

		FOR BHF USE					

LL1

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>0057901</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Lutheran Hillside Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>6901 North Galena Rd</u> <u>Peoria</u> <u>61614</u> Number City Zip Code																											
County: <u>Peoria</u>																											
Telephone Number: <u>(314) 968-9313</u> Fax # <u>(314) 968-5590</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>2/25/2007</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Chad Sneed</u> (Title) <u>Chief Financial Officer</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) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																									
☒ Charitable Corp.	☐ Individual	☐ State																									
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IRS Exemption Code <u>501(c)3</u>	☐ Corporation	☐ Other _____																									
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	☐ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

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Facility Name & ID Number

Lutheran Hillside Village

#

0057901

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

III. STATISTICAL DATA

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

N/A

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	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	107	TOTALS	107	39,055	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	1,185				20,879	3,314	545	25,923
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	1,185				20,879	3,314	545	25,923

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

66.38%

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

0

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

X

NO

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

YES

X

NO

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

Date started

6/1/1976

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

YES

Date

NO

X

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

107

Medicare Intermediary

Wellpoint Federal (NGS)

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

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

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

	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	2,029,960	247,341	34,354	2,311,655		2,311,655	(1,477,344)	834,311		1
2	Food Purchase		1,100,500		1,100,500		1,100,500	(724,192)	376,308		2
3	Housekeeping	756,410	49,432	22,712	828,554		828,554	(535,052)	293,502		3
4	Laundry	66,220	14,145	58,968	139,333		139,333		139,333		4
5	Heat and Other Utilities			1,142,259	1,142,259		1,142,259	(1,015,744)	126,515		5
6	Maintenance	775,465	172,980	717,759	1,666,204		1,666,204	(1,425,477)	240,727		6
7	Other (specify):*										7
8	TOTAL General Services	3,628,055	1,584,398	1,976,052	7,188,505		7,188,505	(5,177,809)	2,010,696		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	3,919,870	106,396	7,841	4,034,107		4,034,107		4,034,107		10
10a	Therapy			857,469	857,469		857,469		857,469		10a
11	Activities	308,163	12,611	35,110	355,884		355,884	(162,698)	193,186		11
12	Social Services	59,527		4,253	63,780		63,780		63,780		12
13	CNA Training										13
14	Program Transportation	145,949	19,259	28,158	193,366		193,366	(157,661)	35,705		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,433,509	138,266	947,831	5,519,606		5,519,606	(320,359)	5,199,247		16
	C. General Administration										
17	Administrative	147,488		796,499	943,987		943,987	(66,565)	877,422		17
18	Directors Fees										18
19	Professional Services			282,941	282,941		282,941	(198,965)	83,976		19
20	Dues, Fees, Subscriptions & Promotions			44,821	44,821	29,089	73,910	(6,664)	67,246		20
21	Clerical & General Office Expenses	649,867	30,360	394,165	1,074,392	(25,347)	1,049,045	(734,862)	314,183		21
22	Employee Benefits & Payroll Taxes			771,039	771,039		771,039		771,039		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,590	5,590		5,590	(3,064)	2,526		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			213,723	213,723		213,723		213,723		26
27	Other (specify):* Marketing	331,028	37,501	33,112	401,641		401,641	(401,641)			27
28	TOTAL General Administration	1,128,383	67,861	2,541,890	3,738,134	3,742	3,741,876	(1,411,761)	2,330,115		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,189,947	1,790,525	5,465,773	16,446,245	3,742	16,449,987	(6,909,929)	9,540,058		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			684,113	684,113		684,113	15,366	699,479		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			478,408	478,408		478,408	(401,964)	76,444		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			11,643	11,643		11,643	(8,389)	3,254		35
36	Other (specify):*										36
37	TOTAL Ownership			1,174,164	1,174,164		1,174,164	(394,987)	779,177		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		200,357	42,152	242,509		242,509		242,509		39
40	Barber and Beauty Shops			20,234	20,234		20,234	(20,234)			40
41	Coffee and Gift Shops		30,964	30,964	30,964		30,964	(9)	30,955		41
42	Provider Participation Fee			237,420	237,420		237,420		237,420		42
43	Other (specify):* AL/IL	2,266,533	35,351	8,337,556	10,639,440	(3,742)	10,635,698	(10,636,252)	(554)		43
44	TOTAL Special Cost Centers	2,266,533	266,672	8,637,362	11,170,567	(3,742)	11,166,825	(10,656,495)	510,330		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,456,480	2,057,197	15,277,299	28,790,976		28,790,976	(17,961,411)	10,829,565		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	(12,012)	2		4
5	Telephone, TV & Radio in Resident Rooms	(43,638)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(71,614)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(85,758)	21		24
25	Fund Raising, Advertising and Promotional	(401,641)	27		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (614,663)		\$	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)	(381,384)		34
35	Other- Attach Schedule	(16,965,364)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (17,346,748)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (17,961,411)		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

