

		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>0019109</u></p> <p>Facility Name: <u>The Lutheran Home</u></p> <p>Address: <u>6901 North Galena Rd</u> <u>Peoria</u> <u>61614</u> <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>314-968-9313</u> Fax # <u>314-968-5590</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/25/2007</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="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Steve Howell</u> <u>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 style="text-align: right; margin-top: 10px;"> 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>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>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 The Lutheran Home

0019109 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	85	Skilled (SNF)	85	31,025	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	85	TOTALS	85	31,025	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	3,385	19,323	5,435	28,143	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,385	19,323	5,435	28,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.71%

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 06/1/1976

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 85 and days of care provided 4,068

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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

The Lutheran Home

0019109

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	283,944	26,011	28,878	338,833		338,833	(9,561)	329,272		1
2	Food Purchase		222,132		222,132		222,132	(306)	221,826		2
3	Housekeeping	173,143	25,392	6,837	205,372		205,372	(90)	205,282		3
4	Laundry	37,405	13,457	9,238	60,100		60,100		60,100		4
5	Heat and Other Utilities			122,277	122,277		122,277		122,277		5
6	Maintenance	107,083	31,033	119,478	257,594		257,594	(10)	257,584		6
7	Other (specify):*										7
8	TOTAL General Services	601,575	318,025	286,708	1,206,308		1,206,308	(9,967)	1,196,341		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,215,344	75,302	27,804	2,318,450		2,318,450		2,318,450		10
10a	Therapy		149	581,865	582,014		582,014		582,014		10a
11	Activities	175,918	14,175	16,457	206,550		206,550		206,550		11
12	Social Services	44,442	127		44,569		44,569		44,569		12
13	CNA Training										13
14	Program Transportation	10,471	3,923	2,287	16,681		16,681	(6,108)	10,573		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,446,175	93,676	634,413	3,174,264		3,174,264	(6,108)	3,168,156		16
	C. General Administration										
17	Administrative	88,480			88,480		88,480		88,480		17
18	Directors Fees										18
19	Professional Services			501,450	501,450		501,450	(82,070)	419,380		19
20	Dues, Fees, Subscriptions & Promotions			15,520	15,520		15,520		15,520		20
21	Clerical & General Office Expenses	156,088	15,172	78,667	249,927		249,927	(22,985)	226,942		21
22	Employee Benefits & Payroll Taxes			789,368	789,368		789,368		789,368		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,044	14,044		14,044		14,044		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,914	67,914		67,914		67,914		26
27	Other (specify):* Marketing	80,987	20,579	15,177	116,743		116,743	(116,743)			27
28	TOTAL General Administration	325,555	35,751	1,482,140	1,843,446		1,843,446	(221,798)	1,621,648		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,373,305	447,452	2,403,261	6,224,018		6,224,018	(237,873)	5,986,145		29

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

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

Facility Name & ID Number

The Lutheran Home

#0019109

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			494,140	494,140		494,140	(156,649)	337,491			30
31	Amortization of Pre-Op. & Org.			3,824	3,824		3,824		3,824			31
32	Interest			228,001	228,001		228,001	(63,269)	164,732			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			725,965	725,965		725,965	(219,918)	506,047			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		223,450	62,023	285,473		285,473		285,473			39
40	Barber and Beauty Shops			19,652	19,652		19,652	(19,652)				40
41	Coffee and Gift Shops			6,485	6,485		6,485	(6)	6,479			41
42	Provider Participation Fee			187,125	187,125		187,125		187,125			42
43	Other (specify):* AL/IL	1,731,494	773,289	6,856,423	9,361,206		9,361,206	(9,361,206)				43
44	TOTAL Special Cost Centers	1,731,494	996,739	7,131,708	9,859,941		9,859,941	(9,380,864)	479,077			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,104,799	1,444,191	10,260,934	16,809,924		16,809,924	(9,838,655)	6,971,269			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 The Lutheran Home

0019109

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	(9,561)	1		4
5	Telephone, TV & Radio in Resident Rooms	(424)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(156,649)	30		9
10	Interest and Other Investment Income	(52,792)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(941)	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	(20,744)	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	(9,515,474)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,756,585)		\$	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)	(82,070)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (82,070)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,838,655)		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

The Lutheran Home

ID# 0019109

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	\$ (19,652)	40	1
2	Transportation Income	(6,108)	14	2
3	Guest Room Rent	(90)	3	3
4	Miscellaneous Income	(700)	21	4
5	Interest on Past Due Accounts	(10,477)	32	5
6	IL and AL Expenses	(9,361,206)	43	6
7	Liquor Expense	(306)	2	7
8	Maintenance Services	(10)	6	8
9	Finance and Late Fees	(176)	21	9
10	Marketing Expenses	(116,743)	27	10
11	Gift and Coffee Shop	(6)	41	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	(9,515,474)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Lutheran Home# 0019109

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	(9,561)	0	0	0	0	0	0	0	0	0	0	(9,561)	1
2	Food Purchase	(306)	0	0	0	0	0	0	0	0	0	0	(306)	2
3	Housekeeping	(90)	0	0	0	0	0	0	0	0	0	0	(90)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(10)	0	0	0	0	0	0	0	0	0	0	(10)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,967)	0	0	0	0	0	0	0	0	0	0	(9,967)	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	(6,108)	0	0	0	0	0	0	0	0	0	0	(6,108)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,108)	0	0	0	0	0	0	0	0	0	0	(6,108)	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	(82,070)	0	0	0	0	0	0	0	0	0	(82,070)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(22,985)	0	0	0	0	0	0	0	0	0	0	(22,985)	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):*	(116,743)	0	0	0	0	0	0	0	0	0	0	(116,743)	27
28	TOTAL General Administration	(139,728)	(82,070)	0	(221,798)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(155,803)	(82,070)	0	(237,873)	29								

STATE OF ILLINOIS

Facility Name & ID Number The Lutheran Home# 0019109

Report Period Beginning:

1/1/2013 Ending:

Summary B

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	(156,649)	0	0	0	0	0	0	0	0	0	0	(156,649)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(63,269)	0	0	0	0	0	0	0	0	0	0	(63,269)	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	(219,918)	0	0	0	0	0	0	0	0	0	0	(219,918)	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	(19,652)	0	0	0	0	0	0	0	0	0	0	(19,652)	40
41	Coffee and Gift Shops	(6)	0	0	0	0	0	0	0	0	0	0	(6)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,361,206)	0	0	0	0	0	0	0	0	0	0	(9,361,206)	43
44	TOTAL Special Cost Centers	(9,380,864)	0	0	0	0	0	0	0	0	0	0	(9,380,864)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(9,756,585)	(82,070)	0	0	0	0	0	0	0	0	0	(9,838,655)	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	\$ 495,285	Lutheran Senior Services	100.00%	\$ 413,215	\$ (82,070)	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		\$ 495,285			\$ 413,215	\$ * (82,070)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jeffrey Bailey	BOD						1
2	Rev. John Bates	BOD						2
3	Dr. James Bauer	BOD						3
4	John Equing	BOD						4
5	John Kotovsky	BOD						5
6	Dan Losby	BOD						6
7	Rev. Ron Miller	BOD						7
8	Richard Moore	BOD						8
9	Tom Pilat	BOD						9
10	Michael Raso	BOD						10
11	Gary Setterland	BOD						11
12	Debra Sippel	BOD						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 The Lutheran Home # 0019109 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 The Lutheran Home

0019109

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	Home Office	Direct Costs	162,198,610	24	\$ 10,015,880	\$ 7,497,646	6,691,671	\$ 413,215	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		\$ 413,215	25

Facility Name & ID Number

The Lutheran Home

0019109

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**					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	IL Finance Authority -						\$	\$			\$	1				
2	2006 Bonds		X	Campus Expansion	\$198,745.00	7/16/2006	5,750,142	5,050,328	2/1/2037	5.0000	228,001	2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$198,745.00		\$ 5,750,142	\$ 5,050,328			\$ 228,001	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 5,750,142	\$ 5,050,328			\$ 228,001	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		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.)		\$			2														
3. Under or (over) accrual (line 2 minus line 1).		\$			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.		\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY		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
FOR BHF USE ONLY																			
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																	
	2009 _____	9																	
	2010 _____	10																	
	2011 _____	11																	
	2012 _____	12																	

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 The Lutheran Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0019109

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach 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 The Lutheran Home

0019109 Report Period Beginning:

1/1/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 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).

Lutheran Hillside Village Operates - 41 Assisted Living Units; 49 Patio Homes; 126 Independent Living Units; and 20 Assisted Memory Care Unit

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: 807,882 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: 4,104 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number The Lutheran Home

0019109

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			1976	1976	\$ 1,676,061	\$ 38,789	40	\$ 38,789		\$ 1,629,300	4
5			1985	1984	481,567	13,733	40	13,733		408,908	5
6			1986	1986	698,529	17,466	40	17,466		484,608	6
7											7
8											8
	Improvement Type**										
9	Various		1976		58,237		20			58,237	9
10	Various		1978		4,465		20			4,465	10
11	Various		1979		149		20			149	11
12	Various		1980		470		20			470	12
13	Various		1982		403		20			403	13
14	Various		1983		1,717		20			1,717	14
15	Various		1984		2,946		20			2,946	15
16	Various		1985		3,290		20			3,290	16
17	Various		1986		5,335		20			5,335	17
18	Various		1987		18,303		20			18,303	18
19	Various		1988		66,182	1,756	20	1,756		56,307	19
20	Various		1990		134,732	3,305	20	3,305		82,859	20
21	Various		1991		40,069	1,091	20	1,091		26,035	21
22	Various		1992		890	29	20	29		652	22
23	Various		1993		748		20			748	23
24	Various		1994		5,993	193	20	193		3,951	24
25	Various		1995		36,256	1,747	20	1,747		33,407	25
26	Various		1996		43,073	1,174	20	1,174		28,196	26
27	Various		1997		32,988	522	20	522		21,063	27
28	Various		1998		13,903	750	20	750		13,780	28
29	Various		1999		122,497	405	20	405		116,599	29
30	Various		2000		63,649	2,956	20	2,956		44,260	30
31	Various		2001		190,577	3,484	20	3,484		162,308	31
32	Various		2002		1,912,111	57,217	20	57,217		686,607	32
33	Various		2003		319,328	16,337	20	16,337		179,709	33
34	Various		2004		220,824	10,173	20	10,173		93,083	34
35	Various		2005		57,276	2,863	20	2,863		25,774	35
36	Various		2006		8,909	297	20	297		2,376	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 The Lutheran Home

0019109

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2007	\$ 474,843	\$ 23,742	20	\$ 23,742	\$	\$ 150,295	37
38	Various	2008	378,947	18,947	20	18,947		107,801	38
39	Various	2009	399,349	19,967	20	19,967		86,641	39
40	WALL PROTECTOR	2010	74	5	15	5		19	40
41	OPTIMUS SETUP-CABLES&CONNECTORS	2010	1,274	85	15	85		297	41
42	WIRING,CABLE,DATA LINE-OPTIMUS EMR	2010	2,957	197	15	197		678	42
43	OPTIMUS SETUP-CABLES&ELECTRICAL LINES	2010	1,915	128	15	128		431	43
44	FLOORING,CARPET-DINING RM	2010	150	21	7	21		67	44
45	DEMOLITION-OLD CARE CENTER LINK	2011	3,676	245	15	245		572	45
46	FLOORING, CARPET	2011	821	117	7	117		332	46
47	FLOORING, CARPET	2011	3,093	442	7	442		1,252	47
48	FLOORING, CARPET-#5	2011	1,316	188	7	188		501	48
49	FIREPLACE INSERT, DIMPLEX 39"	2011	2,356	157	15	157		419	49
50	FLOORING, BINDING CARPET	2011	212	30	7	30		81	50
51	FLOORING,CERAMIC TILE-PUBLIC BATHRMS	2011	1,502	100	15	100		267	51
52	SURVEY,ASBESTOS/LEAD-AREA, OLD REC CENTE	2011	2,190	146	15	146		377	52
53	FIXTURE,PRE RINSE SPRAY VALVE	2011	74	5	15	5		13	53
54	VANITY,-BATHROOM	2011	227	15	15	15		39	54
55	MIRROR,WALL&HOLDERS-BATHROOM	2011	104	7	15	7		18	55
56	CERAMIC TILE&LIGHTING,MIRRORS-BATHRMS	2011	414	28	15	28		71	56
57	FLOORING, CERAMIC PUBLIC-BATHROOMS	2011	1,500	100	15	100		250	57
58	THERAPY & PUBLIC BATHROOMS-DRYWALL,CARPT	2011	12,388	826	15	826		2,065	58
59	PLUMBING,FIXTURE-THERAPY&PUBLIC BATHROOM	2011	3,381	225	15	225		563	59
60	FLOORING, CARPET BASE/RUG	2011	421	60	7	60		145	60
61	FLOORING, CARPET-COMMON AREAS	2011	9,767	1,395	7	1,395		3,372	61
62	FLOORING,VINYL-NEW THERAPY RM	2011	5,267	752	7	752		1,819	62
63	FLOORING,CARPET-HC HALLWAY	2011	3,203	458	7	458		1,068	63
64	ELECTRICAL WK-DEMO OF REC CENTER	2011	735	49	15	49		114	64
65	CONDENSING UNIT, 15 TON, AWNING	2011	21,380	1,425	15	1,425		3,326	65
66	FLOORING, CERAMIC TILE-THERAPY HALLWAY	2011	499	33	15	33		78	66
67	FLOORING, CARPET-THERAPY HALLWAY	2011	173	25	7	25		58	67
68	LIGHT FIXTURE, FLUS MT CEILING LIGHTS	2011	296	20	15	20		46	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,555,980	\$ 244,228		\$ 244,228	\$	\$ 4,558,919	70

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

Facility Name & ID Number The Lutheran Home

0019109

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,555,980	\$ 244,228		\$ 244,228	\$	\$ 4,558,919	1
2	FLOORING,CARPET-PUBLIC AREA	2011	164	23	7	23		55	2
3	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	124	7	124		288	3
4	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	124	7	124		288	4
5	FLOORING, CARPET-HALLWAY, THERAPY	2011	1,511	216	7	216		504	5
6	SECURITY, ACCESS CONTROL ON DOOR-THERAPY	2011	3,000	200	15	200		467	6
7	FLOORING,CARPET BASEBOARD-HC PULIC AREA	2011	196	28	7	28		65	7
8	FLOORING, CARPET & VINYL-#CLOVER CT COMM	2011	3,251	464	7	464		1,084	8
9	FLOORING, CARPET-DOGWOOD CT	2011	3,368	481	7	481		1,123	9
10	INTERIOR CONSULTANTING FEES-NURSES STATI	2011	6,750	450	15	450		1,013	10
11	GLASS, COMMERCIAL-NURSES STATIONS	2011	43	3	15	3		6	11
12	FLOORING, CARPET & VINYL-NURSES STATION	2011	18,570	2,653	7	2,653		5,969	12
13	PLUMBING-NURSES STATION OFFICE	2011	474	32	15	32		71	13
14	CABINETS-NURSES STATION	2011	29,646	1,976	15	1,976		4,447	14
15	PHONES,WIRING, CABLES RELOCATED-NURSE ST	2011	836	56	15	56		125	15
16	FIREPLACE-NURSES STATION/LOBBY	2011	7,880	525	15	525		1,182	16
17	RECEPTION STATION/AREA-NURSES STATION	2011	4,950	330	15	330		742	17
18	ELECTRICAL UPGRADES-NURSES STATION	2011	310	21	15	21		47	18
19	FLOORING, CARPET INSTALLED, COMMON AREAS	2011	2,383	340	7	340		738	19
20	FLOORING, CARPET-#ACON WAY-COMMON AREA	2011	6,750	964	7	964		2,089	20
21	PLUMBING, DRAIN RADIATOR LINES	2011	428	29	15	29		62	21
22	FLOORING, CARPET BASE	2011	590	118	5	118		256	22
23	DEMOLITION OF CORRIDOR LINK	2011	7,303	487	15	487		1,055	23
24	FLOORING, CERAMIC TILE	2011	1,114	74	15	74		155	24
25	ROOFING, MAIN BUILDING	2012	40,400	2,020	20	2,020		3,367	25
26	ASBESTOS MONITORING-INSIDE BLDG	2012	550	37	15	37		52	26
27	EMERGENCY CALL SYSTEM, WIRELESS	2012	185,913	12,394	15	12,394		24,788	27
28	GRANITE-FIREPLACE	2012	792	53	15	53		106	28
29	FLOORING, CARPET-CC	2012	196	39	5	39		78	29
30	FLOORING, CARPET BASE-#CC	2012	47	9	5	9		19	30
31	SCONE GLASS-EMERGENCY CALL SYSTEM	2012	463	31	15	31		62	31
32	FLOORING, TRANSITION STRIPS-ACTIVITY	2012	267	18	15	18		33	32
33	LOCK.MORTOSE-OFFICE DOOR-LAVENDER LANE	2012	414	28	15	28		51	33
34	TOTAL (lines 1 thru 33)		\$ 7,886,265	\$ 268,574		\$ 268,574	\$	\$ 4,609,302	34

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

Facility Name & ID Number The Lutheran Home

0019109

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,886,265	\$ 268,574		\$ 268,574	\$	\$ 4,609,302	1
2	WALLCABINECUBBY AREAS	2012	3,118	208	15	208		381	2
3	CABINETS-CNA CUBBY AREAS	2012	2,260	151	15	151		264	3
4	CABINETS-CUBBY AREA	2012	1,747	116	15	116		194	4
5	CABINETS, CUBBY AREAS-CNA	2012	6,310	421	15	421		701	5
6	WATER & SEWER LINES CAPPED OF	2012	2,303	154	15	154		230	6
7	ELECTRICAL PANEL REMOVED-CC	2012	1,245	83	15	83		118	7
8	ELECTRICAL DEMO-OLD RET HM	2012	255	17	15	17		21	8
9	ELECTRICAL WORK-DISHWASHER-EMANUAL	2012	922	61	15	61		72	9
10	BATHROOM FIXTURES	2012	1,709	114	15	114		123	10
11	HOT WATER MIXING VALVE&CIRC PUMP UPGRADE	2013	4,500	275	15	275		275	11
12	TILES, CERAMIC-PANTRY	2013	379	23	15	23		23	12
13	TILE, CERAMIC-WALL OR FL	2013	122	7	15	7		7	13
14	CABINETRY/SHELVING	2013	666	41	15	41		41	14
15	REMODEL-DEMO-EMMANUE KITCHEN	2013	1,569	87	15	87		87	15
16	REMODEL-CARPENTRY-EMMANUEL KITCHEN	2013	14,378	799	15	799		799	16
17	REMODEL-CABINETS&CTR TOPS-EMMANUEL KITCH	2013	3,137	174	15	174		174	17
18	REMODEL,ELECTRICAL-EMMANUEL KITCHEN	2013	1,307	73	15	73		73	18
19	REMODEL,PLUMBING&FIXTURES-EMMANUEL KITCH	2013	2,353	131	15	131		131	19
20	REMODEL, PAINTING-EMMANUEL KITCHEN	2013	2,091	249	7	249		249	20
21	FLOORING, REMODEL-EMMANUEL KITCHEN	2013	1,307	156	7	156		156	21
22	PANTRY DOOR SECURITY, ACCESS-EMANUAL	2013	1,244	69	15	69		69	22
23	CERAMIC TILE-WALL/FLOOR-EMANUAL PL PANTR	2013	416	25	15	25		25	23
24	FLOORING,CARPET-#1 EMANUEL	2013	243	28	5	28		28	24
25	ELECTRICAL-ADDITIONAL POWER	2013	3,350	130	15	130		130	25
26	CABINETS- CC-COFFEEBAR	2013	1,150	38	15	38		38	26
27	LIGHTING FIXTURES	2013	996	17	15	17		17	27
28	LIGHTING FIXTURES	2013	318	5	15	5		5	28
29	LIGHTING- CARE CENTER	2013	5,858	130	15	130		130	29
30	FLOORING, CARPET & VINYL-HALLWAYS	2013	705	106	5	106		106	30
31	FLOORING-CARPET- EP 1	2013	125	13	5	13		13	31
32	FLOORING-CARPET	2013	60	6	5	6		6	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,952,408	\$ 272,481		\$ 272,481	\$	\$ 4,613,989	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 656,907	\$ 62,924	\$ 62,924	\$	10	\$ 441,159	71
72	Current Year Purchases	21,658	2,084	2,084		7	2,084	72
73	Fully Depreciated Assets	980,718				10	980,718	73
74								74
75	TOTALS	\$ 1,659,283	\$ 65,008	\$ 65,008	\$		\$ 1,423,961	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	Car & Silverado	2000	\$ 30,750	\$	\$	\$	8	\$ 30,750	76
77	Facility	Ford 2002 15 Pass	2002	56,998				5	56,998	77
78	Facility	Dodge Grand Caravan	2006	19,162				5	19,162	78
79	Facility	Vehicle Wheelchair Conversion	2007	16,026				5	16,026	79
80	TOTALS			\$ 122,936	\$	\$	\$		\$ 122,936	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)	\$ 10,063,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 337,489	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 337,489	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)	\$ 6,160,886	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	Non Care Combined Assets	\$ 61,385,425	\$ 2,279,956	\$ 25,570,748	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 61,385,425	\$ 2,279,956	\$ 25,570,748	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.

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? <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	\$	3,271	\$ 222,820	\$	3,271	\$ 222,820	1	
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		679	47,123		679	47,123	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	V10A-3	hrs		4,517	310,754	149	4,517	310,903	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	C39-2	# of prescrpts				168,589		168,589	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			\$	8,467	\$ 580,697	\$ 168,738	8,467	\$ 749,435	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 The Lutheran Home# 0019109Report 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	\$ 2,593,868	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>33,000</u>)	697,991		3
4	Supply Inventory (priced at <u>Cost</u>)	42,493		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	31,482		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Notes Receivable/Misc Receivabl</u>	481,364		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,847,198	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,846,164		12
13	Land	369,068		13
14	Buildings, at Historical Cost	67,575,899		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,816,224		16
17	Accumulated Depreciation (book methods)	(31,731,636)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP & Deffered Marketing</u>	380,564		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,256,283	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 50,103,481	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,929	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	398,501		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,835		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>Other</u>	217,179		36
37	<u>Current Portion of LTD</u>	813,748		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,555,192	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	39,914,697		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Entrance Fee Payable</u>	30,341,546		43
44	<u>Resident Deposits</u>	388,816		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 70,645,059	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 72,200,251	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (22,096,770)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 50,103,481	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (21,344,923)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (21,344,923)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(751,847)	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)	\$ (751,847)	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)	\$ (22,096,770)	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	\$ 6,612,912	1
2	Discounts and Allowances for all Levels	(721,891)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,891,021	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,195,632	6
7	Oxygen	355	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,195,987	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6	12
13	Barber and Beauty Care	24,204	13
14	Non-Patient Meals	9,561	14
15	Telephone, Television and Radio	424	15
16	Rental of Facility Space		16
17	Sale of Drugs	209,400	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,076	19
20	Radiology and X-Ray	9,665	20
21	Other Medical Services	104,958	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 374,294	23
D. Non-Operating Revenue			
24	Contributions	389,454	24
25	Interest and Other Investment Income***	52,792	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 442,246	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	11,876	28
28a	Independent and Assisted Living Revenue	8,142,653	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,154,529	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,058,077	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,206,308	31
32	Health Care	3,174,264	32
33	General Administration	1,843,446	33
B. Capital Expense			
34	Ownership	725,965	34
C. Ancillary Expense			
35	Special Cost Centers	9,672,816	35
36	Provider Participation Fee	187,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,809,924	40
41	Income before Income Taxes (line 30 minus line 40)**	(751,847)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (751,847)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 710,405	44
45	Private Pay - Net Inpatient Revenue	4,512,886	45
46	Medicare - Net Inpatient Revenue	796,698	46
47	Other-(specify) <u>Managed Care</u>	253,764	47
48	Other-(specify) <u>Benevolent Care</u>	(382,732)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,891,021	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 The Lutheran Home

0019109

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	1,986	2,080	\$ 73,701	\$ 35.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,535	9,168	227,355	24.80	3
4	Licensed Practical Nurses	28,375	31,442	647,851	20.60	4
5	CNAs & Orderlies	73,543	81,009	918,737	11.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,885	8,404	186,390	22.18	10
11	Social Service Workers	1,937	2,086	44,442	21.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,150	24,287	283,944	11.69	15
16	Dishwashers					16
17	Maintenance Workers	5,443	6,045	107,083	17.71	17
18	Housekeepers	13,533	14,964	173,143	11.57	18
19	Laundry	3,347	3,548	37,405	10.54	19
20	Administrator	837	2,024	88,480	43.72	20
21	Assistant Administrator					21
22	Other Administrative	20,815	21,300	480,728	22.57	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,800	1,970	23,059	11.71	31
32	Other Health C: Marketing CC	2,739	3,062	80,987	26.45	32
33	Other(specify) Marketing/AL/IL	112,606	122,932	1,731,494	14.08	33
34	TOTAL (lines 1 - 33)	305,531	334,321	\$ 5,104,799 *	\$ 15.27	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	386	\$ 24,527	V1-3	35
36	Medical Director	Monthly	6,000	V9-3	36
37	Medical Records Consultant	7	388	V10-3	37
38	Nurse Consultant			V39-3	38
39	Pharmacist Consultant	910	5,551	V39-3	39
40	Physical Therapy Consultant	10	577	V10a-3	40
41	Occupational Therapy Consultant	4	206	V10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	385	V10a-3	43
44	Activity Consultant	263	8,910	V11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,587	\$ 46,544		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-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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number The Lutheran Home# 0019109

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 - \$8,370; AAHSA - \$4,812
- (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? No
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,630 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. \$ 187,125
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? No Indicate the amount. \$ 9,561
- (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?
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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.