

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

<p>I. IDPH License ID Number: <u>0051078</u></p> <p>Facility Name: <u>Concordia Village Care Ctr</u></p> <p>Address: <u>4101 West Iles Ave</u> <u>Springfield</u> <u>62711</u> <small>Number City Zip Code</small></p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: <u>217-793-9429</u> Fax # <u>217-793-1333</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/1/2012</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Paul Ogier</u> Telephone Number: <u>(314)968-9313</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2013</u> to <u>12/31/2013</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Paul Ogier</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4497</u> Fax # <u>314-925-4350</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Paul Ogier</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4497</u> Fax # <u>314-925-4350</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Paul Ogier</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>Reimbursement Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4497</u> Fax # <u>314-925-4350</u>							

Facility Name & ID Number Concordia Village Care Ctr

0051078 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	64	Skilled (SNF)	64	23,360	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	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	670	16,897	4,398	21,965	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	670	16,897	4,398	21,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.03%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 5/1/2012

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

YES Date 5/1/2012 NO

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

YES NO If YES, enter number of beds certified 64 and days of care provided 4,311

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	346,859	14,760	7,529	369,148		369,148		369,148		1
2	Food Purchase		118,617		118,617		118,617	(5,626)	112,991		2
3	Housekeeping	7,788	1,121	1,593	10,502		10,502		10,502		3
4	Laundry	20,032	8,785	445	29,262		29,262		29,262		4
5	Heat and Other Utilities			160,503	160,503		160,503	(11,039)	149,464		5
6	Maintenance	50,337	4,788	75,141	130,266		130,266	(584)	129,682		6
7	Other (specify):*										7
8	TOTAL General Services	425,016	148,071	245,211	818,298		818,298	(17,249)	801,049		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,934,582	30,163	92,991	2,057,736		2,057,736		2,057,736		10
10a	Therapy		549	688,063	688,612		688,612		688,612		10a
11	Activities	35,383	6,622	6,585	48,590		48,590		48,590		11
12	Social Services	26,890	18		26,908		26,908		26,908		12
13	CNA Training										13
14	Program Transportation	4,329	2,037	1,739	8,105		8,105	(1,551)	6,554		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,001,184	39,389	807,378	2,847,951		2,847,951	(1,551)	2,846,400		16
	C. General Administration										
17	Administrative	91,138			91,138		91,138		91,138		17
18	Directors Fees										18
19	Professional Services			460,317	460,317		460,317	(60,400)	399,917		19
20	Dues, Fees, Subscriptions & Promotions			13,429	13,429		13,429		13,429		20
21	Clerical & General Office Expenses	210,560	23,690	99,704	333,954		333,954	(11,203)	322,751		21
22	Employee Benefits & Payroll Taxes			754,032	754,032		754,032		754,032		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,472	15,472		15,472		15,472		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			44,903	44,903		44,903		44,903		26
27	Other (specify):* Marketing	54,661	4,644	5,062	64,367		64,367	(64,367)			27
28	TOTAL General Administration	356,359	28,334	1,392,919	1,777,612		1,777,612	(135,970)	1,641,642		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,782,559	215,794	2,445,508	5,443,861		5,443,861	(154,770)	5,289,091		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			579,723	579,723		579,723	(121,539)	458,184			30
31	Amortization of Pre-Op. & Org.			9,350	9,350		9,350		9,350			31
32	Interest			556,621	556,621		556,621	(32,469)	524,152			32
33	Real Estate Taxes			25,420	25,420		25,420		25,420			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,171,114	1,171,114		1,171,114	(154,008)	1,017,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,597	33,144	205,741		205,741		205,741			39
40	Barber and Beauty Shops			34,440	34,440		34,440	(34,440)				40
41	Coffee and Gift Shops			73	73		73		73			41
42	Provider Participation Fee			140,280	140,280		140,280		140,280			42
43	Other (specify):*	1,281,078	618,771	6,236,267	8,136,116		8,136,116	(8,136,116)				43
44	TOTAL Special Cost Centers	1,281,078	791,368	6,444,204	8,516,650		8,516,650	(8,170,556)	346,094			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,063,637	1,007,162	10,060,826	15,131,625		15,131,625	(8,479,334)	6,652,291			45

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

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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	(5,626)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,039)	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	(28,893)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,113)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(6,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,365,263)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,418,934)		\$	30

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (8,418,934)		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

