

		FOR BHF USE					

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**2017**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2017)**

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><b>I. IDPH License ID Number:</b> <u>0019109</u></p> <p><b>Facility Name:</b> <u>Lutheran Home, The</u></p> <p><b>Address:</b> <u>7019 N Galena Road</u> <u>Peoria</u> <u>61614</u>  Number City Zip Code</p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> <u>314-968-9313</u> <b>Fax #</b> <u>314-968-5590</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>2/25/2007</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Kevin Wellen</u> <b>Telephone Number:</b> <u>314-925-4446</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</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>Chief Financial Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name &amp; Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  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>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <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>Chief Financial Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>							

Facility Name & ID Number Lutheran Home, The

# 0019109 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,507	18,743	6,054	26,304	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,507	18,743	6,054	26,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.12%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  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 6/1/1976

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 109 and days of care provided 4,339

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Lutheran Home, The # 0019109 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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
	<b>A. General Services</b>										
1	Dietary	522,164	25,918	29,855	577,937		577,937	(104)	577,833		1
2	Food Purchase		206,659		206,659		206,659	(186)	206,473		2
3	Housekeeping	193,790	22,057	5,745	221,592	(1,227)	220,365		220,365		3
4	Laundry	52,202	17,826	5,489	75,517	(3,617)	71,900		71,900		4
5	Heat and Other Utilities			173,841	173,841		173,841		173,841		5
6	Maintenance	124,484	40,201	189,278	353,963	3,643	357,606	(49,811)	307,795		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	892,640	312,661	404,208	1,609,509	(1,201)	1,608,308	(50,101)	1,558,207		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,750	5,750		5,750		5,750		9
10	Nursing and Medical Records	3,081,127	65,950	204,115	3,351,192	(480)	3,350,712		3,350,712		10
10a	Therapy			731,606	731,606		731,606		731,606		10a
11	Activities	245,079	9,939	14,323	269,341	(1,420)	267,921		267,921		11
12	Social Services	59,069	225	3,822	63,116		63,116		63,116		12
13	CNA Training										13
14	Program Transportation	14,075	2,621	3,770	20,466	(327)	20,139	(10,538)	9,601		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,399,350	78,735	963,386	4,441,471	(2,227)	4,439,244	(10,538)	4,428,706		16
	<b>C. General Administration</b>										
17	Administrative	92,216			92,216		92,216		92,216		17
18	Directors Fees										18
19	Professional Services			599,545	599,545		599,545	146,919	746,464		19
20	Dues, Fees, Subscriptions & Promotions			20,939	20,939	3,189	24,128		24,128		20
21	Clerical & General Office Expenses	229,187	17,278	857,019	1,103,484	(4,764)	1,098,720	(706,190)	392,530		21
22	Employee Benefits & Payroll Taxes			941,128	941,128		941,128	(19,015)	922,113		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,140	17,140	547	17,687		17,687		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,674	71,674		71,674		71,674		26
27	Other (specify):* <b>Marketing</b>	95,140	26,821	24,502	146,463		146,463	(146,463)			27
28	<b>TOTAL General Administration</b>	416,543	44,099	2,531,947	2,992,589	(1,028)	2,991,561	(724,749)	2,266,812		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,708,533	435,495	3,899,541	9,043,569	(4,456)	9,039,113	(785,388)	8,253,725		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 &amp; ID Number

Lutheran Home, The

#0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			983,330	983,330		983,330	(285,429)	697,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			506,306	506,306		506,306	(397,452)	108,854			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					4,456	4,456		4,456			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,489,636	1,489,636	4,456	1,494,092	(682,881)	811,211			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,536	70,060	338,596		338,596		338,596			39
40	Barber and Beauty Shops			16,857	16,857		16,857	(16,857)				40
41	Coffee and Gift Shops			9,592	9,592		9,592		9,592			41
42	Provider Participation Fee			175,995	175,995		175,995		175,995			42
43	Other (specify):* AL & IL	2,073,795	976,519	8,632,828	11,683,142		11,683,142	(11,683,142)				43
44	<b>TOTAL Special Cost Centers</b>	2,073,795	1,245,055	8,905,332	12,224,182		12,224,182	(11,699,999)	524,183			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,782,328	1,680,550	14,294,509	22,757,387		22,757,387	(13,168,268)	9,589,119			45

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



Lutheran Home, The

ID# 0019109

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Beauty Shop Income	\$ (16,857)	40	1
2	Transportation Income	(10,538)	14	2
3	Miscellaneous Income	(775)	21	3
4	Interest on Past Due Accounts	(1,881)	32	4
5	Maintenance Income/Expense	125	21	5
6	IL and AL Expenses	(11,683,142)	43	6
7	Finance and Late Fees	(41,854)	21	7
8	Employee Benefits	(19,015)	22	8
9	Meal Delivery Charges Income	(6)	2	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,773,943)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Home, The# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	(104)	0	0	0	0	0	0	0	0	0	0	(104)	1
2	Food Purchase	(186)	0	0	0	0	0	0	0	0	0	0	(186)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(49,811)	0	0	0	0	0	0	0	0	0	0	(49,811)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(50,101)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,101)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(10,538)	0	0	0	0	0	0	0	0	0	0	(10,538)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(10,538)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,538)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	146,919	0	0	0	0	0	0	0	0	0	146,919	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(706,190)	0	0	0	0	0	0	0	0	0	0	(706,190)	21
22	Employee Benefits & Payroll Taxes	(19,015)	0	0	0	0	0	0	0	0	0	0	(19,015)	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):*	(146,463)	0	0	0	0	0	0	0	0	0	0	(146,463)	27
28	<b>TOTAL General Administration</b>	<b>(871,668)</b>	<b>146,919</b>	<b>0</b>	<b>(724,749)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(932,307)</b>	<b>146,919</b>	<b>0</b>	<b>(785,388)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Home, The # 0019109 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(312,529)	27,100	0	0	0	0	0	0	0	0	0	(285,429)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,139)	(362,313)	0	0	0	0	0	0	0	0	0	(397,452)	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	<b>TOTAL Ownership</b>	<b>(347,668)</b>	<b>(335,213)</b>	<b>0</b>	<b>(682,881)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(16,857)	0	0	0	0	0	0	0	0	0	0	(16,857)	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):*	(11,683,142)	0	0	0	0	0	0	0	0	0	0	(11,683,142)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(11,699,999)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,699,999)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(12,979,974)</b>	<b>(188,294)</b>	<b>0</b>	<b>(13,168,268)</b>	<b>45</b>								

**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
<a href="#">See Board Listing at PG6-Supp</a>		<a href="#">Lutheran Convalescent Home</a>	<a href="#">Webster, MO</a>	<a href="#">Lutheran Senior Servi</a>	<a href="#">St. Louis, MO</a>	<a href="#">Home Office</a>
		<a href="#">Mason Pointe Care Center</a>	<a href="#">Chesterfield, MO</a>	<a href="#">In Home Services &amp; H</a>	<a href="#">St. Louis, MO</a>	<a href="#">HHA/Hospice</a>
		<a href="#">Breeze Park</a>	<a href="#">St. Charles, MO</a>	<a href="#">Richmond Terrance</a>	<a href="#">Richmond Heigts, MO</a>	<a href="#">AL</a>
		<a href="#">Heisinger Lutheran Home</a>	<a href="#">Jefferson City, MO</a>	<a href="#">Provident Group</a>	<a href="#">St. Louis, MO</a>	<a href="#">Mgt Co</a>
		<a href="#">Lenori Woods</a>	<a href="#">Columbia, MO</a>	<a href="#">Affordable Housing</a>	<a href="#">St. Louis, MO</a>	<a href="#">Housing</a>
		<a href="#">Meridian Village Care Center</a>	<a href="#">Glen Carbon, IL</a>	<a href="#">LSS Endowment Fun</a>	<a href="#">St. Louis, MO</a>	<a href="#">Foundation</a>
		<a href="#">Meramec Bluffs</a>	<a href="#">St. Louis, MO</a>	<a href="#">Heisinger Hope Found</a>	<a href="#">Jefferson City, MO</a>	<a href="#">Foundation</a>

**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 <a href="#">Management Fee</a>	\$ 572,612	<a href="#">Lutheran Senior Services</a>	100.00%	\$ 719,531	\$ 146,919	1
2	V	30 <a href="#">Management Fee</a>		<a href="#">Lutheran Senior Services</a>	100.00%	27,100	27,100	2
3	V	32 <a href="#">HO Excess Interest Income</a>		<a href="#">Lutheran Senior Services</a>	100.00%	(362,313)	(362,313)	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		\$ 572,612			\$ 384,318	\$ * (188,294)	14

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



Facility Name &amp; ID Number

Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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 Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Lutheran Senior Services

Street Address

1150 Hanlesy Industrial Court

City / State / Zip Code

St. Louis, MO 63144

Phone Number

( 314-968-9313

Fax Number

( 314-968-5590

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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 - Operating	Direct Costs	24	\$ 15,652,446	\$ 12,551,639	10,190,184	\$ 719,532	1
2	30	Home Office - Capital	Direct Costs	24	589,535		10,190,184	27,101	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				\$ 16,241,981	\$ 12,551,639		\$ 746,633	25