Report Period Beginning:

Ending:

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1/1/2025

12/31/2025

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Barber & Beauty Income (limited to expense)	(20,234)	40	3
4	Transportation Income	(7,669)	14	4
5	Interest on Past Due Accounts	(165)	32	5
6	Maintenance Services Income	(7,474)	6	6
7	AL and IL Direct Expenses	(10,636,252)	43	7
8	Activities Income		11	8
9	Gift Shop Income	(9)	41	9
10	Misc Resident - Reimbursable		10	10
11	Non-SNF Dietary Costs	(1,477,344)	1	11
12	Non-SNF Food Purchases	(711,726)	2	12
13	Non-SNF Housekeeping	(535,052)	3	13
14	Non-SNF Utilities	(972,106)	5	14
15	Non-SNF Maintenance	(1,418,003)	6	15
16	Non-SNF Activities	(162,698)	11	16
17	Non-SNF Transportation	(149,992)	14	17
18	Non-SNF Professional Fees	(198,965)	19	18
19	Non-SNF Dues, Fees, Subscriptions, & Promotions	(6,664)	20	19
20	Non-SNF Clerical & Office Expense	(647,604)	21	20
21	Non-SNF Travel & Seminar	(3,064)	24	21
22	Non-SNF Equipment Rental	(8,389)	35	22
23	Liquor Expense	(454)	2	23
24	Telephone Income	(1,500)	21	24
25				25
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47				47
48				48
49	Total	(16,965,364)		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
See Board Listing at PG6-Supp		See Board Listing at PG6-Supp		See Board Listing at PG6-Supp		

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)	
			Item		Name of Related Organization				
1	V	17	Management Fee - Operating	\$ 796,499	Lutheran Senior Services	100.00%	\$ 729,934	\$ (66,565)	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	15,366	15,366	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(330,185)	(330,185)	3
4	V	1	Dieticians	52,555	Lutheran Senior Services	100.00%	52,555		4
5	V	10	Medical Records	21,465	Lutheran Senior Services	100.00%	21,465		5
6	V	21	HR Recruitment	89,188	Lutheran Senior Services	100.00%	89,188		6
7	V	43	Medical Records	11,816	Lutheran Senior Services	100.00%	11,816		7
8	V	21	IT Services		Lutheran Senior Services	100.00%	0		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 971,523			\$ 590,139	\$ * (381,384)	14

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

Report Period Beginning:

Ending:

ID#

0057901

1/1/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

			Place of Residence		Operator/Licensee	Building Co.	Management	
	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Co./Home Office Ownership Percentage
1	David		Anderson	St. Louis	MO			1
2	Rev. Christopher		Sommer	St. Louis	MO			2
3	Dan		Brown	St. Louis	MO			3
4	Brent		Beumer	St. Louis	MO			4
5	Rev. Roy		Christell	St. Louis	MO			5
6	Lauren		Colling	St. Louis	MO			6
7	Adam		Marles	St. Louis	MO			7
8	Megan		Meadows	St. Louis	MO			8
9	Harry		Mueller	St. Louis	MO			9
10	Deborah		Schroeder-Saulinier	St. Louis	MO			10
11	Lisa		Sombart	St. Louis	MO			11
12	Paul		Tice	St. Louis	MO			12
13	Norman		Toon	St. Louis	MO			13
14	Dr. Justin		Hugo	St. Louis	MO			14
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VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Lutheran Convalescent Home	St. Louis, MO			In Home Services and	St. Louis, MO	Hospice	1
2	LSS - Mason Pointe	Town and County, MO			Laclede Groves	St. Louis, MO	AL/IL	2
3	LSS - Breeze Park	Weldon Springs, MO			Mason Pointe	Toun and County, MO	AL/IL	3
4	LSS - Lenoir Woods	Columbia, MO			Breeze Park	Weldon Springs, MO	AL/IL	4
5	LSS - Meridian Village	Glen Carbon, IL			Lenoir Woods	Columbia, MO	AL/IL	5
6	LSS - Meramec Bluffs	Ballwin, MO			Meridian Village	Glen Carbon, IL	AL/IL	6
7	LSS - Concordia Village	Springfield, IL			Meramec Bluffs	Ballwin, MO	AL/IL	7
8	Buffalo Valley Lutheran Village	Lewisburg, PA			Provident Group	St. Louis, MO	Development Co.	8
9	Cumberland Crossings Retirement	Carlisle, PA			Richmond Terrace	Richmond Heights, MO	AL	9
10	Luther Crest Nursing Facility	Allentown, PA			Concordia Village	Springfield, IL	AL/IL	10
11	The Lutheran Home of Tipton	Tipton, PA			202 HUD Projects	St. Louis, MO	Affordable Housing	11
12	LSS - Brooking Park	St. Louis, MO			LSS Endowment Fund	St. Louis, MO	Foundation	12
13					Lutheran Hillside Vill	Peoria, IL	AL/IL	13
14					Lutheran Senior Servi	St. Louis, MO	Home Office	14
15					St. Louis Home Health	St. Louis, MO	Home Health	15
16					Prime Acquisitions LI	St. Louis, MO	PACE	16
17					Prime Acquisitions LI	St. Louis, MO	PACE	17
18					Diakon Lutheran Soci	Middleton, PA	Regional Home Off	18
19					Buffalo Valley	Lewisburg, PA	AL/IL	19
20					Cumberland Crossing	Carlisle, PA	AL/IL	20
21					Luther Crest	Allentown, PA	AL/IL	21
22					Lutheran Home of To	Tipton, PA	AL/IL	22
23					LSS East Foundation	Middleton, PA	Foundation	23
24					Brooking Park Crossi	St. Louis, MO	AL/IL	24
25					Cape Albeon	St. Louis, MO	AL/IL	25
26					Tower Grove Manor	St. Louis, MO	AL/IL	26
27					STAMS	St. Louis, MO	Management Comp	27
28					STACF	St. Louis, MO	Foundation	28
29					STARS HUD Projects	St. Louis, MO	Affordable Housing	29
30					Senior Solutions Cross	St. Louis, MO	Home Care/Private	30

VII. RELATED PARTIES (continued)

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

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

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

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

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

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.)

YESXNO

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related OrganizationLutheran Senior Services
Street Address1150 Hanley Industrial Court
City / State / Zip CodeSt. Louis, MI 63144
Phone Number(314)-968-9313
Fax Number(314)-968-5590

	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	19	Management - Operating	Direct Cost	436,753,747	34	\$ 26,650,439	\$ 17,013,455	11,962,335	\$ 729,934	1
2	30	Management - Capital	Direct Cost	436,753,747	34	560,999		11,962,335	15,365	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					\$ 27,211,438	\$ 17,013,455		\$ 745,299	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	Debt Financing Costs						\$		\$			\$	(50,605)							1
2	2016B Bonds		X	Campus Expansion	Various	7/16/2009		5,750,142		4,153,830	2/1/2037		5.0000					529,013		2
3	2016A Bonds		X	Campus Expansion	Various	2/1/2016		9,325,282		6,975,021	2/1/2046		5.0000							3
4	HO Excess Interest Income Offset																	(330,185)		4
5	Interest Income Offset																	(71,779)		5
	Working Capital																			
6																				6
7																				7
8																				8
9	TOTAL Facility Related							\$ 15,075,424	\$ 11,128,851					\$ 76,444						9
	B. Non-Facility Related*																			
10	AL/IL Bonds								36,604,405											10
11																				11
12																				12
13																				13
14	TOTAL Non-Facility Related							\$	36,604,405					\$						14
15	TOTALS (line 9+line14)							\$ 15,075,424	\$ 47,733,256					\$ 76,444						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.)		\$		2		
3. Under or (over) accrual (line 2 minus line 1).		\$		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.		\$		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			
				14	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 Hillside Village COUNTY Peoria
FACILITY IDPH LICENSE NUMBER 0057901
CONTACT PERSON REGARDING THIS REPORT Chad Sneed
TELEPHONE (314) 446-2405 FAX #: (314) 446-2574

