



Facility Name & ID Number Bethesda Lutheran Home-Aurora

# 0035519 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>45</u>	Intermediate/DD	<u>45</u>	<u>16,425</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>45</u>	<b>TOTALS</b>	<u>45</u>	<u>16,425</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>15,734</u>			<u>15,734</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	<b>TOTALS</b>	<u>15,734</u>			<u>15,734</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.79%

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

234 (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 1/18/1990

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

YES  Date Built 1989 NO

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

YES  NO  If YES, enter number

of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 8/31/2005 Fiscal Year: 8/31/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	117,655	14,596	4,282	136,533		136,533		136,533		1
2	Food Purchase		59,384		59,384		59,384		59,384		2
3	Housekeeping	34,440	17,914	50	52,404		52,404		52,404		3
4	Laundry	102,206	2,299	22,747	127,252		127,252		127,252		4
5	Heat and Other Utilities			59,589	59,589	111	59,700		59,700		5
6	Maintenance	73,163	7,413	47,704	128,280	334	128,614		128,614		6
7	Other (specify):* Waste Removal			2,656	2,656		2,656		2,656		7
8	<b>TOTAL General Services</b>	327,464	101,606	137,028	566,098	445	566,543		566,543		8
<b>B. Health Care and Programs</b>											
9	Medical Director			16,900	16,900		16,900		16,900		9
10	Nursing and Medical Records	178,415	43,620	173,588	395,623		395,623		395,623		10
10a	Therapy	707,963		2,420	710,383		710,383		710,383		10a
11	Activities	22,448	4,402	14,131	40,981		40,981		40,981		11
12	Social Services	57,635			57,635		57,635		57,635		12
13	CNA Training										13
14	Program Transportation		10,197	13,140	23,337	826	24,163	(16,261)	7,902		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	966,461	58,219	220,179	1,244,859	826	1,245,685	(16,261)	1,229,424		16
<b>C. General Administration</b>											
17	Administrative	136,848		59,046	195,894	(59,046)	136,848		136,848		17
18	Directors Fees										18
19	Professional Services					1,630	1,630		1,630		19
20	Dues, Fees, Subscriptions & Promotions			285	285	15,886	16,171		16,171		20
21	Clerical & General Office Expenses	41,555	7,116	11,419	60,090	5,759	65,849		65,849		21
22	Employee Benefits & Payroll Taxes			436,458	436,458	26,520	462,978		462,978		22
23	Inservice Training & Education					347	347		347		23
24	Travel and Seminar			805	805	423	1,228		1,228		24
25	Other Admin. Staff Transportation			1,186	1,186	568	1,754		1,754		25
26	Insurance-Prop.Liab.Malpractice			25,449	25,449	511	25,960	(5,400)	20,560		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	178,403	7,116	534,648	720,167	(7,402)	712,765	(5,400)	707,365		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,472,328	166,941	891,855	2,531,124	(6,131)	2,524,993	(21,661)	2,503,332		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

Bethesda Lutheran Home-Aurora

#0035519

Report Period Beginning:

9/1/2004

Ending:

8/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			120,163	120,163		120,163	(9,305)	110,858			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					6,131	6,131		6,131			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			120,163	120,163	6,131	126,294	(9,305)	116,989			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,546	154,546		154,546		154,546			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			154,546	154,546		154,546		154,546			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,472,328	166,941	1,166,564	2,805,833		2,805,833	(30,966)	2,774,867			45

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



Bethesda Lutheran Home-Aurora

ID# 0035519

Report Period Beginning: 9/1/2004

Ending: 8/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Program Transportation to Workshop	\$ (16,261)	14	1
2	Insurance on Vehicles used for Workshop transport	(5,400)	26	2
3	Depreciation on vehicles for Workshop transport	(9,305)	30	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				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>	(30,966)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning:

9/1/2004

Ending:

8/31/2005

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<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	(16,261)	0	0	0	0	0	0	0	0	0	0	(16,261)	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>	(16,261)	0	0	0	0	0	0	0	0	0	0	(16,261)	16
	<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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,400)	0	0	0	0	0	0	0	0	0	0	(5,400)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(5,400)	0	0	0	0	0	0	0	0	0	0	(5,400)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(21,661)	0	0	0	0	0	0	0	0	0	0	(21,661)	29



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethesda Lutheran Homes & Services, Inc	100%	Bethesda Lutheran Homes & Services, Inc	Watertown, WI			
		Bethesda Lutheran Homes & Services, Inc	Montgomery, IL			
		Bethesda Lutheran Homes & Services, Inc	Plainfield, IL			
		Bethesda Lutheran Homes & Services, Inc	Sycamore, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
	17	Accounting Services	\$ 51,342	Bethesda Lutheran Homes & Services, Inc	100.00%	\$ 51,342	\$	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		\$ 51,342			\$ 51,342	\$ *	14

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

Facility Name & ID Number      Bethesda Lutheran Home-Aurora      #      0035519      Report Period Beginning:      9/1/2004      Ending:      8/31/2005

