

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035519

Facility Name: Bethesda Lutheran Home-Aurora

Address: 1480 Reckinger Road Aurora 60505
 Number City Zip Code

County: Kane

Telephone Number: (630) 851-6777 **Fax #** (630) 851-7819

HFS ID Number: 39-0806446005

Date of Initial License for Current Owners: 5/17/1990

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Karen Holton **Telephone Number:** 920-206-4458

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2005 to 8/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) <u>Regional Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519 Report Period Beginning: 9/1/2005 Ending: 8/31/2006

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	45	Intermediate/DD	45	16,425	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	15,286			15,286
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	15,286			15,286

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.07%

D. How many bed-hold days during this year were paid by the Department? 364 (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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/2006 Fiscal Year: 8/31/2006

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2005 Ending: 8/31/2006

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
	A. General Services										
1	Dietary	126,079	18,115	4,583	148,777		148,777	148,777			1
2	Food Purchase		56,921		56,921		56,921	56,921			2
3	Housekeeping	37,742	21,282		59,024		59,024	59,024			3
4	Laundry	100,101	30,119	440	130,660		130,660	130,660			4
5	Heat and Other Utilities			74,580	74,580	599	75,179	75,179			5
6	Maintenance	69,520	10,688	48,928	129,136	136	129,272	129,272			6
7	Other (specify):* Waste Removal			2,753	2,753		2,753	2,753			7
8	TOTAL General Services	333,442	137,125	131,284	601,851	735	602,586	602,586			8
	B. Health Care and Programs										
9	Medical Director			16,900	16,900		16,900	16,900			9
10	Nursing and Medical Records	158,934	47,030	204,815	410,779		410,779	410,779			10
10a	Therapy	820,771		4,787	825,558		825,558	825,558			10a
11	Activities	29,576	5,219	5,961	40,756		40,756	40,756			11
12	Social Services	55,639			55,639		55,639	55,639			12
13	CNA Training										13
14	Program Transportation		14,512	16,220	30,732	1,040	31,772	(20,194)	11,578		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,064,920	66,761	248,683	1,380,364	1,040	1,381,404	(20,194)	1,361,210		16
	C. General Administration										
17	Administrative	152,001		61,116	213,117	(61,116)	152,001	152,001			17
18	Directors Fees										18
19	Professional Services					1,630	1,630	1,630			19
20	Dues, Fees, Subscriptions & Promotions			921	921	15,638	16,559	16,559			20
21	Clerical & General Office Expenses	55,920	8,236	9,849	74,005	4,806	78,811	78,811			21
22	Employee Benefits & Payroll Taxes			425,187	425,187	28,458	453,645	453,645			22
23	Inservice Training & Education					514	514	514			23
24	Travel and Seminar			1,060	1,060	242	1,302	1,302			24
25	Other Admin. Staff Transportation			1,911	1,911	1,457	3,368	3,368			25
26	Insurance-Prop.Liab.Malpractice			37,353	37,353	470	37,823	(10,629)	27,194		26
27	Other (specify):*										27
28	TOTAL General Administration	207,921	8,236	537,397	753,554	(7,901)	745,653	(10,629)	735,024		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,606,283	212,122	917,364	2,735,769	(6,126)	2,729,643	(30,823)	2,698,820		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.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Bethesda Lutheran Home-Aurora

#0035519

Report Period Beginning:

9/1/2005

Ending:

8/31/2006

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	
	D. Ownership											
30	Depreciation			130,996	130,996		130,996	(9,305)	121,691			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					6,126	6,126		6,126			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			130,996	130,996	6,126	137,122	(9,305)	127,817			37
	Ancillary Expense											
	E. Special Cost Centers											
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			152,972	152,972		152,972		152,972			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			152,972	152,972		152,972		152,972			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,606,283	212,122	1,201,332	3,019,737		3,019,737	(40,128)	2,979,609			45

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning: 9/1/2005

Ending: 8/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,128)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,128)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (40,128)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Bethesda Lutheran Home-Aurora

ID# 0035519

Report Period Beginning: 9/1/2005

Ending: 8/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Progran Transportation to/from Workshop	\$ (20,194)	14	1
2	Insurance on Vehicles used for Workshop Transport	(10,629)	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	Total	(40,128)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2005

Ending:

8/31/2006

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)	
	A. General Services													
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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(20,194)	0	0	0	0	0	0	0	0	0	0	(20,194)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(20,194)	0	0	0	0	0	0	0	0	0	0	(20,194)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	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	(10,629)	0	0	0	0	0	0	0	0	0	0	(10,629)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,629)	0	0	0	0	0	0	0	0	0	0	(10,629)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,823)	0	0	0	0	0	0	0	0	0	0	(30,823)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2005 Ending:

8/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(9,305)	0	0	0	0	0	0	0	0	0	0	(9,305)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,305)	0	(9,305)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(40,128)	0	(40,128)	45									

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		
1	V	17 Accounting Services	\$ 56,792	Bethesda Lutheran Homes & Services, Inc	100.00%	\$ 56,792	\$	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		\$ 56,792			\$ 56,792	\$ *	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: 9/1/2005 Ending: 8/31/2006

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: 9/1/2005

Ending: 3/31/2006

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

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

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

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	Accounting Services	Days	306,423	\$ 1,111,968	\$ 815,376	15,650	\$ 56,792	1
2	17	Central Region Office	Days	56,570	358,523	192,362	15,650	99,185	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				\$ 1,470,491	\$ 1,007,738		\$ 155,977	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																					
1. Real Estate Tax accrual used on 2005 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 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>_____</td><td>8</td></tr> <tr><td>2002</td><td>_____</td><td>9</td></tr> <tr><td>2003</td><td>_____</td><td>10</td></tr> <tr><td>2004</td><td>_____</td><td>11</td></tr> <tr><td>2005</td><td>_____</td><td>12</td></tr> </table>	2001	_____	8	2002	_____	9	2003	_____	10	2004	_____	11	2005	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	_____	8																																			
2002	_____	9																																			
2003	_____	10																																			
2004	_____	11																																			
2005	_____	12																																			
FOR BHF USE ONLY																																					
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Bethesda Lutheran Home-Aurora

0035519 Report Period Beginning:

9/1/2005 Ending:

8/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,394 B. General Construction Type: Exterior Vinyl Siding Frame Wood (Sprinklered) 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).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2005

Ending:

8/31/2006

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 BHF 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		\$ 1,063,112	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Accoustical Ceiling		1991	8,725	291	30	291		4,365	9
10		Multi-Purpose Room		1991	169,382	5,646	30	5,646		84,690	10
11		Replace Roof (Partial)		1994	4,681	156	30	156		1,872	11
12		Shower Stalls		1994	2,950	98	30	98		1,176	12
13		Safety Lighting		1994	3,450	115	30	115		1,380	13
14		Replace Roof (Partial)		1995	7,950	265	30	265		2,915	14
15		Wall Coverings		1995	5,140	171	30	171		1,881	15
16		Fire Door		1995	699	23	30	23		253	16
17		Remodel Bathroom		1995	2,036	68	30	68		748	17
18		Chair Rails		1998	6,253	208	30	208		1,664	18
19		Emergency Generator Upgrade		1999	8,700	290	30	290		4,688	19
20		Remodel Bathroom		2001	2,730	91	30	91		546	20
21		Paint Wings		2001	6,000	200	30	200		1,200	21
22		Paint Wings		2002	9,150	305	30	305		1,525	22
23		Emergency Generator Upgrade		2002	6,998	233	30	233		854	23
24		Carpeting		2004	3,600	120	30	120		360	24
25		Replace Roof (Partial)		2004	6,120	204	30	204		612	25
26		Air Handler		2005	9,450	315	30	315		630	26
27		Flooring		2005	4,878	163	30	163		326	27
28		Replace Roof (Partial)		2006	6,732	224	30	224		224	28
29		Plans Remodeling		2006	6,250	208	30	208		208	29
30		Retile Shower Room		2006	9,280	309	30	309		309	30
31		Kitchen Repairs(Insurance Deductible)		2006	5,000	2,500	2	2,500		2,500	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:

9/1/2005

Ending:

8/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,215,237	\$ 76,172		\$ 76,172	\$	\$ 1,178,038	70

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2005 Ending: 8/31/2006

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	\$ 297,023	\$ 29,703	\$ 29,703	\$	10	\$ 335,428	71
72	Current Year Purchases	30,069	3,007	3,007		10	3,007	72
73	Fully Depreciated Assets	154,914						73
74								74
75	TOTALS	\$ 482,006	\$ 32,710	\$ 32,710	\$		\$ 338,435	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	\$ 13,950	76
77	Transport Clients	2006 Ford Starcraft	2006	40,794	8,159	8,159		5	8,159	77
78	Maintenance	1991 Chevy Truck	1991	11,353				5	11,353	78
79										79
80	TOTALS			\$ 75,395	\$ 12,809	\$ 12,809	\$		\$ 33,462	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)		\$ 3,117,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 121,691	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 121,691	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)		\$ 1,549,935	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 189	\$ 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	17,130	88
89	2000 Foed Bus/Acquired 2000	45,508	740	44,776	89
90					90
91	TOTALS	\$ 172,917	\$ 9,305	\$ 146,488	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	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2005 Ending: 8/31/2006

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 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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ 43,371

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>19</u>
2. From other facilities (f)	<u>31</u>
DROP-OUTS	
1. From this facility	<u>8</u>
2. From other facilities (f)	
TOTAL TRAINED	58

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

Ending:

8/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 89,822	\$ 21,275,059	1
2	Cash-Patient Deposits		604,535	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 40,000)	520,314	4,930,131	3
4	Supply Inventory (priced at <u>cost</u>)		336,687	4
5	Short-Term Investments			5
6	Prepaid Insurance		439,643	6
7	Other Prepaid Expenses		263,712	7
8	Accounts Receivable (owners or related parties)		2,012,723	8
9	Other(specify): <u>Accrued Interest Receivable</u>		580,016	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 610,136	\$ 30,442,506	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		192,120,037	12
13	Land	344,397	9,598,472	13
14	Buildings, at Historical Cost	2,215,237	70,433,276	14
15	Leasehold Improvements, at Historical Cost		411,472	15
16	Equipment, at Historical Cost	737,238	26,069,899	16
17	Accumulated Depreciation (book methods)	(1,650,841)	(44,059,627)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>		755,954	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,646,031	\$ 255,329,483	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,256,167	\$ 285,771,989	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 139,439	\$ 1,465,802	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		358,508	28
29	Short-Term Notes Payable		14,249	29
30	Accrued Salaries Payable		2,339,988	30
31	Accrued Taxes Payable (excluding real estate taxes)		43,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		27,764	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Restricted Funds</u>		11,190,768	36
37	<u>Accrued Fringe Benefits</u>		599,600	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 139,439	\$ 16,040,183	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		632,797	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 632,797	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 139,439	\$ 16,672,980	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,116,728	\$ 269,099,009	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,256,167	\$ 285,771,989	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,810,828	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,810,828	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(309,598)	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)	\$ (309,598)	17
	B. Transfers (Itemize):		
18	Transfer Capital to Home Office	(384,502)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (384,502)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,116,728	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning: 9/1/2005

Ending: 8/31/2006

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,235,637	1
2	Discounts and Allowances for all Levels	(602,472)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,633,165	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	43,371	11
12	Gift and Coffee Shop		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,371	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Reimbursement for Workshop Transportation</u>	33,603	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33,603	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,710,139	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	601,851	31
32	Health Care	1,380,364	32
33	General Administration	753,554	33
B. Capital Expense			
34	Ownership	130,996	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	152,972	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,019,737	40
41	Income before Income Taxes (line 30 minus line 40)**	(309,598)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (309,598)	43

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

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

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

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2005

Ending:

8/31/2006

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	1,352	1,556	\$ 39,765	\$ 25.56	1
2	Assistant Director of Nursing	1,402	1,524	37,194	24.41	2
3	Registered Nurses					3
4	Licensed Practical Nurses	2,115	2,358	45,797	19.42	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,549	1,888	29,576	15.67	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,792	2,152	31,630	14.70	13
14	Head Cook	5,255	5,667	61,167	10.79	14
15	Cook Helpers/Assistants	3,682	3,966	33,282	8.39	15
16	Dishwashers					16
17	Maintenance Workers	5,138	5,652	69,520	12.30	17
18	Housekeepers	4,152	4,529	37,742	8.33	18
19	Laundry	9,150	9,150	100,101	10.94	19
20	Administrator	1,884	2,242	57,140	25.49	20
21	Assistant Administrator					21
22	Other Administrative	3,554	3,969	94,861	23.90	22
23	Office Manager					23
24	Clerical	3,869	4,353	55,920	12.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,860	3,936	55,639	14.14	28
29	Resident Services Coordinator	1,960	2,080	36,178	17.39	29
30	Habilitation Aides (DD Homes)	69,387	75,026	820,771	10.94	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,101	130,048	\$ 1,606,283 *	\$ 12.35	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	106	\$ 4,583	1-3	35
36	Medical Director	13	16,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	298	10-3	39
40	Physical Therapy Consultant	6	527	10A-3	40
41	Occupational Therapy Consultant	31	1,951	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	41	2,309	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	21	788	11-3	45
46	Other(specify) <u>Psychiatric Consultan</u>	6	1,200	10-3	46
47	<u>Behavioral Consultant</u>	11	16,861	10-3	47
48					48
49	TOTAL (lines 35 - 48)	241	\$ 45,417		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	712	\$ 33,450	10-3	50
51	Licensed Practical Nurses	3,244	132,795	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,956	\$ 166,245		53

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 \$5,765
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (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. \$ 152,972
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. \$ 0
- (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? 89%
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. \$ 33,603
- (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? No If no, please explain. Not completed-will send when ready
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.