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>14-10-378-008</u>	<u>7.676 Acres</u>	\$ <u>54,090.74</u>	\$ <u></u>
2.	<u>14-10-378-010</u>	<u>5.386 Acres</u>	\$ <u>116,165.32</u>	\$ <u></u>
3.	<u>14-10-378-011</u>	<u>5.311 Acres</u>	\$ <u>34,564.44</u>	\$ <u></u>
4.	<u>14-10-378-012</u>	<u>4.174 Acres</u>	\$ <u>32,193.54</u>	\$ <u></u>
5.	<u></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>237,014.04</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 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 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: 59,981

B. General Construction Type: Exterior: MasonryFrame: WoodNumber of Stories: 1

C. Does the Operating Entity?

☒ (a) Own the Facility☐ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒ (a) Own the Equipment☐ (b) Rent equipment from a Related Organization.☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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 Hillside Village operates 63 assisted living units, 20 assisted living memory care units, 126 independent living apartments, and 48 patio homes and villas

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)?

YESNO☒ 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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	35,725	1976	\$ 149,068	1
2	Facility	28,611	1985	\$ 180,000	2
3	TOTALS	64,336		\$ 329,068	3

XL OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	107			1976	\$ 1,662,540	\$	40	\$		\$ 1,662,540	4
5				1985	477,628		Various			477,628	5
6				1986	698,531	17,461	Various	17,461		676,665	6
7				2002	3,674,293	70,632	Various	70,632		2,709,185	7
8											8
	Improvement Type**										
9	Building Improvements			1996	36,400	1,174	30	1,174		34,442	9
10	Building Improvements			1997	22,168	520	Various	520		15,967	10
11	Building Improvements			1999	12,125	404	Various	404		10,662	11
12	Building Improvements			2000	7,057					7,057	12
13	Building Improvements			2002	16,862		40			16,862	13
14	Building Improvements			2003	320,977	1,731	Various	1,731		294,798	14
15	Building Improvements			2004	751,742	14,613	Various	14,613		485,053	15
16	Building Improvements			2005	47,424		15			47,424	16
17	Building Improvements			2006	54,399		Various			54,399	17
18	Building Improvements			2007	261,998		Various			261,998	18
19	Building Improvements			2008	243,588		Various			243,588	19
20	Building Improvements			2009	390,805		Various			390,805	20
21	Building Improvements			2010	39,400	1,313	15	1,313		39,400	21
22	Building Improvements			2011	91,956	6,130	Various	6,130		87,590	22
23	Building Improvements			2012	388,513	25,228	Various	25,228		345,672	23
24	Building Improvements			2013	45,342	3,023	Various	3,023		38,459	24
25	Building Improvements			2014	83,533	4,683	Various	4,683		65,991	25
