

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519 Report Period Beginning: 9/1/2007 Ending: 8/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	15,731			15,731
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	15,731			15,731

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.77%

D. How many bed-hold days during this year were paid by the Department? 360 (Do not include bed-hold days in Section B.)

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

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/18/1990

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

YES Date Built 1989 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/2007 Fiscal Year: 08/31/2007

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2007 Ending: 8/31/2008

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	129,655	20,613	4,220	154,488		154,488	154,488			1
2	Food Purchase		62,793		62,793		62,793	62,793			2
3	Housekeeping	39,709	25,007		64,716		64,716	64,716			3
4	Laundry	113,186	5,802	31,702	150,690		150,690	150,690			4
5	Heat and Other Utilities			78,576	78,576	524	79,100	79,100			5
6	Maintenance	79,130	7,291	66,772	153,193	99	153,292	153,292			6
7	Other (specify):*			4,411	4,411		4,411	4,411			7
8	TOTAL General Services	361,680	121,506	185,681	668,867	623	669,490	669,490			8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600	15,600			9
10	Nursing and Medical Records	214,874	59,901	277,825	552,600		552,600	552,600			10
10a	Therapy	772,078		260	772,338		772,338	772,338			10a
11	Activities	34,207	7,339	6,654	48,200		48,200	48,200			11
12	Social Services	48,282			48,282		48,282	48,282			12
13	CNA Training										13
14	Program Transportation		18,933	16,765	35,698	1,128	36,826	(28,467)	8,359		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,069,441	86,173	317,104	1,472,718	1,128	1,473,846	(28,467)	1,445,379		16
	C. General Administration										
17	Administrative	125,536		56,655	182,191	(56,655)	125,536	125,536			17
18	Directors Fees										18
19	Professional Services					125	125	125			19
20	Dues, Fees, Subscriptions & Promotions			1,005	1,005	8,853	9,858	9,858			20
21	Clerical & General Office Expenses	62,676	6,522	8,842	78,040	8,042	86,082	86,082			21
22	Employee Benefits & Payroll Taxes			443,872	443,872	28,431	472,303	472,303			22
23	Inservice Training & Education					642	642	642			23
24	Travel and Seminar			295	295	5	300	300			24
25	Other Admin. Staff Transportation			2,476	2,476	2,358	4,834	4,834			25
26	Insurance-Prop.Liab.Malpractice			31,417	31,417	451	31,868	(5,727)	26,141		26
27	Other (specify):*										27
28	TOTAL General Administration	188,212	6,522	544,562	739,296	(7,748)	731,548	(5,727)	725,821		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,619,333	214,201	1,047,347	2,880,881	(5,997)	2,874,884	(34,194)	2,840,690		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 Bethesda Lutheran Home-Aurora

#0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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			148,112	148,112		148,112	(17,169)	130,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					5,997	5,997		5,997			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			148,112	148,112	5,997	154,109	(17,169)	136,940			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,409	154,409		154,409		154,409			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			154,409	154,409		154,409		154,409			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,619,333	214,201	1,349,868	3,183,402		3,183,402	(51,363)	3,132,039			45

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519Report Period Beginning: 9/1/2007Ending: 8/31/2008

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(51,363)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,363)		\$	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))	\$ (51,363)		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.

		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						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	
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Bethesda Lutheran Home-Aurora

ID# 0035519

Report Period Beginning: 9/1/2007

Ending: 8/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Program Transportation to/from Workshop	\$ (28,467)	14	1
2	Insurance on Vehicles for Workshop Transport	(5,727)	26	2
3	Depreciation on Vehicles for Workshop Transport	(17,169)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51,363)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(28,467)	0	0	0	0	0	0	0	0	0	0	(28,467)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(28,467)	0	0	0	0	0	0	0	0	0	0	(28,467)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(5,727)	0	0	0	0	0	0	0	0	0	0	(5,727)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,727)	0	0	0	0	0	0	0	0	0	0	(5,727)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,194)	0	0	0	0	0	0	0	0	0	0	(34,194)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007 Ending:

8/31/2008

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	(17,169)	0	0	0	0	0	0	0	0	0	0	(17,169)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,169)	0	(17,169)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,363)	0	(51,363)	45									

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Accounting Services	\$ 74,202	Bethesda Lutheran Homes & Services, Inc	100.00%	\$ 74,202	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 74,202			\$ 74,202	\$ *	14

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2007 Ending: 8/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning: 9/1/2007

Ending: 3/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Accounting Services	Client Days	319,561	\$ 1,473,613	\$ 1,085,435	16,091	\$ 74,202	1
2	17	Central Region Office	Client Days	62,549	300,183	155,931	16,091	77,223	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,773,796	\$ 1,241,366		\$ 151,425	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethesda Lutheran Home-Aurora COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0035519

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519 Report Period Beginning:

9/1/2007 Ending:

8/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Direct Care Building</u>		<u>1987</u>	<u>\$ 285,833</u>	1
2	<u>Land Improvements</u>		<u>1991-2008</u>	<u>58,564</u>	2
3	TOTALS			\$ 344,397	3

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	45			1989	\$ 1,919,083	\$ 63,969	30	\$ 63,969	\$	\$ 1,191,050	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Accoustical Ceiling		1991	8,725	291	30	291		4,947	9
10		Multi-purpose Room		1991	169,382	5,646	30	5,646		95,982	10
11		Replace Roof (partial)		1994	4,681	156	30	156		2,184	11
12		Shower Stalls		1994	2,950	98	30	98		1,372	12
13		Safety Lighting		1994	3,450	115	30	115		1,610	13
14		Replace Roof (partial)		1995	7,950	265	30	265		3,445	14
15		Wall Covering		1995	5,140	171	30	171		2,223	15
16		Fire Door		1995	699	23	30	23		299	16
17		Chair Rails		1998	6,253	208	30	208		2,080	17
18		Remodel Bathrooms (Repairs)		2001	2,730	91	30	91		728	18
19		Painting Wings		2001	6,000	200	30	200		1,600	19
20		Painting Wings		2002	9,150	305	30	305		2,135	20
21		Carpetomg		2004	3,600	120	30	120		600	21
22		Replace Roof (partial)		2004	6,120	204	30	204		1,020	22
23		New Air Handler		2005	9,450	315	30	315		1,260	23
24		Flooring		2005	4,878	163	30	163		652	24
25		Reroof Wing		2006	6,732	224	30	224		672	25
26		Plans for Remodeling		2006	6,250	2,083	3	2,083		4,374	26
27		Retile Shower Room		2006	9,280	309	30	309		927	27
28		Fire Sprinkler-Partial Replacement		2007	9,653	322	2	322		644	28
29		Plans for Remodeling		2007	7,000	2,333	30	2,333		4,666	29
30		Replace Roof -One Wing		2007	8,400	280	3	280		560	30
31		Heater/AC Unit		2007	16,153	538	30	538		1,076	31
32		Remodel Shower Room		2007	9,660	322	30	322		644	32
33		Walls-Painting, Tiling, Wainscoat, Chair Rails		2008	163,062	5,435	30	5,435		5,435	33
34		Remodel Bathroom		1995	2,036	68	30	68		884	34
35		Emergency Generator Upgrade		1999	8,700	290	30	290		5,268	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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 Generator Upgrade	2002	\$ 6,998	\$ 233	30	\$ 233	\$	\$ 1,320	37
38 Kitchen Repairs due to Sprinkler Damage	2006	5,000		2			5,000	38
39 Concrete Floor/Sewer Repair	2007	6,190	206	30	206		412	39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,435,355	\$ 84,983		\$ 84,983	\$	\$ 1,345,069	70

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2007 Ending: 8/31/2008

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	\$ 304,586	\$ 30,459	\$ 30,459	\$	10 yrs	\$ 399,601	71
72	Current Year Purchases	26,936	2,694	2,694			2,694	72
73	Fully Depreciated Assets	141,810						73
74								74
75	TOTALS	\$ 473,332	\$ 33,153	\$ 33,153	\$		\$ 402,295	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Clients	2004 Ford Econo Van	2004	\$ 23,248	\$ 4,648	\$ 4,648	\$	5	\$ 23,248	76
77	Transport Clients	2006 Ford Starcraft	2006	40,794	8,159	8,159		5	24,477	77
78	Maintenance	1991 Chevy Truck	1991	11,353					11,353	78
79										79
80	TOTALS			\$ 75,395	\$ 12,807	\$ 12,807	\$		\$ 59,078	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)	\$ 3,328,479	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,943	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,806,442	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	1998 Ford Bus/Acquired 1997	\$ 45,582	\$	\$ 45,582	86
87	2005 Ford Senator/Acquired 2005	42,827	8,565	34,260	87
88	2000 Ford Bus/Acquired 2000	45,508		45,508	88
89	2006 Ford Champion/Acquired 2006	43,019	8,604	17,208	89
90					90
91	TOTALS	\$ 176,936	\$ 17,169	\$ 142,558	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

**

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>40</u>	

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.

\$ 19,826

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>24</u>
2. From other facilities (f)	<u>11</u>
DROP-OUTS	
1. From this facility	<u>4</u>
2. From other facilities (f)	
TOTAL TRAINED	39

- (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 Bethesda Lutheran Home-Aurora# 0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7 8
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519Report Period Beginning: 9/1/2007

Ending:

8/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2008

(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	\$ 48,575	\$ 23,808,500	1
2	Cash-Patient Deposits		770,824	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>72,702</u>)	2,498,253	12,703,646	3
4	Supply Inventory (priced at <u>cost</u>)		326,222	4
5	Short-Term Investments			5
6	Prepaid Insurance		603,414	6
7	Other Prepaid Expenses		501,440	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest,Legacies, Pledges</u>		16,458,877	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,546,828	\$ 55,172,923	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		168,049,335	12
13	Land	344,397	16,521,983	13
14	Buildings, at Historical Cost	2,435,355	91,765,278	14
15	Leasehold Improvements, at Historical Cost		677,268	15
16	Equipment, at Historical Cost	725,663	33,806,493	16
17	Accumulated Depreciation (book methods)	(1,949,000)	(62,802,101)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>		3,330,367	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,556,415	\$ 251,348,623	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,103,243	\$ 306,521,546	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 197,917	\$ 5,239,680	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		500,020	28
29	Short-Term Notes Payable		100,598	29
30	Accrued Salaries Payable		1,553,091	30
31	Accrued Taxes Payable (excluding real estate taxes)		25,099	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		27,540	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Accrued Fringe Benefits</u>		4,221,195	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 197,917	\$ 11,667,223	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		828,530	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Long term Lease</u>		30,786	43
44	<u>Due to Beneficiaries</u>		11,294,506	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,153,822	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 197,917	\$ 23,821,045	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,905,326	\$ 282,700,501	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,103,243	\$ 306,521,546	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,789,385	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,789,385	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(350,492)	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)	\$ (350,492)	17
	B. Transfers (Itemize):		
18	Transfer Capital from Home Office	1,466,433	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,466,433	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,905,326	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519Report Period Beginning: 9/1/2007Ending: 8/31/2008**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,260,990	1
2	Discounts and Allowances for all Levels	(484,606)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,776,384	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	19,826	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,826	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Reimbursement for Workshop Transportation	36,700	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,700	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,832,910	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	668,867	31
32	Health Care	1,472,718	32
33	General Administration	739,296	33
B. Capital Expense			
34	Ownership	148,112	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	154,409	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,183,402	40
41	Income before Income Taxes (line 30 minus line 40)**	(350,492)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (350,492)	43

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

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

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

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2007

Ending:

8/31/2008

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	1,992	2,200	\$ 63,402	\$ 28.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	102	102	3,383	33.17	3
4	Licensed Practical Nurses	1,633	1,869	43,459	23.25	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,803	1,940	34,207	17.63	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,422	37,812	15.61	13
14	Head Cook	4,418	4,918	60,031	12.21	14
15	Cook Helpers/Assistants	3,451	3,723	31,812	8.54	15
16	Dishwashers					16
17	Maintenance Workers	5,411	6,239	79,130	12.68	17
18	Housekeepers	3,887	4,243	39,709	9.36	18
19	Laundry	9,150	9,150	113,186	12.37	19
20	Administrator	1,166	1,390	30,767	22.13	20
21	Assistant Administrator					21
22	Other Administrative	3,826	4,298	94,769	22.05	22
23	Office Manager					23
24	Clerical	3,788	4,155	62,676	15.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,103	3,270	48,282	14.77	28
29	Resident Services Coordinator	4,744	5,141	104,630	20.35	29
30	Habilitation Aides (DD Homes)	57,726	63,646	772,078	12.13	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,280	118,706	\$ 1,619,333 *	\$ 13.64	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	97	\$ 4,220	1-3	35
36	Medical Director	12	15,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	527	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	4	260	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatric Consultan</u>	6	1,200	10-3	46
47	<u>Behavioral Consultant</u>	10	19,278	10-3	47
48					48
49	TOTAL (lines 35 - 48)	141	\$ 41,085		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,026	\$ 96,022	10-3	50
51	Licensed Practical Nurses	3,521	137,877	10-3	51
52	Certified Nurse Assistants/Aides	250	5,344	10-3	52
53	TOTAL (lines 50 - 52)	5,797	\$ 239,243		53

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning: 9/1/2007

Ending: 8/31/2008

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	
Steve Inzerello	Administrator		\$ 23,462	Workers' Compensation Insurance	\$ 39,791	IDPH License Fee	\$ 8,027	
Gary Anderson	Administrator		7,305	Unemployment Compensation Insurance	7,623	Advertising: Employee Recruitment		
Regional Office Allocation	Administrative		40,114	FICA Taxes	116,629	Health Care Worker Background Check		
Home Office Allocation	Accounting Services		54,655	Employee Health Insurance	196,364	(Indicate # of checks performed)	826	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		FSSMC Certification	590	
				Employee disability insurance	18,905	Administrator's License	130	
				Pension	60,678	Exam-Administrator's License	285	
				Employee Physical Exams	3,141			
				Other Miscellaneous	741			
				Allocated Home Office Benefits	16,397	Less: Public Relations Expense	()	
				Allocated Regional Office Benefits	12,034	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,536	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Accounting Services-Home Office Allocation			\$ 19,546					
Administrative-Regional Office Allocation			37,109					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 56,655	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
			\$				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	300
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	TOTAL	\$ 300

* Attach copy of IMRF notifications

**See instructions.

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 154,409
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 84%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 36,700
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Virchow Krause & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Available-will forward ASAP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.