BHF USE ONLY						
48		49		50		51
						52

Concordia Village Care Ctr

ID# 0051078

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Beauty Shop Income	\$ (34,440)	40	1
2	Transportation Income	(1,531)	14	2
3	Non-care SNF Asset Depreciation	(121,539)	30	3
4	Miscellaneous Income	113	21	4
5	Interest on Past Due Accounts	(3,576)	32	5
6	Maintenance Services Income	(584)	6	6
7	Uncompensated Care	(1,987)	21	7
8	Finance and Late Fees	(1,216)	21	8
9	Marketing Expenses	(64,367)	27	9
10	IL and AL Expenses	(8,136,116)	43	10
11	Housekeeping Income	(20)	14	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	(8,365,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concordia Village Care Ctr# 0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,626)	0	0	0	0	0	0	0	0	0	0	(5,626)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,039)	0	0	0	0	0	0	0	0	0	0	(11,039)	5
6	Maintenance	(584)	0	0	0	0	0	0	0	0	0	0	(584)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,249)	0	0	0	0	0	0	0	0	0	0	(17,249)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,551)	0	0	0	0	0	0	0	0	0	0	(1,551)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,551)	0	0	0	0	0	0	0	0	0	0	(1,551)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(60,400)	0	0	0	0	0	0	0	0	0	(60,400)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(11,203)	0	0	0	0	0	0	0	0	0	0	(11,203)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(64,367)	0	0	0	0	0	0	0	0	0	0	(64,367)	27
28	TOTAL General Administration	(75,570)	(60,400)	0	(135,970)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(94,370)	(60,400)	0	(154,770)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concordia Village Care Ctr# 0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(121,539)	0	0	0	0	0	0	0	0	0	0	(121,539)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,469)	0	0	0	0	0	0	0	0	0	0	(32,469)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(154,008)	0	0	0	0	0	0	0	0	0	0	(154,008)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(34,440)	0	0	0	0	0	0	0	0	0	0	(34,440)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,136,116)	0	0	0	0	0	0	0	0	0	0	(8,136,116)	43
44	TOTAL Special Cost Centers	(8,170,556)	0	0	0	0	0	0	0	0	0	0	(8,170,556)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,418,934)	(60,400)	0	0	0	0	0	0	0	0	0	(8,479,334)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp				Lutheran Senior Servi	St. Louis, MO	Home Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management Fee	\$ 452,013	Lutheran Senior Services	100.00%	\$ 391,613	\$ (60,400)	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		\$ 452,013			\$ 391,613	\$ * (60,400)	14

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

Facility Name & ID Number

Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Janice R. Beane	BOD						1
2	Monica Boesdorfer	BOD						2
3	John M. Brandt (Chairperson)	BOD						3
4	Derrell L. Debowey	BOD						4
5	Mark Gerberding	BOD						5
6	John R. Kotovsky (LSS President)	BOD						6
7	Orlando A. Krueger	BOD						7
8	Victor J. Muchow	BOD						8
9	Sharon L O'Brien	BOD						9
10	H.A. Olsen	BOD						10
11	Mike Raso (Sec./Treas./LSS VP)	BOD						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Concordia Village Care Ctr

#

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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

Name of Related Organization Lutheran Senior Services
 Street Address 1150 Hanley Industrial Court
 City / State / Zip Code St. Louis, MO 63144
 Phone Number (314-968-9313
 Fax Number (314-968-5590

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

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	17	Home Office	Direct Costs	24	\$ 10,015,880	\$ 7,497,646	6,341,814	\$ 391,612	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				\$ 10,015,880	\$ 7,497,646		\$ 391,612	25

Facility Name & ID Number

Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Health and Educational Facilities Authority						\$	\$		\$	1						
2	2010 Bonds		X	Campus Expansion		10/13/2010	12,369,734	12,155,713	2042	various	556,621						
3											3						
4											4						
5											5						
Working Capital																	
6											6						
7											7						
8											8						
9	TOTAL Facility Related						\$ 12,369,734	\$ 12,155,713			\$ 556,621	9					
B. Non-Facility Related*																	
10											10						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 12,369,734	\$ 12,155,713			\$ 556,621	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 2012 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.)		\$	25,420		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	25,420		3	
4. Real Estate Tax accrual used for 2013 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.		\$	25,420		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concordia Village Care Ctr COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051078

CONTACT PERSON REGARDING THIS REPORT Paul Ogier

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-02.0-400-068</u>	<u>Land 17.61 acres</u>	\$ <u>282,403.24</u>	\$ <u>25,420.00</u>
2. <u>21-02.0-400-029</u>	<u>Land 6.95 acres</u>	\$ <u>8,229.52</u>	\$ <u> </u>
3. <u>21-02.0-400-066</u>	<u>Land 4.62 acres</u>	\$ <u>5,676.46</u>	\$ <u> </u>
4. <u>21-02.0-400-067</u>	<u>Land 3.94 acres</u>	\$ <u>4,841.02</u>	\$ <u> </u>
5. <u>21-02.0-400-070</u>	<u>Land 4.67 acres</u>	\$ <u>5,737.88</u>	\$ <u> </u>
6. <u>21-02.0-400-39</u>	<u>Land</u>	\$ <u>68.54</u>	\$ <u> </u>
7. <u>21-02.0-400-40</u>	<u>Land</u>	\$ <u>68.54</u>	\$ <u> </u>
8. <u>21-02.0-400-44</u>	<u>Land</u>	\$ <u>68.54</u>	\$ <u> </u>
9. <u>21-02.0-400-52</u>	<u>Land</u>	\$ <u>91.26</u>	\$ <u> </u>
10. <u>21-02.0-400-54 & 21-02.0-400-54</u>	<u>Land</u>	\$ <u>795.42</u>	\$ <u> </u>
TOTALS		\$ <u><u>307,980.42</u></u>	\$ <u><u>25,420.00</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 a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

Facility Name & ID Number Concordia Village Care Ctr

0051078 Report Period Beginning:

1/1/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,445 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

Concordia Village operates 48 Assisted Living Units, 23 Patio Homes, 111 Independent Living Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Care Center</u>	<u>120,000</u>	<u>2010</u>	<u>\$ 77,462</u>	1
2					2
3	TOTALS	120,000		\$ 77,462	3

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	64		2011	\$ 9,122,010	\$ 319,825	various	\$ 319,825	\$	\$ 626,337	
5										
6										
7										
8										
Improvement Type**										
9	WINDOWS REMOVED & FILLED IN - MAIN CORRIDOR/ABOVE E		4/17/2012	3,064	204	15	204		357	
10	PHONE SYSTEM UPGRADE+ 5 HANDSET - SNF CENTER (RECEPT		6/7/2012	3,201	213	15	213		338	
11	FLOORING, VINYL-NURSES STATION		11/1/2012	3,919	784	5	784		914	
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,132,194	\$ 321,026		\$ 321,026	\$	\$ 627,946	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 922,105	\$ 133,327	\$ 133,327	\$	various	\$ 261,844	71
72	Current Year Purchases	9,611	1,328	1,328		various	1,328	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 931,716	\$ 134,655	\$ 134,655	\$		\$ 263,172	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	DODGE CARAVAN, 2000	9/29/2000	\$ 20,792	\$	\$	\$	5	\$ 20,792	76
77	Facility	BUS, 12+2,2009 FORD E-SERIE	6/23/2009	50,940	7,277	7,277		7	32,747	77
78	Facility	TRUCK,PICKUP,'09 FORD F-2	7/13/2009	26,721	3,817	3,817		7	17,178	78
79	Facility	VAN - W/C 2013 FORD E250 5+	8/14/2013	42,355	2,521	2,521		7	2,521	79
80	TOTALS			\$ 140,808	\$ 13,615	\$ 13,615	\$		\$ 73,238	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)	\$ 10,282,180	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 469,296	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 469,296	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)	\$ 964,356	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SNF - Laundry	\$ 1,840,846	\$ 69,232	\$ 138,464	86
87	SNF - Site Improvements - 2009	538,862	27,126	120,969	87
88	SNF - Building Improvements - 2009	544,600	25,181	113,314	88
89	Independent Living	33,972,263	1,420,203	7,248,252	89
90	Assisted Living	8,569,009	387,381	1,732,133	90
91	TOTALS	\$ 45,465,580	\$ 1,929,123	\$ 9,353,132	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2013 Ending: 12/31/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

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		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	4,163	\$ 292,035	\$ 456	4,163	\$ 292,491	1	
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		832	64,590		832	64,590	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	V10A-3	hrs		4,827	331,438	93	4,827	331,531	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	V39-2	# of prescripts				99,930		99,930	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	9,822	\$ 688,063	\$ 100,479	9,822	\$ 788,542	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.

