

		FOR BHF USE						

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: <u>0025023</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Lutheran Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/24</u> to <u>09/30/25</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>702 West Cumberland</u> <u>Altamont</u> <u>62411</u> Number City Zip Code																											
County: <u>Effingham</u>																											
Telephone Number: <u>(618) 483-6136</u> Fax # <u>(618) 483-5586</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>10/01/1980</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Emily Miller</u> (Title) <u>Administrator</u>																									
Type of Ownership:																											
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(C)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(C)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave. Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4446</u> Fax # <u>(314) 925-4350</u>	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																									
☒ Charitable Corp.	☐ Individual	☐ State																									
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IRS Exemption Code <u>501(C)(3)</u>	☐ Corporation	☐ Other _____																									
	☐ "Sub-S" Corp.	_____																									
	☐ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen</u> Telephone Number: <u>(314) 925-4446</u> Email Address: _____																											

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

STATE OF ILLINOIS

Page 2

Facility Name & ID Number

Lutheran Care Center

#

0025023

Report Period Beginning:

10/01/24

Ending:

09/30/25

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	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment							
		Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total
8	SNF	601	2,106			10,173	1,998	530	15,408
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	601	2,106			10,173	1,998	530	15,408

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

43.97%

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

0

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

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

Daycare

F. Does the facility maintain a daily midnight census?

Yes

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

YES

X

NO

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

YES

X

NO

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

Date started

10/1/1980

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

YES

X

Date

10/1/1980

NO

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

96

Medicare Intermediary

WPS GH A

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

09/30/25

Fiscal Year:

09/30/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	354,147	27,268	7,697	389,112		389,112		389,112		1
2	Food Purchase		172,207		172,207		172,207	(22,615)	149,592		2
3	Housekeeping	102,943	13,321		116,264		116,264		116,264		3
4	Laundry	103,282	5,451		108,733		108,733		108,733		4
5	Heat and Other Utilities			103,190	103,190		103,190		103,190		5
6	Maintenance	91,942	12,301	28,480	132,723		132,723		132,723		6
7	Other (specify):*										7
8	TOTAL General Services	652,314	230,548	139,367	1,022,229		1,022,229	(22,615)	999,614		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,647,678	36,947	1,651	1,686,276		1,686,276		1,686,276		10
10a	Therapy	150,624	174	255	151,053		151,053		151,053		10a
11	Activities	83,784	115	7,476	91,375		91,375		91,375		11
12	Social Services	46,572	27	739	47,338		47,338		47,338		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,928,658	37,263	16,121	1,982,042		1,982,042		1,982,042		16
	C. General Administration										
17	Administrative	97,554			97,554		97,554		97,554		17
18	Directors Fees										18
19	Professional Services			41,589	41,589		41,589		41,589		19
20	Dues, Fees, Subscriptions & Promotions			43,742	43,742	1,162	44,904	(84)	44,820		20
21	Clerical & General Office Expenses	161,285	9,444	27,163	197,892	(1,162)	196,730	(47,851)	148,879		21
22	Employee Benefits & Payroll Taxes			603,346	603,346		603,346	(11,717)	591,629		22
23	Inservic Training & Education										23
24	Travel and Seminar			1,344	1,344		1,344		1,344		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			86,979	86,979		86,979		86,979		26
27	Other (specify):*										27
28	TOTAL General Administration	258,839	9,444	804,163	1,072,446		1,072,446	(59,652)	1,012,794		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,839,811	277,255	959,651	4,076,717		4,076,717	(82,267)	3,994,450		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 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			141,003	141,003		141,003	(5,186)	135,818		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			30	30		30	(30)			32
33	Real Estate Taxes			620	620		620	(620)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			141,653	141,653		141,653	(5,836)	135,818		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			85,274	85,274		85,274		85,274		39
40	Barber and Beauty Shops			7,595	7,595		7,595		7,595		40
41	Coffee and Gift Shops			712	712		712		712		41
42	Provider Participation Fee			141,902	141,902		141,902		141,902		42
43	Other (specify):*	489,948	112,259	368,099	970,306		970,306	(970,306)			43
44	TOTAL Special Cost Centers	489,948	112,259	603,582	1,205,789		1,205,789	(970,306)	235,483		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,329,759	389,514	1,704,886	5,424,159		5,424,159	(1,058,409)	4,365,751		45

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

		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	(22,615)	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	(30)	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	(50)	21		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	(410)	21		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(84)	20		29
30	Other-Attach Schedule	(1,035,220)			30
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,058,409)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,058,409)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/01/24

Ending: 09/30/25

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-care related salaries	(489,948)	43	3
4	Non-care related supplies	(112,259)	43	4
5	Non-care related expenses	(368,099)	43	5
6	Miscellaneous Income	(47,391)	21	6
7	Uniform Income	(11,717)	22	7
8	Non-care related real estate taxes	(620)	33	8
9	50% of Chapel Depreciation	(5,186)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,035,220)		49

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
Jeff Stremming, President	0					
Garrett Ziegler, Vice President	0					
Kevin Miller, Treasurer	0					
Norma Wohltman, Secretary	0					
Twila Magnus, Executive Board	0					
Sandy Heiden, Executive Board	0					
Diane Wetherell, David Traub, Kathy Corde	0					

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

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

VII. RELATED PARTIES (continued)

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2	Note: No members of the Board either provided services to the nursing home or owned business entities that provided services to the nursing home										2
3	See attached list of Board of Directors.										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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 OrganizationN/A
Street Address
City / State / Zip Code
Phone Number
Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense									
		YES	NO				Original	Balance												
	A. Directly Facility Related																			
	Long-Term																			
1							\$		\$			\$								1
2																				2
3																				3
4																				4
5																				5
	Working Capital																			
6	Bank of Hillboro		X	Line of Credit		02/24/2025		350,000		02/01/2026		4.0000								6
7																				7
8																				8
9	TOTAL Facility Related							\$	350,000	\$					\$					9
	B. Non-Facility Related*																			
10																				10
11																				11
12																				12
13																				13
14	TOTAL Non-Facility Related							\$		\$					\$					14
15	TOTALS (line 9+line14)							\$	350,000	\$					\$					15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.		\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	620	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	620	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	620	7	
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
		FOR BHF USE ONLY			
		14	FROM R. E. TAX STATEMENT FOR 2024 \$	14	
		15	PLUS APPEAL COST FROM LINE 5 \$	15	
		16	LESS REFUND FROM LINE 6 \$	16	
		17	AMOUNT TO USE FOR RATE CALCULATION \$	17	

- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lutheran Care Center COUNTY Effingham
FACILITY IDPH LICENSE NUMBER 0025023
CONTACT PERSON REGARDING THIS REPORT Emily Miller
TELEPHONE (618) 483-6136 FAX #: (618) 483-5586

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>09-02-016-021</u>	<u>Vacant Lot</u>	\$ <u>620.00</u>	\$ <u></u>
2.	<u>Facility is a not-for-profit entity, therefore is not subject to real estate tax.</u>		\$ <u></u>	\$ <u></u>
3.	<u>Non-care related real estate taxes</u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u>have been removed from report at</u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u>Sch. V, Line 33, Col7</u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u>620.00</u>	\$ <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 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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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:25,884

B. General Construction Type:ExteriorBrickFrameSteel

Number of Stories1

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 ground (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 Villas - Independent Living, 15 Units - 7,700 square fee
Lutheran Terrace - Independent Living, 16 Units - 13,688 square feet
Child Enrichment Center - Day Care, 4,219 square feet

F. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO X
If so, please complete the following:
1. Total Amount Incurred: N/A2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	239,085	1980	\$ 35,000	1
2	Resident Care	197,415	1987	28,710	2
3	TOTALS	436,500		\$ 63,710	3

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	96		1980	1969	\$879,500	\$		\$		\$879,500	4
5			1980	1981	3,764					3,764	5
6			1980	1982	141,000					141,000	6
7				2014	213,250	7,108		7,108		89,564	7
8				2002	236,474	5,186		5,186		149,185	8
	Improvement Type**										
9	1980 Improvements		1980		30,660		Various				9
10	1986 Improvements		1986		2,904		Various			2,904	10
11	1987 Improvements		1987		3,173		Various			3,173	11
12	1989 Improvements		1989		44,772		Various			44,772	12
13	1990 Improvements		1990		38,528		Various			38,528	13
14	1991 Improvements		1991		6,000		Various			6,000	14
15	1992 Improvements		1992		11,467		Various			11,467	15
16	1993 Improvements		1993		86,395	1,662	Various	1,662		86,395	16
17	1994 Improvements		1994		52,066	1,302	Various	1,302		40,680	17
18	1995 Improvements		1995		12,474	200	Various	200		10,628	18
19	1996 Improvements		1996		17,779		Various			17,779	19
20	1997 Improvements		1997		197,527		Various			197,527	20
21	1998 Improvements		1998		21,846		Various			21,846	21
22	1999 Improvements		1999		23,687		Various			23,687	22
23	2002 Improvements		2002		103,225		Various			103,225	23
24	2003 Improvements		2003		22,862		Various			22,862	24
25	2004 Improvements		2004		206,888	47	Various	47		206,888	25
26	2006 Improvements		2006		137,899	6,444	Various	6,444		124,210	26
27	2007 Improvements		2007		289,274	13,662	Various	13,662		269,210	27
28	2008 Improvements		2008		139,339	1,412	Various	1,412		135,440	28
29	2009 Improvements		2009		10,517		Various			10,517	29
30	2010 Improvements		2010		75,292		Various			75,292	30
31	2011 Improvements		2011		81,826	4,632	Various	4,632		73,614	31
32	2012 Improvements		2012		52,970	1,996	Various	1,996		37,444	32
33	2013 Improvements		2013		47,914	424	Various	424		44,684	33
34	2014 Improvements		2014		41,855	377	Various	377		40,558	34
35	2015 Improvements		2015		133,365	6,754	Various	6,754		121,150	35
36	2016 Improvements		2016		19,729	1,880	Various	1,880		18,278	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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2017 Improvements	2017	\$ 39,821	\$ 3,873	Various	\$ 3,873		\$ 33,670	37
38	2018 Improvements	2018	80,976	7,633	Various	7,633		61,449	38
39	2019 Improvements	2019	16,292	365	Various	365		14,977	39
40	2020 Improvements	2020	8,940	969	Various	969		6,048	40
41	RES RM REMODEL 44&46-FLOORING	2021	1,510	150	10	150		717	41
42	RESIDENT ROOM REMODEL 44&46 Painting/Blinds	2021	2,115	212	10	212		1,005	42
43	GARAGE STORAGE FOR COVID SUPPLIES	2021	2,495	250	10	250		1,143	43
44	DOOR CLOSER ARM, NORTON 7705DE	2022	757	152	30	152		562	44
45	CONFERENCE RM FLOORING	2022	2,420	242	15	242		847	45
46	FIRE SYSTEM PANEL SWAP OUT	2022	1,600	320	10	320		1,121	46
47	SIDEWALL SPRINKLERS & PENDANTS	2022	866	173	10	173		606	47
48	WATER HEATER, BRADFORD WHT 75 GAL G	2023	2,718	543	10	543		1,449	48
49	RPL WTR LINE IN KITCHEN	2023	508	51	15	51		135	49
50	HEAT PUMP UNIT, H2H AREA	2023	521	52	15	52		126	50
51	PLANTS & MULCH FOR COURTYARD	2023	549	110	5	110		265	51
52	2-VERTICAL ROD EXIT PANIC BARS FIRE	2023	920	184	10	184		414	52
53	8'6" CONCRETE PAD IN COURTYARD	2023	2,500	250	25	250		542	53
54	RPLC WATER LINES IN KITCHEN	2024	3,006	301	10	301		526	54
55	ADD TO DIET KITCHEN WTR LINE REPAIR	2024	247	25	10	25		39	55
56	A/C COMPRESSOR,FAN MOTOR,PRSSR CONTROL	2024	2,598	260	10	260		411	56
57	A/C DAMPER,REGISTERS,BREAKERS,CONTROL BRD	2024	2,244	224	10	224		355	57
58	A/C SYSTEM IN LAUNDRY, A&H	2024	10,500	1,050	10	1,050		1,576	58
59	A/C SYSTEM IN SOUTH HALL	2024	10,700	1,070	10	1,070		1,427	59
60	COMPRESSOR, WLK IN FRZR IN SM GARAGE	2024	2,971	594	5	594		792	60
61	FIRE SPRINKLERS, DRY PENDENT in Kitchen	2024	3,648	334	10	334		334	61
62	A/C SYSTEM FOR KITCHEN	2024	11,145	1,022	10	1,022		1,022	62
63	AWNING 2X6X33, HUNTER GREEN at front entrance	2024	6,645	554	10	554		554	63
64	HEATING PKG & BREAKER-ACT	2025	666	50	10	50		50	64
65	AQUASTAT FOR N BOILER	2025	563	33	10	33		33	65
66	FLOWERS,MULCH,ROCK,LANDSCAPE FELT	2025	27,969	2,797	5	2,797		2,797	66
67	A/C SYSTEM in North Hall from R&H	2025	10,800	270	10	270		270	67
68	ROCK, LG BOULDER from Kiefer Landscaping	2025	550	18	5	18		18	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,645,982	\$ 77,217		\$ 77,217	\$	\$ 3,187,051	70

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

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	\$456,118	\$52,518	\$52,518	\$	Various	\$298,780	71
72	Current Year Purchases	26,477	2,083	2,083		Various	2,083	72
73	Fully Depreciated Assets	742,569				Various	740,880	73
74								74
75	TOTALS	\$1,225,164	\$54,601	\$54,601	\$		\$1,041,743	75

D. Vehicle Costs. (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2011 DODGE GRAND CARAV	2011	\$ 37,570	\$	\$	\$	10	\$ 37,570	76
77										77
78										78
79	Facility Use	2006 Cadillac dts, gold 4d & HOV	2018 & 2020	42,000	4,000	4,000		5	25,200	79
80	TOTALS			\$ 79,570	\$ 4,000	\$ 4,000	\$		\$ 62,770	80

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)		\$	5,014,426
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$	135,818
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$	135,818
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)		\$	4,291,564

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	Lutheran Villas	\$1,771,158	\$68,007	\$1,257,249
87	Lutheran Terrace	1,297,979	36,094	930,187
88	Child Enrichement Center	566,083	22,368	436,064
89	Chapel (50%)	236,474	5,186	149,185
90				
91	TOTALS	\$3,871,694	\$131,655	\$2,772,685

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$42,775
93		
94		
95		\$42,775

* 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:
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: \$4,920 Description: Cable TV Access Tower
- ☐ YES☒ NO
- (Attach a schedule detailing the breakdown of movable equipment)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
Fiscal Year EndingAnnual Rent
12. /2026\$
13. /2027\$
14. /2028\$

* 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	Service	Schedule V Line & Column Reference	2		3	4		5	6		7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
					Units	Cost							
1	Licensed Occupational Therapist	10A-1	hrs	\$ 27,167				\$			\$ 27,167	1	
2	Licensed Speech and Language Development Therapist	10A-1	hrs	2,672							2,672	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A-1, 10A-2	hrs	120,785					174		120,959	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39-3	# of prescripts						70,189		70,189	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education	10A-3	hrs						255		255	11	
12	Other (specify): <u>Lab & Xrays, Medicar</u>	39-3							15,085		15,085	12	
13	Other (specify):											13	
14	TOTAL			\$ 150,624		\$		\$ 85,703		\$ 236,327		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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,677,950	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	434,323		3
4	Supply Inventory (priced at)	46,430		4
5	Short-Term Investments			5
6	Prepaid Insurance	58,694		6
7	Other Prepaid Expenses	100		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,217,497	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710		13
14	Buildings, at Historical Cost	7,327,749		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,494,661		16
17	Accumulated Depreciation (book methods)	(7,064,249)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec CIP)	42,775		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,864,646	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,082,143	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,274	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,687		30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule	23,583		36
37	See Schedule	36,398		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,857	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Endowment Funds	1,157,195		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,157,195	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,525,052	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,557,091	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,082,143	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$2,604,933	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$2,604,933	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(47,842)	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)	\$(47,842)	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)	\$2,557,091	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,422,470	1
2	Discounts and Allowances for all Levels	346,242	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,768,712	3
B. Ancillary Revenue			
4	Day Care	406,617	4
5	Other Care for Outpatients		5
6	Therapy	202,093	6
7	Oxygen	10,530	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 619,240	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	6,267	12
13	Barber and Beauty Care	7,550	13
14	Non-Patient Meals	22,615	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	120,120	16
17	Sale of Drugs	105,283	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,903	19
20	Radiology and X-Ray		20
21	Other Medical Services	24,959	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 296,697	23
D. Non-Operating Revenue			
24	Contributions	115,505	24
25	Interest and Other Investment Income***	1,345	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 116,850	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Grouping	516,347	28
28a	Miscellaneous Income	58,471	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 574,818	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,376,317	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,022,229	31
32	Health Care	1,982,042	32
33	General Administration	1,072,446	33
B. Capital Expense			
34	Ownership	141,653	34
C. Ancillary Expense			
35	Special Cost Centers	1,063,887	35
36	Provider Participation Fee	141,902	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,424,159	40
41	Income before Income Taxes (line 30 minus line 40)**	(47,842)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (47,842)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 119,839.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	419,934.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,403,803.00	48
49	Medicare Part A	688,375.00	49
50	Other-(specify) Medicare Advantage	136,761.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,768,712	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,977	1,977	\$ 88,206	\$ 44.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,639	9,639	353,964	36.72	3
4	Licensed Practical Nurses	6,638	6,638	191,979	28.92	4
5	CNAs & Orderlies	41,402	41,402	906,318	21.89	5
6	CNA Trainees					6
7	Licensed Therapist	4,706	4,706	150,624	32.01	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,836	4,836	83,784	17.33	10
11	Social Service Workers	2,032	2,032	46,572	22.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,405	22,405	354,147	15.81	15
16	Dishwashers					16
17	Maintenance Workers	4,534	4,534	91,942	20.28	17
18	Housekeepers	6,174	6,174	102,943	16.67	18
19	Laundry	6,035	6,035	103,282	17.11	19
20	Administrator	1,981	1,981	97,554	49.24	20
21	Assistant Administrator					21
22	Other Administrative	7,752	7,752	161,285	20.81	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	938	938	18,259	19.47	31
32	Other Health C:Qual/Assur/Care S	3,020	3,020	88,952	29.45	32
33	Other(specify) Villa/Daycare/Ter	28,884	28,884	489,948	16.96	33
34	TOTAL (lines 1 - 33)	152,953	152,953	\$ 3,329,759 *	\$ 21.77	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	63	\$ 6,814	V01-3	35
36	Medical Director	Monthly	6,000	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,565	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	9	739	V11-3	44
45	Social Service Consultant	9	739	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	81	\$ 15,857		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

Facility Name & ID NumberLutheran Care Center

STATE OF ILLINOIS

#0025023

Report Period Beginning:10/01/24

Ending:09/30/25

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XX. GENERAL INFORMATION:

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

No

(2)Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name	Amount
LEADING AGE	4,250
LIFE SERVICES NETWORK (LSN)	6,650
Other, please specify	1,720
	12,620Total

(3)List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

LEADING AGE	
LIFE SERVICES NETWORK (LSN)	
Other, please specify	
	Total

(4)EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

LEADING AGE	4,250
LIFE SERVICES NETWORK (LSN)	6,650
Other, please specify	1,720
	12,620Total

(5)Indicate the total amount of both disposable and non-disposable incontinent expens and the location of this expense on Sch. V.

\$5,813

LineV10-2

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

Yes

If NO, attach a complete explanation.

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

\$141,902

This amount is to be recorded on line 42 of Schedule V.

(8)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.

(9)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

(10)Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(11)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.

\$22,615

(12)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 program during this reporting period.

\$N/A

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

None

d. Have vehicle usage logs been maintained?

Yes

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

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

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

\$N/A

(13)Has an audit been performed by an independent certified public accounting firm

Firm Name:CLA, LLP

Yes

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

Yes

(15)Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

N/A

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