26	Building Improvements			2015	1,008	67	15	67		728	26
27	Building Improvements			2016	2,302,992	139,012	Various	139,012		1,492,874	27
28	Building Improvements			2017	788,034	49,609	Various	49,609		467,332	28
29	Building Improvements			2018	44,366	1,428	Various	1,428		33,573	29
30	Building Improvements			2019	34,751	2,415	Various	2,415		15,833	30
31	Building Improvements			2020	328,318	22,053	Various	22,053		117,997	31
32											32
33	Home Office Allocation					15,366		15,366			33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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	Sprinkler system(dry) ACCELERATOR	2021	\$ 1,613	\$ 108	15	\$ 108		\$ 538	37
38	Shower VALVE(2) 1 & 4 ACORN	2021	2,959	197	15	197		953	38
39	Water softening equipment SP	2021	14,045	936	15	936		4,525	39
40	Shower TILE DOGWOOD PT 6	2021	1,845	123	15	123		584	40
41	Boiler CONTROLLER	2021	5,968	398	15	398		1,691	41
42	LV LANE/ACORN CC LUX VINYL TILE	2022	2,763	395	7	395		1,546	42
43	LAVENDER LNE & ACORN WAY CC LVT FLR	2022	20,669	2,953	7	2,953		11,565	43
44	ACORN HALL LVP INSTALL	2022	6,531	933	7	933		3,634	44
45	CARE CENTER RE-ROOF 1&2	2022	92,249	6,150	15	6,150		23,575	45
46	PHASE 1 4-STORY SHINGLE RE-ROOF	2022	74,631	4,975	15	4,975		19,072	46
47	LV LANE/ACORN CC LUX VINYL TILE	2022	2,771	396	7	396		1,517	47
48	LV LANE/ACORN CC LUX VINYL TILE	2022	6,281	897	7	897		3,440	48
49	LAVENDER LNE & ACORN WAY CC LVT FLR	2022	446	64	7	64		244	49
50	OVERSIGHT CARE CENTER ROOF PROJECT	2022	3,700	247	15	247		925	50
51	SNF CLOVER CT/DGWOOD PT. LVT FLOOR	2022	2,623	375	7	375		1,374	51
52	CARE CENTER RE-ROOF 1&2	2022	82,400	5,493	15	5,493		20,142	52
53	SNF CLOVER CT/DGWOOD PT. LVT FLOOR	2022	5,350	764	7	764		2,802	53
54	SNF CLOVER CT/DGWOOD PT. LVT FLOOR	2022	5,350	764	7	764		2,738	54
55	CLOVER CT/DOGWOODPOINT SNF LVT FLR	2022	18,097	2,585	7	2,585		9,264	55
56	VISION LINK II UPGRADE	2022	19,926	1,328	15	1,328		4,760	56
57	CARE CENTER RE-ROOF 1&2	2022	122,255	8,150	15	8,150		29,205	57
58	SNF CLOVER CT/DGWOOD PT. LVT FLOOR	2022	2,623	375	7	375		1,343	58
59	CAT 6 CABLES 2PCKS/5 20" LED MONITR	2022	648	43	15	43		155	59
60	OVERSIGHT CARE CENTER ROOF PROJECT	2022	1,850	123	15	123		442	60
61	CAT 6 CABLE & POWER SUPPLY	2022	663	44	15	44		158	61
62	CAT 6 CABLE & 750VA SMART PWR BKUP	2022	550	37	15	37		132	62
63	20" SCEPTRE LED MONITORS	2022	622	41	15	41		149	63
64	CAT 6 CABLES 6PCKS/11 MON WALL MTS	2022	318	21	15	21		76	64
65	VLINKII 600FT OF CAT6 CABLE INSTALL	2022	1,627	108	15	108		380	65
66	CC RE-ROOF AREA 1&2	2022	55,125	3,675	15	3,675		12,556	66
67	REACH CARE C HALLWAYS LVT FLOORING	2022	23,401	3,343	7	3,343		11,422	67
68	FRNT DESK/TIMCLCK DATA DROPS	2022	1,886	126	15	126		430	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,408,533	\$ 423,029		\$ 423,029	\$	\$ 10,265,879	70

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,408,533	\$ 423,029		\$ 423,029		\$ 10,265,879	1
2	ADDITIONAL CURB/SIDEWALK CIRCLE DRIVE	2022	6,507	434	15	434		1,446	2
3	REACH 1ST HALL LVT FLOORING	2022	4,480	640	7	640		2,133	3
4	REACH 1ST HALL LVT FLOORING PREP	2022	2,155	308	7	308		1,026	4
5	REACH 2ND HALL LVT FLOORING	2022	2,155	308	7	308		1,001	5
6	REACH 2ND HALL LVT FLOORING	2022	4,480	640	7	640		2,080	6
7	REACH HALLWAYS LVT FLOORING	2022	2,155	308	7	308		975	7
8	REACH HALLWAYS LVT FLOORING	2022	4,480	640	7	640		2,027	8
9	REACH CC HALLWAYS LVT FLOORING	2022	300	43	7	43		136	9
10	Engineering Design	2023	1,600	80	20	80		240	10
11	Woodchuck Building Fees &permits	2023	250	8	30	8		24	11
12	6 CLOVER COURT INSTALL SHOWER VALVE	2023	350	24	14	24		71	12
13	KITCHEN AHU HVAC BLOWER MOTOR	2023	1,997	138	14	138		403	13
14	6 CLOVER COURT REMOVE/REINSTAL TILE	2023	350	24	14	24		71	14
15	6 CLOVER COURT INSTALL SHOWER VALVE	2023	1,081	75	14	75		212	15
16	Woodchuck Building Delivery	2023	121,138	4,038	30	4,038		11,441	16
17	REACH THERAPY SLIDER DOOR SRVICE	2023	1,960	137	14	137		378	17
18	REACH BLDG 1ST 100GAL WATER HEATER	2023	16,295	1,127	14	1,127		2,912	18
19	REACH/MECH RM 2ND 100GAL WATR HEATR	2023	16,901	1,169	14	1,169		3,020	19
20	AW 6/7/8 CARE CENTR PICTURE WINDOWS	2023	12,295	615	20	615		1,537	20
21	OXYGEN ROOM DOOR RH	2023	2,240	159	14	159		383	21
22	AMBULANCE DOOR	2023	12,800	907	14	907		2,191	22
23	KITCHEN DOUBLE DOOR	2023	7,300	517	14	517		1,250	23
24	COMMUNITY CENTER CARPET FLOORING	2023	47,142	7,053	7	7,053		17,045	24
25	AW 6/7/8 CARE CENTR PICTURE WINDOWS	2023	10,318	535	19	535		1,294	25
26	DOOR 15 MILL/OVERLAY THE 1/2 CIRCLE	2023	15,600	1,079	14	1,079		2,608	26
27	Main Dining Hall Demo	2023	7,713	514	15	514		1,243	27
28	Material and Demo of Private Dining Area	2023	4,235	282	15	282		682	28
29	SHOPMANS OFFICE CARPET FLOORING	2023	496	71	7	71		159	29
30	ILA ELEVATORS CARPET FLOORING	2023	550	79	7	79		177	30
31	Material and Demo of CC Alternates-Offices	2023	9,278	619	15	619		1,392	31
32	Manhole Drainage	2023	21,283	1,419	15	1,419		3,074	32
33	Air Compressor Replacement	2023	4,000	267	15	267		556	33
34	TOTAL (lines 1 thru 33)		\$ 13,752,417	\$ 447,286		\$ 447,286		\$ 10,329,066	34

**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	\$242,699	\$36,693	\$36,693	\$	Various	\$124,953	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,803,842	215,500	215,500		Various	1,803,842	73
74								74
75	TOTALS	\$2,046,541	\$252,193	\$252,193	\$		\$1,928,795	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Center	Car	2000	\$10,630	\$	\$	\$		\$10,630	76
77	Care Center	Vehicle Wheelchair Coversion	2007	16,029					16,029	77
78										78
79										79
80	TOTALS			\$26,659	\$	\$	\$		\$26,659	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$16,154,685	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$699,479	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$699,479	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$12,284,520	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL/IL	\$88,805,000	\$3,234,654	\$53,788,451	86
87	Land	169,067			87
88	Non-Care Site Improvements	811,597	41,025	373,226	88
89	Non-Care Bldg & Bldg Imprvmnts	6,524,268	164,805	1,485,988	89
90					90
91	TOTALS	\$96,309,932	\$3,440,484	\$55,647,665	91

G. Construction-in-Progress

	Description	Cost	
92	Fixed Asset Clearing	\$151,015	92
93	CIP - IL Renovation	48,000	93
94			94
95		\$199,015	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: \$11,643Description: Portable A/C & boom lifts
- ☐ YES☒ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent
12. /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		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		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	V10A-03	hrs	\$	3,759	\$ 320,628	\$	3,759	\$ 320,628	1					
2	Licensed Speech and Language Development Therapist	V10A-03	hrs		903	91,628		903		91,628	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist	V10A-03	hrs		5,898	445,213		5,898		445,213	4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy	V39-02	# of prescripts					110,518		110,518	9				
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Other (specify): Billable Supplies and E	V39-02						89,839		89,839	12				
13	Other (specify): Lab, Xray, Hospital	V39-03						42,152		42,152	13				
14	TOTAL			\$	10,559	\$ 899,621	\$ 200,357	10,559	\$ 1,099,978	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	\$ 13,422,843	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 122,375)	518,266		3
4	Supply Inventory (priced at)	62,257		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,103		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	7,801		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,019,270	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	369,068		13
14	Buildings, at Historical Cost	103,263,583		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,161,034		16
17	Accumulated Depreciation (book methods)	(67,932,185)		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 (specify):	199,015		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,060,515	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 59,079,785	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 497,952	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	868,586		30
	Accrued Taxes Payable (excluding real estate taxes)	27,554		31
32	Accrued Real Estate Taxes(Sch.IX-B)	248,865		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Long Term Debt	1,019,278		36
37	Other Current Liabilities	2,752,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,414,235	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	47,723,953		43
44	Entrance fees payable and resident deposit	38,404,759		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 86,128,712	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 91,542,947	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (32,463,162)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 59,079,785	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (32,859,939)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (32,859,939)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	396,777	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)	\$ 396,777	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)	\$ (32,463,162)	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,188,971	1
2	Discounts and Allowances for all Levels	(1,012,326)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,176,645	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,550,628	6
7	Oxygen	1,354	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,551,982	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	9	12
13	Barber and Beauty Care	25,988	13
14	Non-Patient Meals	12,012	14
15	Telephone, Television and Radio	1,500	15
16	Rental of Facility Space		16
17	Sale of Drugs	128,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,443	19
20	Radiology and X-Ray	6,749	20
21	Other Medical Services	75,672	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 266,574	23
D. Non-Operating Revenue			
24	Contributions	480,842	24
25	Interest and Other Investment Income***	71,614	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 552,456	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		15,308	28
28a		16,624,788	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,640,096	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 29,187,753	30

2		
II. Expenses		Amount
A. Operating Expenses		
31	General Services	7,188,505
32	Health Care	5,519,606
33	General Administration	3,738,134
B. Capital Expense		
34	Ownership	1,174,164
C. Ancillary Expense		
35	Special Cost Centers	10,933,147
36	Provider Participation Fee	237,420
D. Other Expenses (specify):		
37		
38		
39		
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,790,976
41	Income before Income Taxes (line 30 minus line 40)**	396,777
42	Income Taxes	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 396,777

III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 214,751.00
45	Medicaid Managed Long Term Services and Supports (MLTSS)	
46	MMAI-Medicaid is the Primary Payer	
47	MMAI-Medicare is the Primary Payer	
48	Private Pay	8,843,087.00
49	Medicare Part A	862,948.00
50	Other-(specify) Managed Care	255,859.00
51	Other-(specify)	
52	Other-(specify)	
53	Other-(specify)	
54	Other-(specify)	
55	Other-(specify)	
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,176,645

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	9,627	9,662	\$ 485,136	\$ 50.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,324	14,495	710,775	49.04	3
4	Licensed Practical Nurses	21,612	21,776	827,967	38.02	4
5	CNAs & Orderlies	77,494	77,871	1,846,315	23.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,790	9,858	308,163	31.26	10
11	Social Service Workers	1,794	1,809	59,527	32.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	90,814	91,322	2,029,960	22.23	15
16	Dishwashers					16
17	Maintenance Workers	22,758	22,968	775,465	33.76	17
18	Housekeepers	32,754	32,975	756,410	22.94	18
19	Laundry	3,103	3,113	66,220	21.27	19
20	Administrator	2,080	2,080	147,488	70.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,391	15,735	649,867	41.30	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	1,753	1,757	49,677	28.27	31
32	Other Health C:Transportation	6,290	6,374	145,949	22.90	32
33	Other(specify) Marketing/AL/IL	82,880	83,531	2,597,561	31.10	33
34	TOTAL (lines 1 - 33)	390,464	395,326	\$ 11,456,480 *	\$ 28.98	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	80	15,000	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,327	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	80	\$ 22,327		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 Hillside Village

STATE OF ILLINOIS

#0057901

Report Period Beginning:1/1/2025

Ending:12/31/2025

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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

27,500

27,500Total

(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

Total

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

LEADING AGE

27,500

27,500Total

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

\$36,938

Line39

(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.

\$237,420

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.

\$

No

Has any meal income been offset against
related costs?Indicate the amount.

\$

(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 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?

N/A

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

N/A

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

N/A

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

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:

CliftonLarsonAllen LLP

Yes

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

Yes

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