4,597,973	37.36	3
4	Licensed Practical Nurses	22,709	24,808	691,223	27.86	4
5	CNAs & Orderlies	267,681	295,212	5,299,357	17.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	22,019	23,610	570,864	24.18	10
11	Social Service Workers	14,000	15,293	430,820	28.17	11
12	Dietician					12
13	Food Service Supervisor	16,190	17,818	571,631	32.08	13
14	Head Cook	13,520	15,052	246,672	16.39	14
15	Cook Helpers/Assistants	82,357	86,858	1,230,316	14.16	15
16	Dishwashers					16
17	Maintenance Workers	38,982	42,453	926,911	21.83	17
18	Housekeepers	71,053	78,453	1,098,876	14.01	18
19	Laundry	11,737	12,614	169,469	13.43	19
20	Administrator	1,779	2,000	189,104	94.55	20
21	Assistant Administrator	1,757	1,977	213,045	107.76	21
22	Other Administrative	38,002	40,843	1,084,371	26.55	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	3,424	3,851	73,471	19.08	31
32	Other Health Care(specify)	11,875	13,351	566,498	42.43	32
33	Other(specify)	56,924	61,600	1,475,461	23.95	33
34	TOTAL (lines 1 - 33)	807,899	881,319	\$ 20,291,230 *	\$ 23.02	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	12 months	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 months	41,318	10-3	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	8	512	21-3	45
46	Other(specify) MDS Consultant	64	5,325	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 83,155		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	47	\$ 2,050	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	10,608	284,293	10-3	52
53	TOTAL (lines 50 - 52)	10,655	\$ 286,343		53

STATE OF ILLINOIS

Facility Name & ID Number

Lutheran Home for the Aged

0005090

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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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	
Sarah Kurth	Administrator		\$ 186,503	Workers' Compensation Insurance	\$ 538,892	IDPH License Fee	\$ 1,990	
Andrew Kazmierczak	Executive Director		210,115	Unemployment Compensation Insurance	60,043	Advertising: Employee Recruitment		
				FICA Taxes	1,257,202	Health Care Worker Background Check		
				Employee Health Insurance	1,761,112	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Leading Age Dues	33,300	
				Retirement	203,869	Illinois Aging Services Network	19,323	
				Benefit Offset	(16,836)	Subscriptions & Publications	7,083	
				Life Insurance/Disability	18,447	Dues & Memberships	6,969	
				Physicals	19,608	Non-Care Amount	(17,439)	
				Tuition Reimbursement	13,979	Less: Public Relations Expense (		
				Other / Covid Benefits	41,674	Non-allowable advertising (		
						Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 396,618	line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
				to Owners or Employees				
Description		Amount	Description	Line #	Amount	Description	Amount	
		\$			\$	Out-of-State Travel	\$	
						In-State Travel	922	
TOTAL (agree to Schedule V, line 17, col. 3)						Seminar Expense	17,061	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount				Non-Care Amount	(4,567)	
Lutheran Life Communities	Mgmt Fee	\$ 2,489,524				Entertainment Expense (		
See Attached	Legal	251,057				(agree to Sch. V,		
Bradley Associates	Accounting	38,216				line 24, col. 8)		
CliftonLarsonAllen	Accounting	55,478				TOTAL	\$ 13,416	
TOTAL (agree to Schedule V, line 19, column 3)			TOTAL					
(For legal fee disclosure, see page 39 of instructions)			\$					
			2,834,275					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lutheran Home for the Aged	STATE OF ILLINOIS # 0005090	Report Period Beginning: 7/1/2019	Ending: 6/30/2020
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Leading Age - 33,300

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 279,516 Line 10-2

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

(8) Are you presently operating under a sale and leaseback arrangement? N/A
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 675,322
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 383,902

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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