

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0019109

Facility Name: The Lutheran Home

Address: 6901 North Galena Road Peoria 61614
 Number City Zip Code

County: Peoria

Telephone Number: 314-968-9313 **Fax #** 314-968-5590

HFS ID Number: 370818454002

Date of Initial License for Current Owners: 2/25/2007

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 _____	<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: Paul Ogier **Telephone Number:** 314-968-9313

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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) Paul Ogier

(Title) CFO

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Deborah S Elsey
Principal

(Firm Name & Address) Larson Allen LLP
220 South Sixth Street- Suite 300, Minneapolis, MN 55402

(Telephone) 612-376-4646 Fax # 612-376-4850

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 The Lutheran Home

0019109 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 NA

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	85	TOTALS	85	31,025	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,426	21,185	3,868	28,479	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,426	21,185	3,868	28,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.79%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 06-01-1976

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 85 and days of care provided 3,868

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	304,979	24,350	21,826	351,155		351,155	(19,882)	331,273			1
2	Food Purchase		169,336		169,336	(7,337)	161,999		161,999			2
3	Housekeeping	156,518	18,437	245	175,200		175,200	(460)	174,740			3
4	Laundry	82,283	6,321	6,949	95,553		95,553		95,553			4
5	Heat and Other Utilities			83,315	83,315		83,315		83,315			5
6	Maintenance	107,605	10,061	135,272	252,938		252,938		252,938			6
7	Other (specify):*											7
8	TOTAL General Services	651,385	228,505	247,607	1,127,497	(7,337)	1,120,160	(20,342)	1,099,818			8
	B. Health Care and Programs											
9	Medical Director			3,851	3,851		3,851		3,851			9
10	Nursing and Medical Records	2,036,207			2,036,207	36,048	2,072,255	(720)	2,071,535			10
10a	Therapy			551,183	551,183		551,183		551,183			10a
11	Activities	71,837	17,525		89,362		89,362	660	90,022			11
12	Social Services	105,796	744	4,361	110,901		110,901		110,901			12
13	CNA Training											13
14	Program Transportation	7,479		3,911	11,390		11,390		11,390			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,221,319	18,269	563,306	2,802,894	36,048	2,838,942	(60)	2,838,882			16
	C. General Administration											
17	Administrative	46,217			46,217		46,217	85,350	131,567			17
18	Directors Fees											18
19	Professional Services			163,154	163,154	(860)	162,294	(120,153)	42,141			19
20	Dues, Fees, Subscriptions & Promotions			16,271	16,271	900	17,171	(595)	16,576			20
21	Clerical & General Office Expenses	16,928	10,066	67,866	94,860	(900)	93,960	(2,359)	91,601			21
22	Employee Benefits & Payroll Taxes			633,604	633,604	7,337	640,941	12,153	653,094			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,490	2,490	7,704	10,194	1,469	11,663			24
25	Other Admin. Staff Transportation			13,954	13,954	(7,704)	6,250	(1,091)	5,159			25
26	Insurance-Prop.Liab.Malpractice			28,898	28,898		28,898	928	29,826			26
27	Other (specify):* Marketing	4,549	756	102	5,407		5,407	(5,407)				27
28	TOTAL General Administration	67,694	10,822	926,339	1,004,855	6,477	1,011,332	(29,705)	981,627			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,940,398	257,596	1,737,252	4,935,246	35,188	4,970,434	(50,107)	4,920,327			29

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

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

Facility Name & ID Number The Lutheran Home

#0019109

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			309,761	309,761		309,761	(57,090)	252,671			30
31	Amortization of Pre-Op. & Org.			(2,450)	(2,450)		(2,450)	8,751	6,301			31
32	Interest			307,130	307,130		307,130	(175,975)	131,155			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							2,911	2,911			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			614,441	614,441		614,441	(221,403)	393,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		405,148	10,638	415,786	(35,188)	380,598		380,598			39
40	Barber and Beauty Shops			14,764	14,764		14,764	(14,764)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,538	46,538		46,538		46,538			42
43	Other (specify):* AL & IL			9,116,811	9,116,811		9,116,811	(9,116,811)				43
44	TOTAL Special Cost Centers		405,148	9,188,751	9,593,899	(35,188)	9,558,711	(9,131,575)	427,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,940,398	662,744	11,540,444	15,143,586		15,143,586	(9,403,085)	5,740,501			45

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,337)	1		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	(57,090)	30		9
10	Interest and Other Investment Income	(175,975)	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	(1,887)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,833)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(536)	21		24
25	Fund Raising, Advertising and Promotional	(2,749)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,151,678)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,403,085)		\$	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))	\$ (9,403,085)		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

The Lutheran HomeID# 0019109Report Period Beginning: 01/01/2007Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salaries	\$ (4,549)	27	1
2	Marketing Supplies	(756)	27	2
3	Marketing Other	(102)	27	3
4	Other Division Costs	(9,116,811)	43	4
5	Advance Funding Adjustment	8,751	31	5
6	Notions Income	(1,313)	21	6
7	Beauty Shop Income	(14,764)	40	7
8	Transportation Income	(1,165)	25	8
9	Guest Suite Rent	(460)	3	9
10	Telephone Charges	(471)	21	10
11	Personal Services Income	(720)	10	11
12	Miscellaneous Income	(515)	21	12
13	Home Office Marketing	(3,534)	17	13
14	Home Office Marketing	(544)	21	14
15	Home Office Marketing	(1,977)	20	15
16	Home Office Marketing	(203)	24	16
17	Assisted Living Dietary Consulting	(12,545)	1	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,151,678)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(19,882)	0	0	0	0	0	0	0	0	0	0	(19,882)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(460)	0	0	0	0	0	0	0	0	0	0	(460)	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	(20,342)	0	0	0	0	0	0	0	0	0	0	(20,342)	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	(720)	0	0	0	0	0	0	0	0	0	0	(720)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	660	0	0	0	0	0	0	0	0	0	660	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	(720)	660	0	(60)	16								
	C. General Administration													
17	Administrative	(3,534)	88,884	0	0	0	0	0	0	0	0	0	85,350	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,833)	(114,320)	0	0	0	0	0	0	0	0	0	(120,153)	19
20	Fees, Subscriptions & Promotions	(4,726)	4,131	0	0	0	0	0	0	0	0	0	(595)	20
21	Clerical & General Office Expenses	(5,266)	2,907	0	0	0	0	0	0	0	0	0	(2,359)	21
22	Employee Benefits & Payroll Taxes	0	12,153	0	0	0	0	0	0	0	0	0	12,153	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(203)	1,672	0	0	0	0	0	0	0	0	0	1,469	24
25	Other Admin. Staff Transportation	(1,165)	74	0	0	0	0	0	0	0	0	0	(1,091)	25
26	Insurance-Prop.Liab.Malpractice	0	928	0	0	0	0	0	0	0	0	0	928	26
27	Other (specify):*	(5,407)	0	0	0	0	0	0	0	0	0	0	(5,407)	27
28	TOTAL General Administration	(26,134)	(3,571)	0	(29,705)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,196)	(2,911)	0	(50,107)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(57,090)	0	0	0	0	0	0	0	0	0	0	(57,090)	30
31	Amortization of Pre-Op. & Org.	8,751	0	0	0	0	0	0	0	0	0	0	8,751	31
32	Interest	(175,975)	0	0	0	0	0	0	0	0	0	0	(175,975)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	2,911	0	0	0	0	0	0	0	0	0	2,911	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	(224,314)	2,911	0	(221,403)	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	(14,764)	0	0	0	0	0	0	0	0	0	0	(14,764)	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):*	(9,116,811)	0	0	0	0	0	0	0	0	0	0	(9,116,811)	43
44	TOTAL Special Cost Centers	(9,131,575)	0	0	0	0	0	0	0	0	0	0	(9,131,575)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,403,085)	0	0	0	0	0	0	0	0	0	0	(9,403,085)	45

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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
See attached Lisiting of Board Members						
				Lutheran Senior Servi	St. Loius, MO	Home Office

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management Fee	\$ 115,779	Lutheran Senior Services	100.00%	\$	\$ (115,779)	1
2	V	11 Home Office Allocation				660	660	2
3	V	17 Home Office Allocation				88,884	88,884	3
4	V	19 Home Office Allocation				1,459	1,459	4
5	V	20 Home Office Allocation				4,131	4,131	5
6	V	21 Home Office Allocation				2,907	2,907	6
7	V	22 Home Office Allocation				12,153	12,153	7
8	V	24 Home Office Allocation				1,672	1,672	8
9	V	25 Home Office Allocation				74	74	9
10	V	26 Home Office Allocation				928	928	10
11	V	34 Home Office Allocation				2,911	2,911	11
12	V							12
13	V							13
14	Total		\$ 115,779			\$ 115,779	\$ *	14

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

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Not Applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 Lutheran Senior Services
 Street Address 709 S Laclede Station Road
 City / State / Zip Code St. Louis, MO 63119
 Phone Number (314 968-9313
 Fax Number (314-968-5590

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Home Office	Direct Costs	7,375,082	42	\$ 7,375,082	\$ 4,748,780	115,779	\$ 115,779	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,375,082	\$ 4,748,780		\$ 115,779	25

Facility Name & ID Number

The Lutheran Home

0019109

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	IL Finance Authority -						\$	\$			\$	1						
2	2006 Bonds		X	Campus Expansion	\$198,745.00	7/19/2006	46,065,000	46,065,000	02/01/2037	5.0000	295,459	2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Lutheran Senior Services		X	Guarantee Fee					2/01/2007		11,671	6						
7												7						
8												8						
9	TOTAL Facility Related				\$198,745.00		\$ 46,065,000	\$ 46,065,000			\$ 307,130	9						
	B. Non-Facility Related*																	
10	Interest Income										(175,975)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(175,975)	14						
15	TOTALS (line 9+line14)						\$ 46,065,000	\$ 46,065,000			\$ 131,155	15						

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Lutheran Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0019109

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number The Lutheran Home

0019109 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lutheran Hillside Village operates -63 Assisted Living Units; 49 Patio Homes; 126 Independent Living Units and 20 Assisted Living Memory Loss units

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

1. Total Amount Incurred: 807,882 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 6,301 4. Dates Incurred: _____

Nature of Costs: Bond Issuance Costs

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1976	1976	\$ 1,676,061	\$		\$ 38,789	\$ 38,789	\$ 1,396,566	4
5			1984	1984	481,567			13,733	13,733	326,510	5
6			1986	1986	698,529			17,466	17,466	379,812	6
7											7
8											8
Improvement Type**											
9	Various		1976		58,237		20			58,237	9
10	Various		1978		4,465		20			4,465	10
11	Various		1979		149		20			149	11
12	Various		1980		470		20			470	12
13	Various		1982		403		20			403	13
14	Various		1983		1,717		20			1,717	14
15	Various		1984		2,946		20			2,946	15
16	Various		1985		3,290		20			3,290	16
17	Various		1986		5,335		20			5,335	17
18	Various		1987		18,303		20			18,303	18
19	Various		1988		66,182		20	1,756	1,756	45,771	19
20	Various		1990		134,732		20	3,305	3,305	63,029	20
21	Various		1991		40,069		20	1,091	1,091	19,489	21
22	Various		1992		890		20	29	29	478	22
23	Various		1993		748		20	42	42	651	23
24	Various		1994		5,993		20	193	193	2,793	24
25	Various		1995		36,256		20	1,747	1,747	22,925	25
26	Various		1996		43,073		20	1,369	1,369	20,648	26
27	Various		1997		32,988		20	664	664	17,409	27
28	Various		1998		13,903		20	857	857	8,852	28
29	Various		1999		122,497		20	8,635	8,635	112,191	29
30	Various		2000		63,646		20	3,432	3,432	26,238	30
31	Various		2001		190,577		20	15,679	15,679	109,753	31
32	Various		2002		1,912,111		20	57,217	57,217	343,302	32
33	Various		2003		319,328		20	16,337	16,337	81,685	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 The Lutheran Home

0019109

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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							(309,761)	69
70	TOTAL (lines 4 thru 69)	\$ 5,934,465	\$ 309,761		\$ 182,341	\$ (127,420)	\$ 3,073,417	70

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

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 5,934,465	\$ 309,761		\$ 182,341	\$ (127,420)	\$ 3,073,417	1
2	Lightpole At Main Entrance	2004	771		20	46	46	184	2
3	Hallway Remodel	2004	12,883		20	208	208	832	3
4	Backflow Preventors	2004	1,414		20	101	101	404	4
5	Energy Mgmt Program	2004	3,067		20	68	68	272	5
6	Common Room Conversion	2004	3,199		20	95	95	380	6
7	Hvac Condensing Units	2004	19,480		20	649	649	2,596	7
8	Chapel Emergency Lights	2004	139		20	9	9	36	8
9	Update Nursing Chapel	2004	227		20	14	14	56	9
10	Pump Motor	2004	813		20	42	42	167	10
11	Plumbing Repair	2004	761		20	38	38	152	11
12	Sidewalk	2004	3,157		20	158	158	632	12
13	Boiler	2004	746		20	37	37	149	13
14	Flush Valve	2004	501		20	25	25	100	14
15	Door Monitor	2004	700		20	35	35	140	15
16	Wing Renovation	2004	98,120		20	4,906	4,906	14,718	16
17	Memory Loss Courtyard	2004	74,846		20	3,742	3,742	11,226	17
18	Courtyard Fence	2005	5,230		20	262	262	785	18
19	Sunroom Installation	2005	4,620		20	231	231	693	19
20	Water Main Extension	2005	(29,172)		20	(1,459)	(1,459)	(4,376)	20
21	Fire Door Hardware	2005	5,573		20	279	279	836	21
22	Survey - Project #22	2005	37,230		20	1,862	1,862	5,585	22
23	Condensor Replacement	2005	33,795		20	1,690	1,690	5,070	23
24	Architecture On Building	2006	8,909		20	594	594	891	24
25	Roof Replacement	2007	30,000		20	125	125	125	25
26	Room Renovations	2007	14,463		20	60	60	60	26
27	Room Renovations	2007	14,266		20	59	59	59	27
28	Room Renovations	2007	14,266		20	59	59	59	28
29	Room Renovations	2007	14,266		20	119	119	119	29
30	Room Renovations	2007	14,059		20	176	176	176	30
31	Room Renovations	2007	14,276		20	178	178	178	31
32	Room Renovations	2007	7,252		20	121	121	121	32
33	Carnes Diffusers	2007	1,260		20	21	21	21	33
34	TOTAL (lines 1 thru 33)		\$ 6,345,582	\$ 309,761		\$ 196,890	\$ (112,871)	\$ 3,115,863	34

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

Facility Name & ID Number The Lutheran Home

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		\$ 6,345,582	\$ 309,761		\$ 196,890	\$ (112,871)	\$ 3,115,863	1
2	Room Renovations	2007	14,663		20	244	244	244	2
3	Water Heater	2007	39,438		20	1,643	1,643	1,643	3
4	Various Upgrades	2007	24,850		20	104	104	104	4
5	Medicine Cabinets	2007	1,386		20	6	6	6	5
6	Paints	2007	419		20	2	2	2	6
7	Flooring, Carpet and Vinyl	2007	463		20	2	2	2	7
8	Flooring, Carpet and Vinyl	2007	986		20	4	4	4	8
9	9 Vanity Tops	2007	1,598		20	7	7	7	9
10	Flooring, Carpet and Vinyl	2007	8,122		20	34	34	34	10
11	Flooring, Carpet and Vinyl	2007	705		20	3	3	3	11
12	Ceiling Tile and Accessories	2007	1,198		20	5	5	5	12
13	Water Heater	2007	4,484		20	19	19	19	13
14	Bathroom Fixtures	2007	751		20	38	38	38	14
15	3 Commodes	2007	670		20	3	3	3	15
16	Lighting Fixtures	2007	479		20	2	2	2	16
17	Cable and Wiring Upgrades	2007	2,960		20	12	12	12	17
18	Flooring, Carpet and Vinyl	2007	2,344		20	10	10	10	18
19	Flooring, Carpet and Vinyl	2007	2,692		20	11	11	11	19
20	Flooring, Carpet and Vinyl	2007	80		20	1	1	1	20
21	Window Treatments	2007	360		20	2	2	2	21
22	Window Treatments	2007	13,874		20	116	116	116	22
23	Flooring, Carpet and Vinyl	2007	15,746		20	131	131	131	23
24	Grab Bars	2007	6,052		20	50	50	50	24
25	Bathroom Accessories	2007	858		20	7	7	7	25
26	Fixtures	2007	3,261		20	27	27	27	26
27	Flooring, Carpet and Vinyl	2007	667		20	6	6	6	27
28	15 Commodes	2007	4,040		20	34	34	34	28
29	Flooring Carpet	2007	38,691		20	484	484	484	29
30	Hardware	2007	323		20	4	4	4	30
31	Counter and Vanity Tops	2007	2,822		20	35	35	35	31
32	Fixtures	2007	294		20	4	4	4	32
33	Painting	2007	2,953		20	37	37	37	33
34	TOTAL (lines 1 thru 33)		\$ 6,543,811	\$ 309,761		\$ 199,977	\$ (109,784)	\$ 3,118,950	34

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

Facility Name & ID Number The Lutheran Home

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		\$ 6,543,811	\$ 309,761		\$ 199,977	\$ (109,784)	\$ 3,118,950	1
2	Fixtures, Daybright Lights	2007	6,258		20	78	78	78	2
3	Shower Fixtures	2007	170		20	2	2	2	3
4	Safety Bars	2007	191		20	3	3	3	4
5	Ceramic Tile Flooring	2007	26,301		20	438	438	438	5
6	Lighting Fixtures	2007	283		20	5	5	5	6
7	Renovation Demolition	2007	968		20	16	16	16	7
8	28 Medicine Cabinets	2007	2,216		20	37	37	37	8
9	Flooring Carpet	2007	13,936		20	232	232	232	9
10	23 Smoke Dispenser	2007	270		20	5	5	5	10
11	14 Sewer Strainers	2007	152		20	3	3	3	11
12	15 Medicine Cabinets	2007	2,257		20	38	38	38	12
13	Insulation for Light Fixtures	2007	477		20	10	10	10	13
14	Lint Separator	2007	7,250		20	151	151	151	14
15	Ceiling Tile	2007	3,486		20	73	73	73	15
16	Flooring, Laminated	2007	1,386		20	29	29	29	16
17	Bathroom Fixtures	2007	1,658		20	41	41	41	17
18	Vanities, Hardware	2007	532		20	13	13	13	18
19	Kitchen Counters	2007	380		20	11	11	11	19
20	Window Treatments	2007	129		20	4	4	4	20
21	Counter Tops	2007	918		20	27	27	27	21
22	Sprinkler Systems	2007	52,400		20	1,747	1,747	1,747	22
23	Painting	2007	2,485		20	83	83	83	23
24	Flooring, Baseboard Trim	2007	2,109		20	70	70	70	24
25	Window Treatments	2007	409		20	15	15	15	25
26	Paneling	2007	624		20	23	23	23	26
27	Flooring, Carpet	2007	1,641		20	75	75	75	27
28	Storage Building	2007	2,691		20	11	11	11	28
29	Parking Lot Upgrades	2007	11,900		20	298	298	298	29
30	Sewer Upgrades	2007	9,030			301	301	301	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,696,318	\$ 309,761		\$ 203,816	\$ (105,945)	\$ 3,122,789	34

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

Facility Name & ID Number The Lutheran Home # 0019109 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 388,312	\$	\$ 35,027	\$ 35,027	10	\$ 183,725	71
72	Current Year Purchases	132,082		3,777	3,777	10	3,777	72
73	Fully Depreciated Assets	869,766				10	869,766	73
74								74
75	TOTALS	\$ 1,390,160	\$	\$ 38,804	\$ 38,804		\$ 1,057,268	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	Car & Silverado	2000	\$ 30,750	\$	\$ 3,281	\$ 3,281	8	\$ 29,790	76
77	Facility	Ford 2002 15 Pass	2002	56,998				5	56,998	77
78	Facility	Dodge Grand Caravan	2006	19,162		3,832	3,832	5	5,201	78
79	Facility	Vehicle Wheelchair converson	2007	16,026		2,938	2,938	5	2,938	79
80	TOTALS			\$ 122,936	\$	\$ 10,051	\$ 10,051		\$ 94,927	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)	\$ 8,538,482	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 309,761	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 252,671	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (57,090)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,274,984	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non Care Combined Assets	\$ 57,541,801	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 57,541,801	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Lutheran Home

0019109

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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.

Facility Name & ID Number The Lutheran Home# 0019109 Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$		\$ 203,698	\$		\$ 203,698	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs			87,702			87,702	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			256,391			256,391	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	C39-2	# of prescrpts				210,371		210,371	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			\$		\$ 547,791	\$ 210,371		\$ 758,162	14

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

Facility Name & ID Number The Lutheran Home# 0019109Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(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	\$ 3,246,330	\$	1
2	Cash-Patient Deposits	2,000		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 58,000)	953,450		3
4	Supply Inventory (priced at)	35,025		4
5	Short-Term Investments			5
6	Prepaid Insurance	54,557		6
7	Other Prepaid Expenses	43,308		7
8	Accounts Receivable (owners or related parties)	43,488		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,378,158	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,828,176		12
13	Land	369,068		13
14	Buildings, at Historical Cost	51,040,502		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	14,670,713		16
17	Accumulated Depreciation (book methods)	(17,153,922)		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 (spe CIP	8,458		22
23	Other(specify): <u>Bond Insurance Costs</u>	736,018		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 58,499,013	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 62,877,171	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 366,259	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	512,302		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,123		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	993,724		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Detail</u>	28,529,235		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 30,404,643	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	46,065,000		40
41	Bonds Payable			41
42	Deferred Compensation	1,745,385		42
	Other Long-Term Liabilities(specify):			
43	<u>Bond Premium</u>	451,564		43
44	<u>Due to Related Party</u>	447,911		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 48,709,860	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 79,114,503	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (16,237,332)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 62,877,171	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (13,387,669)	1
2	Restatements (describe):		2
3	<u>Amortization on Refundable Entrance Fees</u>	<u>(3,680,458)</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (17,068,127)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	830,795	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)	\$ 830,795	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)	\$ (16,237,332)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Lutheran Home# 0019109Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 5,798,152	1
2	Discounts and Allowances for all Levels	(447,019)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,351,133	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	834,022	6
7	Oxygen	21,567	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 855,589	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	1,770	12
13	Barber and Beauty Care	27,640	13
14	Non-Patient Meals	7,337	14
15	Telephone, Television and Radio	471	15
16	Rental of Facility Space		16
17	Sale of Drugs	252,481	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,862	19
20	Radiology and X-Ray		20
21	Other Medical Services	83,722	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 388,283	23
D. Non-Operating Revenue			
24	Contributions	182,357	24
25	Interest and Other Investment Income***	175,975	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 358,332	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	9,021,044	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,021,044	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,974,381	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,127,497	31
32	Health Care	2,802,894	32
33	General Administration	1,004,855	33
B. Capital Expense			
34	Ownership	614,441	34
C. Ancillary Expense			
35	Special Cost Centers	430,550	35
36	Provider Participation Fee	46,538	36
D. Other Expenses (specify):			
37	<u>Non-Reimbursable</u>	9,116,811	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,143,586	40
41	Income before Income Taxes (line 30 minus line 40)**	830,795	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 830,795	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 The Lutheran Home

0019109

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,824	2,040	\$ 60,933	\$ 29.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,621	21,920	511,230	23.32	3
4	Licensed Practical Nurses	26,246	28,600	588,500	20.58	4
5	CNAs & Orderlies	67,442	73,659	875,545	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,668	5,228	71,836	13.74	10
11	Social Service Workers	2,483	2,831	53,094	18.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,959	27,030	304,979	11.28	15
16	Dishwashers					16
17	Maintenance Workers	6,031	6,616	107,604	16.26	17
18	Housekeepers	21,091	22,958	156,518	6.82	18
19	Laundry	6,037	6,598	82,284	12.47	19
20	Administrator	1,515	1,710	46,217	27.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	938	1,068	16,928	15.85	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 Care(specify)					32
33	Other(specify) <u>Sch Attached</u>	2,598	2,722	64,730	23.78	33
34	TOTAL (lines 1 - 33)	185,453	202,980	\$ 2,940,398 *	\$ 14.49	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	182	\$ 9,084	V01-3	35
36	Medical Director	Monthly	3,851	V09-3	36
37	Medical Records Consultant	16	860	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,800	V10-3	39
40	Physical Therapy Consultant	54	2,986	V10a-3	40
41	Occupational Therapy Consultant	6	367	V10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	39	V10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,892	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	331	\$ 21,879		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Lutheran Home

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. 2292
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,388 Line 10
- (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. \$ 46,538
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,337
- (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. \$ NA
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
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. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson Allen, 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. _____
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.