## 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									\$	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 Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2004 Ending: 3/31/2005

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 Bethesda Lutheran Homes & Services, Inc  
 Street Address 600 Hoffmann Drive  
 City / State / Zip Code Watertown, WI 53094  
 Phone Number (920) 206-4458  
 Fax Number (920) 206-7711

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	Accounting Services	Resident Days	306,309	\$ 984,698	\$ 724,612	15,971	\$ 51,342	1
2	17	Regional Office Administration	Resident Days	56,226	338,344	178,214	15,971	96,107	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				\$ 1,323,042	\$ 902,826		\$ 147,449	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$			\$	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								

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

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

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

Facility Name & ID Number **Bethesda Lutheran Home-Aurora**# **0035519** Report Period Beginning: **9/1/2004** Ending: **8/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2004 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 2005 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	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:		2000	_____	8	
		2001	_____	9	
		2002	_____	10	
		2003	_____	11	
		2004	_____	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2004		\$		13
14	PLUS APPEAL COST FROM LINE 5		\$		14
15	LESS REFUND FROM LINE 6		\$		15
16	AMOUNT TO USE FOR RATE CALCULATION		\$		16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bethesda Lutheran Home-Aurora COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0035519

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 2004 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 2004.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519 Report Period Beginning:9/1/2004 Ending:8/31/2005**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 21,394 B. General Construction Type: Exterior Vinyl Siding Frame Wood (sprinklered) Number of Stories 1C. 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).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Direct Care Building</u>	<u>396,832</u>	<u>1987</u>	<u>\$ 285,833</u>	<u>1</u>
2	<u>Land Improvements</u>		<u>1991-2004</u>	<u>58,564</u>	<u>2</u>
3	<b>TOTALS</b>	<u>396,832</u>		<u>\$ 344,397</u>	<u>3</u>

Facility Name & ID Number Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning:

9/1/2004

Ending:

8/31/2005

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	45		1989	\$ 1,919,083	\$ 63,969	30	\$ 63,969		\$ 999,143	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Accoustical Ceiling		1991	8,725	291	30	291		4,074	9
10	Multi-Purpose Room		1991	169,382	5,646	30	5,646		79,044	10
11	Replace Roof (Partial)		1994	4,681	156	30	156		1,716	11
12	Shower Stalls		1994	2,950	98	30	98		1,078	12
13	Safety Lighting		1994	3,450	115	30	115		1,265	13
14	Replace Roof (Partial)		1995	7,950	265	30	265		2,650	14
15	Wall Covering		1995	5,140	171	30	171		1,710	15
16	Fire Door		1995	699	23	30	23		230	16
17	Remodel Bathroom		1995	2,036	68	30	68		680	17
18	Chair Rails		1998	6,253	208	30	208		1,456	18
19	Emergency Generator Upgrade		1999	8,700	290	30	290		4,398	19
20	Remodel Bathroom		2001	2,730	91	30	91		455	20
21	Paint Wings		2001	6,000	200	30	200		1,000	21
22	Paint Wings		2002	9,150	305	30	305		1,220	22
23	Emergency Generator Upgrade		2002	6,998	233	30	233		621	23
24	Carpeting		2004	3,600	120	30	120		240	24
25	Replace Roof (Partial)		2004	6,120	204	30	204		408	25
26	Air Handler		2005	9,450	315	30	315		315	26
27	Flooring		2005	4,878	163	30	163		163	27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning:

9/1/2004

Ending:

8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,187,975	\$ 72,931		\$ 72,931	\$	\$ 1,101,866	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 213,067	\$ 21,307	\$ 21,307	\$	10	\$ 293,755	71
72	Current Year Purchases	119,702	11,970	11,970		10	11,970	72
73	Fully Depreciated Assets	127,069						73
74								74
75	TOTALS	\$ 459,838	\$ 33,277	\$ 33,277	\$		\$ 305,725	75

D. Vehicle Depreciation (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	Transport Clients	2004 Ford Econo Van	2004	\$ 23,248	\$ 4,650	\$ 4,650	\$	5	\$ 9,300	76
77	Maintenance	1991 Chevy Truck	1991	11,353				5	11,353	77
78										78
79										79
80	TOTALS			\$ 34,601	\$ 4,650	\$ 4,650	\$		\$ 20,653	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 12L, if applicable)	\$ 3,026,811	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 110,858	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 110,858	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 1,428,244	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	1989 Ford Van/Acquired 1989	\$ 39,000	\$	\$ 39,000	86
87	1998 Ford Bus/Acquired 1997	45,582		45,582	87
88	2005 Ford Senator/Acquired 2005	42,827	8,565	8,565	88
89	2000 Ford Bus/Acquired 2000	45,508	740	44,036	89
90					90
91	TOTALS	\$ 172,917	\$ 9,305	\$ 137,183	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: \_\_\_\_\_  
 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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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	<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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input 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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>COMMUNITY COLLEGE      <input type="checkbox"/></p> <p>HOURS PER CNA      <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER CNA      <u>80</u></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	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.

\$ 9,045

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	<u>27</u>
2. From other facilities (f)	<u>7</u>
DROP-OUTS	
1. From this facility	<u>10</u>
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>44</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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning: 9/1/2004

Ending:

8/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2005

(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	\$ 31,305	\$ 2,838,073
2	Cash-Patient Deposits		
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,000 )	1,275,557	5,836,750
4	Supply Inventory (priced at Cost )		330,829
5	Short-Term Investments		10,554,740
6	Prepaid Insurance		497,495
7	Other Prepaid Expenses		3,592,696
8	Accounts Receivable (owners or related parties)		
9	Other(specify): <u>Accrued Interest Receivable</u>		526,861
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,306,862	\$ 24,177,444
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		3,328,655
12	Long-Term Investments		127,825,653
13	Land	344,397	6,981,084
14	Buildings, at Historical Cost	2,187,975	67,312,635
15	Leasehold Improvements, at Historical Cost		457,602
16	Equipment, at Historical Cost	674,276	22,729,675
17	Accumulated Depreciation (book methods)	(1,565,427)	(40,174,049)
18	Deferred Charges		
19	Organization & Pre-Operating Costs		
20	Accumulated Amortization - Organization & Pre-Operating Costs		
21	Restricted Funds		
22	Other Long-Term Assets (specify):		
23	Other(specify): <u>Construction in Progress</u>		4,678,036
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,641,221	\$ 193,139,291
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,948,083	\$ 217,316,735

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 137,255	\$ 1,786,466
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		
30	Accrued Salaries Payable		1,787,804
31	Accrued Taxes Payable (excluding real estate taxes)		52,872
32	Accrued Real Estate Taxes(Sch.IX-B)		
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Restricted Funds</u>		4,370,166
37	<u>Accrued Fringe Benefits</u>		1,902,442
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 137,255	\$ 9,899,750
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		660,068
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
<b>Other Long-Term Liabilities(specify):</b>			
43			
44			
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 660,068
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 137,255	\$ 10,559,818
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,810,828	\$ 206,756,917
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,948,083	\$ 217,316,735

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,031,781	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,031,781	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(118,084)	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)	\$ (118,084)	17
<b>B. Transfers (Itemize):</b>			
18		897,131	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 897,131	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,810,828	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning: 9/1/2004

Ending:

8/31/2005

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,231,457	1
2	Discounts and Allowances for all Levels	(586,648)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,644,809</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	9,045	11
12	Gift and Coffee Shop	237	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 9,282</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Reimbursement for Workshop transportation	33,658	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 33,658</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,687,749</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	566,098	31
32	Health Care	1,244,859	32
33	General Administration	720,167	33
<b>B. Capital Expense</b>			
34	Ownership	120,163	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	154,546	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,805,833</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(118,084)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (118,084)</b>	<b>43</b>

\* 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 &amp; ID Number Bethesda Lutheran Home-Aurora

# 0035519

Report Period Beginning: 9/1/2004

Ending: 8/31/2005

## 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	1,864	2,080	\$ 50,889	\$ 24.47	1
2	Assistant Director of Nursing	2,036	2,223	56,013	25.20	2
3	Registered Nurses					3
4	Licensed Practical Nurses	1,887	2,176	42,697	19.62	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,359	1,441	22,448	15.58	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,976	2,160	30,821	14.27	13
14	Head Cook	3,872	4,320	47,602	11.02	14
15	Cook Helpers/Assistants	4,527	4,792	39,232	8.19	15
16	Dishwashers					16
17	Maintenance Workers	5,079	5,767	73,163	12.69	17
18	Housekeepers	3,940	4,184	34,440	8.23	18
19	Laundry	9,150	9,150	102,206	11.17	19
20	Administrator	1,982	2,120	48,640	22.94	20
21	Assistant Administrator					21
22	Other Administrative	3,535	4,046	88,208	21.80	22
23	Office Manager					23
24	Clerical	2,985	3,300	41,555	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,962	4,112	57,635	14.02	28
29	Resident Services Coordinator	1,576	1,739	28,816	16.57	29
30	Habilitation Aides (DD Homes)	57,271	63,404	707,963	11.17	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,001	117,014	\$ 1,472,328 *	\$ 12.58	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	98	\$ 4,282	1-3	35
36	Medical Director	13	16,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	14	794	10A-3	40
41	Occupational Therapy Consultant	15	845	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	781	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	98	3,413	11-3	45
46	Other(specify)				46
47	Psychiatric Consultant	6	1,200	10-3	47
48	Behavioral Consultant	13	17,672	10-3	48
49	TOTAL (lines 35 - 48)	271	\$ 45,887		49

## C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,366	\$ 63,980	10-3	50
51	Licensed Practical Nurses	1,819	73,931	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,185	\$ 137,911		53





Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519Report Period Beginning: 9/1/2004Ending: 8/31/2005**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. IARF \$5,633
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? \_\_\_\_\_  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (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. \$ 154,546  
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. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 84.5%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 33,658**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Virchow Krause & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (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 \$2500, 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.