Facility Name & ID Number Concordia Village Care Ctr# 0051078Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,926,260	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	501,855		3
4	Supply Inventory (priced at)	36,409		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,157		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current Assets</u>	153,773		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 13,635,454	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,126,732		13
14	Buildings, at Historical Cost	51,829,351		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,791,676		16
17	Accumulated Depreciation (book methods)	(10,317,488)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	594,863		22
23	Other(specify): <u>CIP</u>	211,834		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,236,968	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 59,872,422	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 161,211	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	265,200		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,591		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Refund Clearing Account</u>	(7,688)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 429,314	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	858,692		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to LSS - Related Party</u>	48,771,062		43
44	<u>Entrance Fees and Resident Deposits</u>	19,757,213		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 69,386,967	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 69,816,281	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,943,860)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 59,872,421	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,031,516)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,031,516)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(912,344)	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)	\$ (912,344)	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)	\$ (9,943,860)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,474,109	1
2	Discounts and Allowances for all Levels	(1,243,986)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,230,123	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,419,848	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,419,848	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	46,068	13
14	Non-Patient Meals	5,626	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	114,425	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,310	19
20	Radiology and X-Ray	2,057	20
21	Other Medical Services	34,523	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,009	23
D. Non-Operating Revenue			
24	Contributions	21,161	24
25	Interest and Other Investment Income***	28,893	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,054	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	5,598	28
28a	IL and AL Revenue	7,303,649	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,309,247	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,219,281	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	818,298	31
32	Health Care	2,847,951	32
33	General Administration	1,777,612	33
B. Capital Expense			
34	Ownership	1,171,114	34
C. Ancillary Expense			
35	Special Cost Centers	8,376,370	35
36	Provider Participation Fee	140,280	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,131,625	40
41	Income before Income Taxes (line 30 minus line 40)**	(912,344)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (912,344)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 146,730	44
45	Private Pay - Net Inpatient Revenue	4,291,272	45
46	Medicare - Net Inpatient Revenue	785,149	46
47	Other-(specify) <u>Benevolent Care</u>	(68,627)	47
48	Other-(specify) <u>Managed Care</u>	75,600	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,230,124	49

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

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

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

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

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	1,907	1,605	\$ 58,617	\$ 36.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,815	11,414	291,422	25.53	3
4	Licensed Practical Nurses	19,088	21,465	514,721	23.98	4
5	CNAs & Orderlies	60,922	68,788	868,936	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,792	1,989	39,713	19.97	10
11	Social Service Workers	965	1,043	26,890	25.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,540	28,839	346,859	12.03	15
16	Dishwashers					16
17	Maintenance Workers	2,507	2,722	50,337	18.49	17
18	Housekeepers	656	713	7,788	10.92	18
19	Laundry	1,965	2,079	20,032	9.64	19
20	Administrator	1,960	2,056	91,138	44.33	20
21	Assistant Administrator					21
22	Other Administrative	16,725	18,557	395,836	21.33	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,004	1,105	15,609	14.13	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Marketing CC</u>	1,944	2,086	54,661	26.20	32
33	Other(specify) <u>IL and AL</u>	91,710	99,063	1,281,078	12.93	33
34	TOTAL (lines 1 - 33)	239,500	263,524	\$ 4,063,637 *	\$ 15.42	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	3	180	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	647	2,264	39-3	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)	650	\$ 20,444		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
MaryAnn Walker	Care Center Administrator	0	\$ 91,138	Workers' Compensation Insurance	\$ 93,078	IDPH License Fee	\$ 663		
				Unemployment Compensation Insurance	24,559	Advertising: Employee Recruitment	5,467		
				FICA Taxes	233,896	Health Care Worker Background Check			
				Employee Health Insurance	339,327	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks	2,070		
				Illinois Municipal Retirement Fund (IMRF)*		LSN Dues	1,809		
				Disability Insurance	10,178	AAHSA	956		
				Life Insurance	4,278	State Journal Register	1,209		
				Pension	2,209	Other	1,255		
				Savings & Revenue	43,844				
				Tuition Reimbursement	2,663	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 91,138				\$ 754,032			\$ 13,429		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
N/A	\$					\$	Out-of-State Travel	\$	
							In-State Travel	5,381	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		10,091
\$				\$			Entertainment Expense		()
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 15,472
C. Professional Services									
Vendor/Payee	Type	Amount							
Lutheran Senior Services	Management Services	\$ 452,013							
CliftonLarsonAllen LLP	Accounting Services	4,092							
Smith,Hemmesch,Burke & Kaczynski	Legal Services	3,614							
Lowenbaum Partnership & Husch B	Legal Services	598							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 460,317				\$					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Concordia Village Care Ctr

0051078

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$1,809; AAHSA - \$956
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,183 Line 39
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 140,280
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,626
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A 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
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.