Facility Name & ID Number

Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	IL Finance Authority -						\$	\$			\$	1				
2	2006 Bonds		X	Campus Expansion	Various	7/16/2006	5,750,142	4,623,277	2/1/2037	5.0000	279,011	2				
3	2016A Bonds		X	Campus Expansion	Various	2/1/2016	9,325,282	7,763,305	2/1/2046	5.0000	270,262	3				
4	Bond Costs			Amortized Bond Costs							(42,967)	4				
5	Interest Income										(397,452)	5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 15,075,424	\$ 12,386,582			\$ 108,854	9				
<b>B. Non-Facility Related*</b>																
10												10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 15,075,424	\$ 12,386,582			\$ 108,854	15				

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



# 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lutheran Home, The COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0019109

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 2016 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 2016.

	(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>14-10-378-010</u>	<u>Lot 5</u>	\$ <u>101,341.62</u>	\$ _____
2.	<u>14-10-378-012</u>	<u>Lot 4</u>	\$ <u>26,609.12</u>	\$ _____
3.	<u>14-10-378-008</u>	<u>Lot 2</u>	\$ <u>49,251.48</u>	\$ _____
4.	<u>14-10-378-011</u>	<u>Lot 3</u>	\$ <u>30,937.70</u>	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u>208,139.92</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Lutheran Home, The

# 0019109 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

**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 63 assisted living units, 20 assisted living memory care units, 126 independent living apartments, and 48 patio homes and villas

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: 7,647 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	109		1976	\$ 1,676,061	\$	40	\$	\$	\$ 1,676,061	4
5			1985	481,567	13,733	40	13,733		450,107	5
6			1986	698,529	17,466	40	17,466		537,006	6
7										7
8										8
	<b>Improvement Type**</b>									
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	VARIOUS	1,756		61,575	19
20	Various		1990	134,732	3,305	VARIOUS	3,305		92,774	20
21	Various		1991	40,069	1,091	VARIOUS	1,091		29,308	21
22	Various		1992	890	29	VARIOUS	29		739	22
23	Various		1993	748		20			748	23
24	Various		1994	5,993	193	VARIOUS	193		4,530	24
25	Various		1995	36,256		VARIOUS			36,256	25
26	Various		1996	43,073	1,174	VARIOUS	1,174		31,718	26
27	Various		1997	32,988	522	VARIOUS	522		22,629	27
28	Various		1998	13,903	209	VARIOUS	209		13,866	28
29	Various		1999	122,497	405	VARIOUS	405		117,814	29
30	Various		2000	63,646	2,719	VARIOUS	2,719		52,406	30
31	Various		2001	190,577	2,255	VARIOUS	2,255		170,296	31
32	Various		2002	1,912,111	57,217	VARIOUS	57,217		858,259	32
33	Various		2003	319,328	16,337	VARIOUS	16,337		228,720	33
34	Various		2004	220,824	10,173	VARIOUS	10,173		123,602	34
35	Various		2005	57,276	2,865	VARIOUS	2,865		34,367	35
36	Various		2006	8,909	297	VARIOUS	297		3,267	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 &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	\$ 474,844	\$ 23,742	VARIOUS	\$ 23,742	\$	\$ 221,523	37
38	Various	2008	378,947	18,466	VARIOUS	18,466		224,168	38
39	Various	2009	399,349	26,336	VARIOUS	26,336		226,052	39
40	WALL PROTECTOR	2010	74	2	15	2		35	40
41	OPTIMUS SETUP-CABLES&CONNECTORS	2010	1,274	42	15	42		595	41
42	WIRING,CABLE,DATA LINE-OPTIMUS EMR	2010	2,957	99	15	99		1,380	42
43	OPTIMUS SETUP-CABLES&ELECTRICAL LINES	2010	1,915	64	15	64		894	43
44	FLOORING,CARPET-DINING RM	2010	150	11	7	11		150	44
45	DEMOLITION-OLD CARE CENTER LINK	2011	3,676	245	15	245		1,552	45
46	FLOORING, CARPET	2011	821	108	7	108		792	46
47	FLOORING, CARPET	2011	3,093	405	7	405		2,982	47
48	FLOORING, CARPET-#5	2011	1,316	172	7	172		1,237	48
49	FIREPLACE INSERT, DIMPLEX 39"	2011	2,356	157	15	157		1,047	49
50	FLOORING, BINDING CARPET	2011	212	28	7	28		199	50
51	FLOORING,CERAMIC TILE-PUBLIC BATHRMS	2011	1,502	92	15	92		659	51
52	SURVEY,ASBESTOS/LEAD-AREA, OLD REC CENTE	2011	2,190	146	15	146		961	52
53	FIXTURE,PRE RINSE SPRAY VALVE	2011	74	5	15	5		32	53
54	VANITY,-BATHROOM	2011	227	14	15	14		98	54
55	MIRROR,WALL&HOLDERS-BATHROOM	2011	104	6	15	6		45	55
56	CERAMIC TILE&LIGHTING.MIRRORS-BATHRMS	2011	414	25	15	25		179	56
57	FLOORING, CERAMIC PUBLIC-BATHROOMS	2011	1,500	92	15	92		642	57
58	THERAPY & PUBLIC BATHROOMS-DRYWALL,CARPT	2011	12,388	757	15	757		5,299	58
59	PLUMBING,FIXTURE-THERAPY&PUBLIC BATHROOM	2011	3,381	207	15	207		1,446	59
60	FLOORING, CARPET BASE/RUG	2011	421	55	7	55		381	60
61	FLOORING, CARPET-COMMON AREAS	2011	9,767	1,279	7	1,279		8,837	61
62	FLOORING,VINYL-NEW THERAPY RM	2011	5,267	690	7	690		4,766	62
63	FLOORING,CARPET-HC HALLWAY	2011	3,203	419	7	419		2,860	63
64	ELECTRICAL WK-DEMO OF REC CENTER	2011	735	49	15	49		310	64
65	CONDENSING UNIT, 15 TON, AWNING	2011	21,380	1,425	15	1,425		9,027	65
66	FLOORING, CERAMIC TILE-THERAPY HALLWAY	2011	499	30	15	30		208	66
67	FLOORING, CARPET-THERAPY HALLWAY	2011	173	23	7	23		154	67
68	FLOORING,CARPET-PUBLIC AREA	2011	164	21	7	21		146	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,555,847	\$ 206,958		\$ 206,958	\$	\$ 5,360,019	70

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,555,847	\$ 206,958		\$ 206,958	\$	\$ 5,360,019	1
2	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	113	7	113		772	2
3	FLOORING, VINYL-THERAPY&KITCHEN	2011	865	113	7	113		772	3
4	FLOORING, CARPET-HALLWAY, THERAPY	2011	1,511	198	7	198		1,349	4
5	SECURITY, ACCESS CONTROL ON DOOR-THERAPY	2011	3,000	200	15	200		1,267	5
6	FLOORING,CARPET BASEBOARD-HC PULIC AREA	2011	196	26	7	26		175	6
7	FLOORING, CARPET & VINYL-#CLOVER CT COMM	2011	3,251	426	7	426		2,903	7
8	FLOORING, CARPET-DOGWOOD CT	2011	3,368	441	7	441		3,008	8
9	INTERIOR CONSULTANTING FEES-NURSES STATI	2011	6,750	450	15	450		2,813	9
10	GLASS, COMMERCIAL-NURSES STATIONS	2011	43	3	15	3		18	10
11	FLOORING, CARPET & VINYL-NURSES STATION	2011	18,570	2,432	7	2,432		16,359	11
12	PLUMBING-NURSES STATION OFFICE	2011	474	32	15	32		198	12
13	CABINETS-NURSES STATION	2011	29,646	1,976	15	1,976		12,353	13
14	PHONES,WIRING, CABLES RELOCATED-NURSE ST	2011	836	56	15	56		349	14
15	FIREPLACE-NURSES STATION/LOBBY	2011	7,880	525	15	525		3,283	15
16	RECEPTION STATION/AREA-NURSES STATION	2011	4,950	330	15	330		2,062	16
17	ELECTRICAL UPGRADES-NURSES STATION	2011	310	21	15	21		129	17
18	FLOORING, CARPET INSTALLED, COMMON AREAS	2011	2,383	312	7	312		2,071	18
19	FLOORING, CARPET-#ACON WAY-COMMON AREA	2011	6,750	884	7	884		5,866	19
20	PLUMBING, DRAIN RADIATOR LINES	2011	428	29	15	29		176	20
21	FLOORING, CARPET BASE	2011	590		5			590	21
22	DEMOLITION OF CORRIDOR LINK	2011	7,303	487	15	487		3,002	22
23	FLOORING, CERAMIC TILE	2011	1,114	68	15	68		446	23
24	ROOFING, MAIN BUILDING	2012	40,400	2,020	20	2,020		11,447	24
25	ASBESTOS MONITORING-INSIDE BLDG	2012	550	37	15	37		199	25
26	EMERGENCY CALL SYSTEM, WIRELESS	2012	185,913	12,394	15	12,394		74,365	26
27	GRANITE-FIREPLACE	2012	792	53	15	53		317	27
28	FLOORING, CARPET-CC	2012	196		5			196	28
29	FLOORING, CARPET BASE-#CC	2012	47		5			47	29
30	SCONE GLASS-EMERGENCY CALL SYSTEM	2012	463	31	15	31		185	30
31	FLOORING, TRANSITION STRIPS-ACTIVITY	2012	267	16	15	16		102	31
32	LOCK,MORTOSE-OFFICE DOOR-LAVENDER LANE	2012	414	28	15	28		161	32
33	WALLCABINECUBBY AREAS	2012	3,118	208	15	208		1,213	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,889,090	\$ 230,867		\$ 230,867	\$	\$ 5,508,212	34

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 7,889,090	\$ 230,867		\$ 230,867	\$	\$ 5,508,212	1
2	CABINETS-CNA CUBBY AREAS	2012	2,260	151	15	151		866	2
3	CABINETS-CUBBY AREA	2012	1,747	116	15	116		660	3
4	CABINETS, CUBBY AREAS-CNA	2012	6,310	421	15	421		2,384	4
5	WATER & SEWER LINES CAPPED OF	2012	2,303	154	15	154		844	5
6	ELECTRICAL PANEL REMOVED-CC	2012	1,245	83	15	83		450	6
7	ELECTRICAL DEMO-OLD RET HM	2012	255	17	15	17		89	7
8	ELECTRICAL WORK-DISHWASHER-EMANUAL	2012	922	61	15	61		317	8
9	HOT WATER MIXING VALVE&CIRC PUMP UPGRADE	2013	4,500	300	15	300		1,475	9
10	TILES, CERAMIC-PANTRY	2013	379	25	15	25		124	10
11	TILE, CERAMIC-WALL OR FL	2013	122	8	15	8		40	11
12	CABINETRY/SHELVING	2013	666	44	15	44		218	12
13	REMODEL-DEMO-EMMANUE KITCHEN	2013	1,569	105	15	105		505	13
14	REMODEL-CARPENTRY-EMMANUAL KITCHEN	2013	14,378	959	15	959		4,633	14
15	REMODEL-CABINETS&CTR TOPS-EMMANUEL KITCH	2013	3,137	209	15	209		1,011	15
16	REMODEL,ELECTRICAL-EMMANUAL KITCHEN	2013	1,307	87	15	87		421	16
17	REMODEL,PLUMBING&FIXTURES-EMMANUAL KITCH	2013	2,353	157	15	157		758	17
18	REMODEL, PAINTING-EMMANUAL KITCHEN	2013	2,091	299	7	299		1,444	18
19	FLOORING, REMODEL-EMMANUAL KITCHEN	2013	1,307	187	7	187		903	19
20	PANTRY DOOR SECURITY, ACCESS-EMANUAL	2013	1,244	83	15	83		401	20
21	CERAMIC TILE-WALL/FLOOR-EMANUAL PL PANTR	2013	416	28	15	28		136	21
22	FLOORING,CARPET-#1 EMANUEL	2013	243	49	5	49		223	22
23	ELECTRICAL-ADDITIONAL POWER	2013	3,350	223	15	223		1,024	23
24	CABINETS- CC-COFFEEBAR	2013	1,150	77	15	77		345	24
25	LIGHTING FIXTURES	2013	996	66	15	66		282	25
26	LIGHTING FIXTURES	2013	318	21	15	21		90	26
27	LIGHTING- CARE CENTER	2013	5,858	391	15	391		1,692	27
28	FLOORING, CARPET & VINYL-HALLWAYS	2013	705	141	5	141		670	28
29	FLOORING-CARPET- EP 1	2013	125	25	5	25		113	29
30	FLOORING-CARPET	2013	60	12	5	12		54	30
31	FLOORING- CARPET- EVERGREEN DINING	2014	8,319	1,188	7	1,188		4,655	31
32	FLOORING- VINYL- EVERGREEN DINING	2014	1,107	158	7	158		619	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,959,832	\$ 236,712		\$ 236,712	\$	\$ 5,535,658	34

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,959,832	\$ 236,712		\$ 236,712	\$	\$ 5,535,658	1
2	EVERGREEN DINING 1/2 WALL	2014	2,680	179	15	179		685	2
3	ELECTRICAL- FOOD PREP- EVERGREEN DINING	2014	3,502	233	15	233		895	3
4	FLOORING- CARPET- EVERGREEN DINING	2014	2,826	404	7	404		1,548	4
5	LIGHT FIXTURE- HEAT LAMP (2)	2014	749	50	15	50		191	5
6	LIGHT FIXTURE- HEAT LAMP (2)	2014	569	38	15	38		145	6
7	HAND SINK - EVERGREEN DINING	2014	703	47	15	47		180	7
8	FLOORING- COVE BASE- EVERGREEN DINING	2014	525	75	7	75		288	8
9	FLOORING- COVE BASE- EVERGREEN DINING	2014	158	23	7	23		87	9
10	Sink for evergreen	2014	1,251	83	15	83		313	10
11	Carpet for evergreen	2014	358	51	7	51		192	11
12	FLOORING - CARPET BP3	2014	471	94	5	94		330	12
13	FLOORING-CARPETING #C7	2014	303	61	5	61		192	13
14	FLOORING-CARPETING #C7	2014	150	10	15	10		32	14
15	ROOM FINISHES	2014	52	3	15	3		11	15
16	SARA 3000 W/SCALE W/O SIDE GRP	2014	5,193	346	15	346		405	16
17	SARA 3000 SLING-LARGE	2014	224	15	15	15		18	17
18	FURNISH 8 TOWEL BARS AND TOILET PAPER HOLDERS	2014	730	49	15	49		52	18
19	LOCKSETS FOR BATHROOM DOORS IN SNF	2014	937	62	15	62		193	19
20	DEMOLISH AND REFURBISH 8 BATHROOMS IN SNF	2014	53,500	3,567	15	3,567		4,168	20
21	- remove tile on walls, light fixtures, wallpaper, flooring								21
22	and toilets								22
23	- add storage unit above toilet, mirrors, grab bars								23
24	- patch and paint entire bathrooms, add tile accent on walls								24
25	- new vinyl flooring, updates faucets and drains								25
26	WOOD FLOORING-CHERRY SUNROOM	2015	1,008	67	15	67		190	26
27	THERAPY SHOWER WALLBOARD, CERAMIC	2016	990	66	15	66		132	27
28	Dining area replace window	2016	1,900	127	15	127		211	28
29	COPPER/FIBER CABLE E.H.R. NTRK PROJ	2016	39,170	2,611	15	2,611		3,699	29
30	FINANCE CHRG REPLACE COMPRESSOR	2016	136	9	15	9		11	30
31	REPLACE HEAT EXC EVERGREEN PANTRY	2016	2,810	187	15	187		219	31
32	WANDER GUARD ALARM REACH	2016	3,388	226	15	226		282	32
33	WANDER GUARD ALARM REACH	2016	1,922	128	15	128		160	33
34	TOTAL (lines 1 thru 33)		\$ 8,086,037	\$ 245,523		\$ 245,523	\$	\$ 5,550,487	34

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 8,086,037	\$ 245,523		\$ 245,523	\$	\$ 5,550,487	1
2	45 Interior Signs	2016	3,111	207	15	207		242	2
3	147 Interior Signs	2016	8,379	559	15	559		652	3
4	2 Interior Directional Signs	2016	180	12	15	12		14	4
5	Furnish/Install 46 Lock Cylinders	2016	10,923	728	15	728		850	5
6	10 Bed Sta w/Call Placed LED	2016	1,356	90	15	90		105	6
7	7-8' Call Cord for Bed Station	2016	185	12	15	12		14	7
8	3-10' Call Cord for Bed Station	2016	83	6	15	6		6	8
9	30 Pull Cord Stations	2016	3,501	233	15	233		272	9
10	28 Single Line White Phones	2016	322	21	15	21		25	10
11	Programmed 24 resident rooms	2016	689	46	15	46		54	11
12	10 Interior Signs	2016	176	12	15	12		14	12
13	Install IP DECT Cordless Phn	2016	2,525	168	15	168		196	13
14	8 Interior Signs	2016	132	9	15	9		10	14
15	Power for Touch Town Sys	2016	839	56	15	56		65	15
16	Power/Data Temp Concierge	2016	1,474	98	15	98		115	16
17	Labor/Install Storeroom Lock	2016	522	35	15	35		41	17
18	1 Set Cust Granite Counters	2016	2,350	157	15	157		183	18
19	Flooring	2016	217,818	31,117	7	31,117		36,303	19
20	Painting	2016	136,142	9,076	15	9,076		10,589	20
21	Touch up	2016	5,000	333	15	333		389	21
22	Plumbing	2016	269,722	17,981	15	17,981		20,978	22
23	Heating, Ventilating, and Air Conditioni	2016	438,883	29,259	15	29,259		34,135	23
24	Electrical	2016	1,131,609	75,441	15	75,441		88,014	24
25	UPS COMPONENTS EHR NETWORK PROJ	2016	1,610	107	15	107		116	25
26	UPS COMPONENTS EHR NETWORK PROJ	2016	2,209	147	15	147		160	26
27	FIBER OPTIC CABLE QTY 25 *	2016	650	43	15	43		54	27
28	DATA DROPS IL BLDG	2016	12,284	819	15	819		955	28
29	REPLACE DRYWALL CC RM D-1	2017	6,000	400	15	400		400	29
30	WATER SOFTENER C-WING CC	2017	26,550	1,770	15	1,770		1,770	30
31	PROGRESS BILLING-ADD ACCESS CTRL	2017	4,582	305	15	305		305	31
32	INSTL WTR SOFTENER VALVES C-WING	2017	1,229	75	15	75		75	32
33	Emanuel Tub	2017	12,785	710	15	710		710	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,389,857	\$ 415,555		\$ 415,555	\$	\$ 5,748,298	34

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

Facility Name &amp; ID Number Lutheran Home, The

# 0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 10,389,857	\$ 415,555		\$ 415,555	\$	\$ 5,748,298	1
2	<u>SMOKE DETECTORS - HC B WING</u>	2017	1,118	62	15	62		62	2
3	<u>Furn/Install 9 Keymark Cylinders</u>	2017	1,806	90	15	90		90	3
4	<u>Replace Locks-Rm 3 &amp; 6</u>	2017	598	30	15	30		30	4
5	<u>DOOR &amp; HARDWARE QTY 4</u>	2017	4,341	193	15	193		193	5
6	<u>139 Interior Signs</u>	2017	7,840	348	15	348		348	6
7	<u>Countertop - BP Saïdo Rm</u>	2017	2,457	109	15	109		109	7
8	<u>Interior Signage Qty 15</u>	2017	9,159	407	15	407		407	8
9	<u>Painting</u>	2017	39,315	3,744	7	3,744		3,744	9
10	<u>Plumbing</u>	2017	29,665	1,318	15	1,318		1,318	10
11	<u>Electrical</u>	2017	49,826	2,214	15	2,214		2,214	11
12	<u>Interior Signage Qty 15</u>	2017	788	31	15	31		31	12
13	<u>Plumbing</u>	2017	54,098	1,803	15	1,803		1,803	13
14	<u>Heating, Ventilating, and Air Conditioni</u>	2017	97,924	3,264	15	3,264		3,264	14
15	<u>Electrical</u>	2017	394,465	13,149	15	13,149		13,149	15
16	<u>Furn/Inst Locks HC Kitchen Qty 3</u>	2017	1,649	37	15	37		37	16
17	<u>PAINT UNIT 19</u>	2017	309	11	7	11		11	17
18	<u>REPL CLOSED CIRCUIT CAMERAS QTY 2</u>	2017	1,563	17	15	17		17	18
19	<u>REPL CLOSED CIRCUIT CAMERAS QTY 5</u>	2017	4,705	52	15	52		52	19
20	<u>Carpet Tile - Samaritan Landing</u>	2017	2,804	33	7	33		33	20
21	<u>Fire Device Programming Changes</u>	2017	2,933	16	15	16		16	21
22	<u>Interior Signage Qty 17</u>	2017	718	4	15	4		4	22
23	<u>Addition to Secure Care</u>	2017	4,271	24	15	24		24	23
24	<u>Plumbing</u>	2017	3,418	19	15	19		19	24
25	<u>Heating, Ventilating, and Air Conditioni</u>	2017	13,804	77	15	77		77	25
26	<u>Painting</u>	2017	1,476	18	7	18		18	26
27	<u>Plumbing</u>	2017	2,195	12	15	12		12	27
28	<u>Electrical</u>	2017	3,643	20	15	20		20	28
29	<u>Rounding</u>		(4)	3		3		(1)	29
30									30
31	<u>HO Capital Allocation</u>			27,100		27,100			31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,126,741	\$ 469,760		\$ 469,760	\$	\$ 5,775,399	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	\$ 1,278,136	\$ 184,792	\$ 184,792	\$		\$ 373,784	71
72	Current Year Purchases	542,428	35,856	35,856			35,856	72
73	Fully Depreciated Assets	1,504,904	7,493	7,493			1,504,904	73
74								74
75	TOTALS	\$ 3,325,468	\$ 228,141	\$ 228,141	\$		\$ 1,914,544	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,807,936	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 697,901	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 697,901	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)	\$ 7,716,602	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	\$ 79,985,682	\$ 3,250,172	\$ 33,733,351	86
87	Non Care Land	40,000			87
88					88
89					89
90					90
91	TOTALS	\$ 80,025,682	\$ 3,250,172	\$ 33,733,351	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.

Facility Name & ID Number

Lutheran Home, The

# 0019109

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 4,456 Description: Maintenance, Nursing & Activities

(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	<b>TOTAL</b>		\$	\$	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.

**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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	4,721	\$ 300,988	\$	4,721	\$ 300,988	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,484	91,813		1,484	91,813	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		5,189	338,805		5,189	338,805	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 prescrpts				181,522		181,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	V39-2					87,014		87,014	12
13	Other (specify): <u>See WTB For Detail</u>	V39-3				7,060			7,060	13
14	<b>TOTAL</b>			\$	11,394	\$ 738,666	\$ 268,536	11,394	\$ 1,007,202	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 &amp; ID Number

Lutheran Home, The

#

0019109

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (9,166,519)	\$	1
2	Cash-Patient Deposits	2,000		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (673,000) )	740,919		3
4	Supply Inventory (priced at )	55,513		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	50,212		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Other Current Assets</b>	41,141		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ (8,276,734)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,571,775		12
13	Land	369,068		13
14	Buildings, at Historical Cost	89,108,025		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,356,525		16
17	Accumulated Depreciation (book methods)	(41,449,953)		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):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 59,955,440	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 51,678,706	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 107,601	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	638,754		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,148		31
32	Accrued Real Estate Taxes(Sch.IX-B)	208,040		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Other Current Liabilities</b>	80,558		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,059,101	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,435,123		39
40	Mortgage Payable	49,803,562		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Entrance Fees Payable</b>	28,595,587		43
44	<b>Resident Deposits</b>	458,878		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 80,293,150	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 81,352,251	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (29,673,545)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 51,678,706	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(26,203,332)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(26,203,332)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(3,470,214)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>1</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(3,470,213)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(29,673,545)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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**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		2	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,192,411	1
2	Discounts and Allowances for all Levels	(2,186,494)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,005,917	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,911,443	6
7	Oxygen	5,698	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,917,141	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	16	12
13	Barber and Beauty Care	21,488	13
14	Non-Patient Meals	104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	256,670	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,506	19
20	Radiology and X-Ray	8,190	20
21	Other Medical Services	127,125	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 433,099	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	407,503	24
25	Interest and Other Investment Income***	33,258	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 440,761	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other Revenue</b>	184,205	28
28a	<b>IL and AL Revenue</b>	10,306,050	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,490,255	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 19,287,173	30

1		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,609,509	31
32	Health Care	4,441,471	32
33	General Administration	2,992,589	33
<b>B. Capital Expense</b>			
34	Ownership	1,489,636	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,048,187	35
36	Provider Participation Fee	175,995	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 22,757,387	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(3,470,214)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (3,470,214)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 375,899	44
45	Private Pay - Net Inpatient Revenue	5,003,143	45
46	Medicare - Net Inpatient Revenue	591,488	46
47	Other-(specify) <b>Benevolent Care</b>	(244,605)	47
48	Other-(specify) <b>Managed Care</b>	279,992	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,005,917	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.

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**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	1,980	2,090	\$ 89,798	\$ 42.97	1
2	Assistant Director of Nursing	1,903	2,031	74,593	36.73	2
3	Registered Nurses	17,506	18,637	626,790	33.63	3
4	Licensed Practical Nurses	34,015	36,723	975,911	26.57	4
5	CNAs & Orderlies	77,036	87,738	1,285,438	14.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,573	14,308	259,154	18.11	10
11	Social Service Workers	2,268	2,268	59,069	26.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,595	37,968	522,164	13.75	15
16	Dishwashers					16
17	Maintenance Workers	5,522	6,014	124,484	20.70	17
18	Housekeepers	13,199	14,480	193,790	13.38	18
19	Laundry	4,343	4,581	52,202	11.40	19
20	Administrator	2,080	1,952	92,216	47.24	20
21	Assistant Administrator					21
22	Other Administrative	8,689	12,014	229,187	19.08	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	1,977	1,977	28,597	14.46	31
32	Other Health C: <u>Marketing CC</u>	1,573	1,573	95,140	60.48	32
33	Other(specify) <u>IL and AL</u>	170,509	191,842	2,073,795	10.81	33
34	TOTAL (lines 1 - 33)	391,768	436,196	\$ 6,782,328 *	\$ 15.55	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 5,750	V9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	885	8,041 V39-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	48	3,816 V11-3	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	933	\$ 17,607	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



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12/31/2017**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. LeadingAge - \$8,614
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,766 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 175,995  
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. \$ 104
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees