

Facility Name & ID Number Lutheran Care Center

0025023 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	4,054	4,498	2,416	10,968	8
9	SNF/PED					9
10	ICF	6,986	9,734		16,720	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,040	14,232	2,416	27,688	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.02%

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

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

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

Day Care

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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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 10/01/1980

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

YES Date 10/01/1980 NO

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

YES NO If YES, enter number of beds certified 96 and days of care provided 2,416

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/2006 Fiscal Year: 09/30/2006

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	290,736	31,516	6,133	328,385		328,385		328,385		1
2	Food Purchase		175,734		175,734		175,734	(3,003)	172,731		2
3	Housekeeping	83,472	20,052		103,524		103,524		103,524		3
4	Laundry	89,944	19,551		109,495		109,495		109,495		4
5	Heat and Other Utilities			102,988	102,988		102,988		102,988		5
6	Maintenance	39,095	2,845	23,294	65,234		65,234		65,234		6
7	Other (specify):*										7
8	TOTAL General Services	503,247	249,698	132,415	885,360		885,360	(3,003)	882,357		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	1,200,367	70,604	2,130	1,273,101		1,273,101		1,273,101		10
10a	Therapy	130,234	126	15,805	146,165		146,165		146,165		10a
11	Activities	56,315	1,390	1,134	58,839		58,839	(253)	58,586		11
12	Social Services	35,770	157	437	36,364		36,364		36,364		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,422,686	72,277	24,906	1,519,869		1,519,869	(253)	1,519,616		16
	C. General Administration										
17	Administrative	60,727			60,727		60,727		60,727		17
18	Directors Fees										18
19	Professional Services			50,210	50,210		50,210		50,210		19
20	Dues, Fees, Subscriptions & Promotions			14,325	14,325		14,325	(2,984)	11,341		20
21	Clerical & General Office Expenses	95,078	5,443	21,266	121,787		121,787	(3,738)	118,049		21
22	Employee Benefits & Payroll Taxes			636,693	636,693		636,693	(5,281)	631,412		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,705	12,705		12,705		12,705		24
25	Other Admin. Staff Transportation			4,550	4,550		4,550		4,550		25
26	Insurance-Prop.Liab.Malpractice			119,482	119,482		119,482		119,482		26
27	Other (specify):*										27
28	TOTAL General Administration	155,805	5,443	859,231	1,020,479		1,020,479	(12,003)	1,008,476		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,081,738	327,418	1,016,552	3,425,708		3,425,708	(15,259)	3,410,449		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lutheran Care Center

#0025023

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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			115,598	115,598		115,598	2,207	117,805			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,383	6,383		6,383	(6,383)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			559	559		559		559			35
36	Other (specify):*											36
37	TOTAL Ownership			122,540	122,540		122,540	(4,176)	118,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,843		48,843		48,843		48,843			39
40	Barber and Beauty Shops			13,438	13,438		13,438		13,438			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):* Nonallowable Cost	186,336	36,495	279,971	502,802		502,802	(502,802)				43
44	TOTAL Special Cost Centers	186,336	85,338	345,969	617,643		617,643	(502,802)	114,841			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,268,074	412,756	1,485,061	4,165,891		4,165,891	(522,237)	3,643,654			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(2,944)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,195)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,207	30		9
10	Interest and Other Investment Income	(6,383)	32		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	(5,460)	43		24
25	Fund Raising, Advertising and Promotional	(12,895)	43		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 See PG5A	(495,567)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (522,237)		\$	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))	\$ (522,237)		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.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

ID# 0025023
 Report Period Beginning: 10/01/2005
 Ending: 09/30/2006

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Medicare Lab Expense	\$ (4,034)	43	1
2	Disallow Medicare X-Ray Expense	(4,300)	43	2
3	Disallow Medicare Outpatient Expense	(300)	43	3
4	Disallow personal purchases	(211)	43	4
5	Offset dietary income against related expense	(59)	2	5
6	Offset various misc. revenues against misc. expense	(3,726)	21	6
7	Offset telephone income against telephone expense	(12)	21	7
8	Disallow non-allowable dues & charges	(137)	20	8
9	Disallow promotional advertising	(2,847)	20	9
10	Offset uniform income against uniform expense	(5,281)	22	10
11	Offset activities income against activities expens	(253)	11	11
12				12
13				13
14				14
15	Disallow non-care related salaries	(186,336)	43	15
16	Disallow non-care related supplies	(36,495)	43	16
17	Disallow non-care related expenses	(251,576)	43	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	(495,567)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,003)	0	0	0	0	0	0	0	0	0	0	(3,003)	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	(3,003)	0	(3,003)	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	(253)	0	0	0	0	0	0	0	0	0	0	(253)	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(253)	0	(253)	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	(2,984)	0	0	0	0	0	0	0	0	0	0	(2,984)	20
21	Clerical & General Office Expenses	(3,738)	0	0	0	0	0	0	0	0	0	0	(3,738)	21
22	Employee Benefits & Payroll Taxes	(5,281)	0	0	0	0	0	0	0	0	0	0	(5,281)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(12,003)	0	(12,003)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,259)	0	(15,259)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

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	2,207	0	0	0	0	0	0	0	0	0	0	2,207	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,383)	0	0	0	0	0	0	0	0	0	0	(6,383)	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	(4,176)	0	(4,176)	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):*	(502,802)	0	0	0	0	0	0	0	0	0	0	(502,802)	43
44	TOTAL Special Cost Centers	(502,802)	0	(502,802)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(522,237)	0	(522,237)	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
		N/A				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		\$			\$	\$	1
2	V							2
3	V			N/A				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		\$			\$	\$ *	14

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

Facility Name & ID Number

Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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	See attached schedule of Board of Directors									
6	Note: No members of the Board of Directors provided services to the nursing home nor owned business entities that provided services to the nursing home.									
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023 Report Period Beginning: 10/01/2005 Ending: 9/30/2006

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4			N/A						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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	First Mid-IL Bank & Trust		X	Line of Credit		6/13/97	75,000	134,301	demand	0.0575	6,383									
7																				
8																				
9	TOTAL Facility Related						\$ 75,000	\$ 134,301			\$ 6,383									
B. Non-Facility Related*																				
10	First Mid-IL Bank & Trust		X	Luther Terrace Mortgage	\$6,994.00	6/16/97	1,000,000	159,906	06/15/27	0.0750	13,404									
11											(6,383)									
12											(13,404)									
13																				
14	TOTAL Non-Facility Related				\$6,994.00		\$ 1,000,000	\$ 159,906			\$ (6,383)									
15	TOTALS (line 9+line14)						\$ 1,075,000	\$ 294,207			\$									

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 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.)		\$	N/A
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:	2001	_____	8
	2002	_____	9
	2003	_____	10
	2004	_____	11
	2005	N/A	12
This entity is a not-for-profit facility and does not pay real estate taxes.			
	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Lutheran Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0025023

CONTACT PERSON REGARDING THIS REPORT Karen Hille

TELEPHONE (618) 483-6136 FAX #: (618) 483-5607

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. _____	<u>N/A</u>	\$ _____	\$ _____
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 Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,884 B. General Construction Type: Exterior Brick Frame Steel 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).

<u>Luther Villas - Independent Living</u>	<u>7 units - 7,700 square feet</u>
<u>Luther Terrace - Independent Living</u>	<u>16 units - 13,688 square feet</u>
<u>Child Enrichment Center - Day Care</u>	<u>4,219 square feet</u>

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>239,085</u>	<u>1980</u>	<u>\$ 35,000</u>	<u>1</u>
2	<u>Resident Care</u>	<u>197,415</u>	<u>1987</u>	<u>28,900</u>	<u>2</u>
3	TOTALS	436,500		\$ 63,900	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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	96	1980	1969	\$ 867,500	\$	25	\$	\$	\$ 867,500	4
5		1980	1969	12,000		25			12,000	5
6		1980	1974	141,000		25			141,000	6
7		1980	1969	10,000		25			10,000	7
8		1980	1977	1,000		25			1,000	8
	Improvement Type**									
9	Therapy Room		1981	3,764	113	25	124	11	3,764	9
10	Land Improvements		1980	28,500		25			28,500	10
11	Land Improvements		1986	2,000	80	25	80		1,566	11
12	Land Improvements		1987	2,143	86	25	86		1,694	12
13	Land Improvements		1991	491	20	25	20		375	13
14	Building Improvements		1981	3,486		5			3,486	14
15	Building Improvements		1982	6,557		20			6,557	15
16	Building Improvements		1982	163		10			163	16
17	Building Improvements		1985	940		10			940	17
18	Building Improvements		1985	2,512		20			2,512	18
19	Building Improvements		1986	955		10			955	19
20	Building Improvements		1986	1,949	23	20	24	1	1,949	20
21	Building Improvements		1987	2,150		10			2,150	21
22	Building Improvements		1987	1,023	51	20	51		980	22
23	Building Improvements		1988	1,500		10			1,500	23
24	Building Improvements		1989	16,021		10			16,021	24
25	Building Improvements		1989	241		15			241	25
26	Building Improvements		1989	14,979		20			14,979	26
27	Building Improvements		1990	6,315		5			6,315	27
28	Building Improvements		1990	20,381		10			20,381	28
29	Building Improvements		1990	10,176		15			10,176	29
30	Building Improvements		1990	1,656	83	20	83		1,346	30
31	Building Improvements		1991	6,000		10			6,000	31
32	Building Improvements		1992	7,122		7			7,122	32
33	Building Improvements		1992	4,345		10			4,345	33
34	Misc Flooring/ Wallpaper		1993	3,762		5			3,762	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room	1993	\$ 82,632	\$ 2,623	31.5	\$ 2,623	\$	\$ 33,773	37
38	Sprinkler System	1994	31,932	798	40	798		9,750	38
39	Additional Patio Work	1994	1,725	43	40	43		523	39
40	Dining Room Floor	1994	2,788	70	40	70		851	40
41	Breakroom Wallpaper	1994	302	8	40	8		97	41
42	Admin Office Wallpaper	1994	381	10	40	10		120	42
43	Lobby Wall Covering	1994	2,759	69	40	69		840	43
44	Floor Tile	1994	683	17	40	17		207	44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		426	45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		2,437	46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		258	47
48	Misc. Land Improvements	1994	1,279	32	40	32		392	48
49	Building Improvements	1995	7,804	200	40	195	(5)	2,282	49
50	Carpet for Lobby	1995	1,465	73	10	75	2	1,465	50
51	Office Wallpaper	1995	622	31	10	31		622	51
52	Front Office Wallpaper	1995	825	41	10	43	2	825	52
53	Activity Office Counter Top	1995	1,575	79	10	80	1	1,575	53
54	Flooring North Hall	1996	717	36	10	35	(1)	717	54
55	Air Conditioner Unit	1996	8,400	420	10	420		8,400	55
56	Air Conditioner Unit	1996	940	47	10	47		940	56
57	Air Conditioner Unit	1996	560	28	10	28		560	57
58	Gas Line	1996	947	47	10	46	(1)	947	58
59	Flooring Halls	1995	1,822	91	10	138	47	1,822	59
60	Flooring Halls	1994	1,267	63	10	93	30	1,267	60
61	Fire Alarm System	1996	2,429	121	10	121		2,429	61
62	Building Improvements	1996	697	35	10	34	(1)	697	62
63	Parking lot improvements	1997	1,500	75	20	75		713	63
64	Parking lot improvements	1997	2,510	251	10	251		2,385	64
65	Electrical wiring	1997	1,171	117	10	117		1,112	65
66	5 ton air conditioner unit	1997	5,330	533	10	533		5,064	66
67	Front entrance awning	1997	2,867	287	10	287		2,725	67
68	Electrical wiring	1997	966	97	10	97		919	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,359,743	\$ 7,053		\$ 7,139	\$ 86	\$ 1,266,419	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,359,743	\$ 7,053		\$ 7,139	\$ 86	\$ 1,266,419	1
2	New administrative offices	1997	77,471		40	2,905	2,905	17,023	2
3	Dietary refrigeration system	1997	18,095	2,431	10	1,810	(621)	17,518	3
4	Cabinets & counter tops	1997	11,664	1,166	10	1,166		11,079	4
5	Roof	1998	178,417	8,921	20	8,921		75,828	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms)	1998	2,445	122	20	122		1,038	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms)	1998	384		10			384	7
8	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	834	122	10	83	(39)	706	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Rooms)	1998	3,548	694	10	355	(339)	3,018	9
10	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Medicare R	1998	2,576	354	10	258	(96)	2,434	10
11	Parking lot improvements	1998	1,298	130	10	130		1,104	11
12									12
13	Building Improvements - per 1994 audit	1981	1,140		10			1,140	13
14	Building Improvements - per 1994 audit	1982	2,159		10			2,159	14
15	Building Improvements - per 1994 audit	1984	1,677		10			1,677	15
16									16
17	Landscaping	1999	4,080	204	20	204		1,530	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295	30	10	30		223	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196	20	10	20		149	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474	105	10	104	(1)	1,474	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms)	1999	652	65	10	65		488	21
22	Cove base (Medicare room remodeling)	1999	77	8	10	8		59	22
23	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		1,184	23
24	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		2,648	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		1,705	25
26	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		1,014	26
27	Air Conditioner Improvements	1999	677		5			677	27
28	Wallcoverings, hand rails, chair rails (Remodeling - Medicare Rooms)	2000	1,684	168	10	168		1,093	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056	206	10	206		1,338	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59	6	10	6		42	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853	915	10	885	(30)	5,768	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59	6	10	6		39	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,699,093	\$ 23,599		\$ 25,464	\$ 1,865	\$ 1,420,958	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,699,093	\$ 23,599		\$ 25,464	\$ 1,865	\$ 1,420,958	1
2	Sidewalk	2000	2,300	115	20	115		748	2
3	Flooring	2002	6,306	631	10	631		2,787	3
4	Windows	2002	3,635	364	10	364		1,517	4
5	Seed for lawn	2001	425	21	20	43	22	188	5
6	Chapel	2002	414,840	10,371	40	10,371		42,349	6
7	Windows	2002	26,539	2,654	10	2,654		10,837	7
8	Sidewalk	2002	2,083	208	10	208		849	8
9	Cabinets	2002	9,246	925	10	925		3,777	9
10	Wiring	2002	5,107	511	10	511		2,087	10
11	Landscaping	2002	6,280	628	10	628		2,564	11
12	Screen	2002	1,716	172	10	172		702	12
13	Cable	2002	7,954	795	10	795		3,246	13
14	Door guard	2002	4,955	496	10	496		2,025	14
15									15
16	Driveway & parking lot	2002	87,004	8,700	10	8,700		30,450	16
17	Plants/Rocks/Stone	2003	853	85	10	85		298	17
18	Window replacement project	2003	14,285	1,429	10	1,429		5,001	18
19	Laundry replacement	2002	1,983	198	10	198		693	19
20	Painting - hallways & west wing	2003	6,347	635	10	635		2,222	20
21	Painting - hallways	2003	2,230	223	10	223		781	21
22	Paintings - hallways	2003	5,000		10	500	500	1,500	22
23	Counter tops & cabinets	2003	696	99	7	99		347	23
24									24
25	Garage Expansion	2004	15,214	761	20	761		1,902	25
26	Room Painting and Wallpaper	2004	17,526	1,753	10	1,753		4,369	26
27	Painting building, trim, & eaves	2004	1,978	198	10	198		412	27
28	Generator	2004	160,787	16,078	10	16,078		33,497	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,504,382	\$ 71,649		\$ 74,036	\$ 2,387	\$ 1,576,106	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12C, Carried Forward		\$ 2,504,382	\$ 71,649		\$ 74,036	\$ 2,387	\$ 1,576,106	1
2	Paint	2004	371	37	10	37		71	2
3	Window Coverings	2004	3,307	331	10	331		634	3
4	Wiring	2004	11,383	569	20	569		1,043	4
5	Garage Expansion	2005	373	19	20	19		30	5
6	Window Tint	2005	510	51	10	51		81	6
7	Rocks	2005	116	12	10	12		13	7
8									8
9	Review for to IDPH for Therapy Building Plans	2006	6,000	120	25	120		120	9
10	Architecture Fees for Therapy building	2006	26,205	524	25	524		524	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	TOTAL (lines 1 thru 33)		\$ 2,552,647	\$ 73,312		\$ 75,699	\$ 2,387	\$ 1,578,622	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 311,687	\$ 33,412	\$ 33,049	\$ (363)	5-7 years	\$ 271,407	71
72	Current Year Purchases	43,585	3,756	3,756		5-25 years	3,756	72
73	Fully Depreciated Assets	383,758				5-7 years	383,758	73
74								74
75	TOTALS	\$ 739,030	\$ 37,168	\$ 36,805	\$ (363)		\$ 658,921	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	Facility use	2001 Dodge E250 van	2001	\$ 39,825	\$ 3,983	\$ 4,166	\$ 183	5	\$ 39,825	76
77	Facility use	1990 Oldsmobile wagon	2001	3,340				3	3,340	77
78	Facility use	Chevy Lumina	2004	5,675	1,135	1,135		5	2,870	78
79										79
80	TOTALS			\$ 48,840	\$ 5,118	\$ 5,301	\$ 183		\$ 46,035	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)	\$ 3,404,417	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,598	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,805	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,283,578	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	Net Fixed Assets	\$	\$	\$	86
87	Luther Villas & Luther Terrace	1,654,094	48,603	470,418	87
88					88
89	Net Fixed Assets				89
90	Child Enrichment Center	500,945	8,091	8,091	90
91	TOTALS	\$ 2,155,039	\$ 56,694	\$ 478,509	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Lutheran Care Center	\$ 71,284	92
93	CIP - Lutheran Villas	7,000	93
94			94
95		\$ 78,284	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				<u>N/A</u>			4
5								5
6								6
7	TOTAL				\$			7

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 N/A
by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A *

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: \$ 559 Description: Dishwasher Lease - \$559

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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	10A(2,3)	hrs	\$	195	\$ 9,753	\$ 20	195	\$ 9,773	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		119	5,951		119	5,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	4132 hrs	86,832	2	101	106	4,134	87,039	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				48,843		48,843	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			\$ 86,832	316	\$ 15,805	\$ 48,969	4,448	\$ 151,606	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

Provider #: 0025023

10/1/2005 to 9/30/2006

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	-----------------------	-------------------------------------	-------------	-----------------

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning: 10/01/2005

Ending:

09/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 401,174	\$ 401,174	1
2	Cash-Patient Deposits	1,884	1,884	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,001)	490,398	490,398	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,996	35,996	6
7	Other Prepaid Expenses	18,183	18,183	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 947,635	\$ 947,635	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	2,326,126	2,391,860	14
15	Leasehold Improvements, at Historical Cost	160,787	160,787	15
16	Equipment, at Historical Cost	783,392	787,870	16
17	Accumulated Depreciation (book methods)	(2,208,213)	(2,283,578)	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 (see Sch 17A)	83,999	83,999	22
23	Other(specify): <u>Net F/A Villas, Terrace & CEC</u>	1,749,324	1,676,530	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,959,125	\$ 2,881,368	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,906,760	\$ 3,829,003	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 56,636	\$ 56,636	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,884	1,884	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	206,475	206,475	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,736	2,736	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Withholdings</u>	527	527	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 271,173	\$ 271,173	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	294,207	294,207	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Revenue</u>	237,602	237,602	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 531,809	\$ 531,809	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 802,982	\$ 802,982	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,103,778	\$ 3,026,021	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,906,760	\$ 3,829,003	48

Lutheran Care Center
Provider #: 0025023
10/1/2005 to 9/30/2006

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

Line 22 Other Long Term Care Assets (specify):

Description	Operating	After Consolidation
LCC CIP - LCC Renovations	71,079	71,079
LV CIP - Villa in Process	7,000	7,000
LT Mortgage Costs	5,920	5,920
Total Other Long Term Care Assets	83,999	83,999

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,050,781	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,050,781	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,005	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) ROUNDING	(8)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 52,997	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,103,778	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,830,002	1
2	Discounts and Allowances for all Levels	116,161	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,946,163	3
	B. Ancillary Revenue		
4	Day Care	36,234	4
5	Other Care for Outpatients		5
6	Therapy	223,046	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 259,280	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,561	13
14	Non-Patient Meals	16,179	14
15	Telephone, Television and Radio	754	15
16	Rental of Facility Space		16
17	Sale of Drugs	69,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,298	19
20	Radiology and X-Ray		20
21	Other Medical Services	71,270	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 184,931	23
	D. Non-Operating Revenue		
24	Contributions	364,938	24
25	Interest and Other Investment Income***	11,993	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 376,931	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch19A	9,595	28
28a	Rental of Independent Living Units	441,996	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 451,591	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,218,896	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	885,360	31
32	Health Care	1,519,869	32
33	General Administration	1,020,479	33
	B. Capital Expense		
34	Ownership	122,540	34
	C. Ancillary Expense		
35	Special Cost Centers	565,083	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,165,891	40
41	Income before Income Taxes (line 30 minus line 40)**	53,005	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 53,005	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No-NFP 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Lutheran Care Center
Provider #: 0025023
10/1/2005 to 9/30/2006

Schedule 19A

XVII. INCOME STATEMENT

E. Other Revenue (specify):****

Line 28

Description	Amount
Dietary Fund Income	59
Personal Purchase Income	2,743
Employee Uniform Income	5,281
Miscellaneous Income	1,236
Interest Income - Luther Villas	130
LT Employee Uniform Income	146
Total Other Revenue	9,595

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

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	1,729	1,972	\$ 48,912	\$ 24.80	1
2	Assistant Director of Nursing	1,848	2,081	44,979	21.61	2
3	Registered Nurses	1,913	3,078	59,890	19.46	3
4	Licensed Practical Nurses	15,490	21,741	309,279	14.23	4
5	CNAs & Orderlies	48,616	69,626	648,545	9.31	5
6	CNA Trainees					6
7	Licensed Therapist	3,841	4,132	86,832	21.01	7
8	Rehab/Therapy Aides	4,190	4,267	43,402	10.17	8
9	Activity Director	1,894	2,127	25,473	11.98	9
10	Activity Assistants	2,877	4,139	30,842	7.45	10
11	Social Service Workers	1,896	2,235	35,770	16.00	11
12	Dietician	1,950	2,290	33,297	14.54	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,416	31,014	257,439	8.30	15
16	Dishwashers					16
17	Maintenance Workers	3,251	3,512	39,095	11.13	17
18	Housekeepers	8,369	11,427	83,472	7.30	18
19	Laundry	7,461	10,436	89,944	8.62	19
20	Administrator	1,841	2,086	60,727	29.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,784	7,496	95,078	12.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	5,509	6,061	88,762	14.64	32
33	Other(specify) See Sch 20A	18,624	22,514	186,336	8.28	33
34	TOTAL (lines 1 - 33)	159,499	212,234	\$ 2,268,074 *	\$ 10.69	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	120	\$ 5,423	1(3)	35
36	Medical Director	Monthly	5,400	9(3)	36
37	Medical Records Consultant	Monthly	1,590	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	540	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	437	11(3)	44
45	Social Service Consultant	29	437	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	178	\$ 13,827		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

Provider #: 0025023

10/1/2005 to 9/30/2006

Schedule 20A

XVIII. A: STAFFING AND SALARY COSTS

Line 32: Other Health Care (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Care Plan Nurse	2,024	2,268	42,573	18.77
Quality Assurance Coordinator	1,598	1,722	25,969	15.08
Ward Clerk	1,887	2,071	20,220	9.76
	<u>5,509</u>	<u>6,061</u>	<u>88,762</u>	<u>14.64</u>

Line 33: Other (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Independent Living Facility	12,373	16,152	135,574	8.39
Child Enrichment Center	6,251	6,362	50,762	7.98
	<u>18,624</u>	<u>22,514</u>	<u>186,336</u>	<u>8.28</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Hille	Administrator	0	\$ 60,727	Workers' Compensation Insurance	\$ 109,004	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,504	
				FICA Taxes	150,574	Health Care Worker Background Check		
				Employee Health Insurance	354,222	(Indicate # of checks performed <u>37</u>)	592	
				Employee Meals		Patient Background Checks	5 80	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network Membership Dues	4,394	
				Other Employee Benefits	16,300	Miscellaneous Subscriptions	1,477	
				Employee Physicals	925	Miscellaneous Membership	1,072	
				Employee Uniforms	387	Miscellaneous Licenses	369	
TOTAL (agree to Schedule V, line 17, col. 1)						Promotional & Yellow Page Advertising	2,847	
(List each licensed administrator separately.)			\$ 60,727			Less: Public Relations Expense	(137)	
						Non-allowable advertising	(2,398)	
						Yellow page advertising	(449)	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,341	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 631,412	
N/A				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
				Description	Line #	Amount		
TOTAL (agree to Schedule V, line 17, col. 3)				G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)								
C. Professional Services						Description	Amount	
Vendor/Payee	Type		Amount			Out-of-State Travel	\$	
Taylor Law Offices	Legal		\$ 105					
Altschuler, Melvoin & Glasser LLP	Accounting		23,009					
RSM McGladrey, Inc.	Accounting		1,740	N/A				
ADP	Payroll Services		19,071			In-State Travel	143	
Achieve	Computer Consulting		6,285					
						Seminar Expense		
						See attached	12,562	
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 50,210			TOTAL	\$ 12,705	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023Report Period Beginning: 10/01/2005Ending: 09/30/2006**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. Life Services Network of Illinois - \$4,394
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,288 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,560
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,944
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP 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. N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees