



Facility Name & ID Number Lutheran Care Center

# 0025023 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,962	15,368	2,472	28,802	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,962	15,368	2,472	28,802	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.97%

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)  
Daycare

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/01/1980

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/1980 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 96 and days of care provided 2,472

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/2008 Fiscal Year: 09/30/2008

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

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

**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
	<b>A. General Services</b>										
1	Dietary	299,523	31,096	7,023	337,642		337,642		337,642		1
2	Food Purchase		196,974		196,974		196,974	(21,065)	175,909		2
3	Housekeeping	91,117	21,711		112,828		112,828		112,828		3
4	Laundry	94,667	17,804		112,471		112,471		112,471		4
5	Heat and Other Utilities			113,641	113,641		113,641		113,641		5
6	Maintenance	46,710	5,239	25,766	77,715		77,715		77,715		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	532,017	272,824	146,430	951,271		951,271	(21,065)	930,206		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,257,671	72,994	2,461	1,333,126		1,333,126		1,333,126		10
10a	Therapy	144,352	2,093	261	146,706		146,706		146,706		10a
11	Activities	93,083	2,111	1,096	96,290		96,290	(463)	95,827		11
12	Social Services	41,432	493	561	42,486		42,486		42,486		12
13	CNA Training										13
14	Program Transportation		523		523		523		523		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,536,538	78,214	10,379	1,625,131		1,625,131	(463)	1,624,668		16
	<b>C. General Administration</b>										
17	Administrative	67,544			67,544		67,544		67,544		17
18	Directors Fees										18
19	Professional Services			63,031	63,031		63,031		63,031		19
20	Dues, Fees, Subscriptions & Promotions			13,990	13,990		13,990	(414)	13,576		20
21	Clerical & General Office Expenses	103,731	5,283	17,427	126,441		126,441	(5,609)	120,832		21
22	Employee Benefits & Payroll Taxes			655,735	655,735		655,735	(7,615)	648,120		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,322	3,322		3,322		3,322		24
25	Other Admin. Staff Transportation		7,586		7,586		7,586		7,586		25
26	Insurance-Prop.Liab.Malpractice			88,421	88,421		88,421		88,421		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	171,275	12,869	841,926	1,026,070		1,026,070	(13,638)	1,012,432		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,239,830	363,907	998,735	3,602,472		3,602,472	(35,166)	3,567,306		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## 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	
	<b>D. Ownership</b>											
30	Depreciation			122,558	122,558		122,558	21,762	144,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,488	37,488		37,488	(3,442)	34,046			32
33	Real Estate Taxes			547	547		547	(547)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,939	1,939		1,939		1,939			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			162,532	162,532		162,532	17,773	180,305			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,226	341	46,567		46,567		46,567			39
40	Barber and Beauty Shops			18,798	18,798		18,798		18,798			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,136	53,136		53,136		53,136			42
43	Other (specify):* <b>Non-allowable cost</b>	351,488	80,442	358,125	790,055		790,055	(790,055)				43
44	<b>TOTAL Special Cost Centers</b>	351,488	126,668	430,400	908,556		908,556	(790,055)	118,501			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,591,318	490,575	1,591,667	4,673,560		4,673,560	(807,448)	3,866,112			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,510)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,608)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,762	30		9
10	Interest and Other Investment Income	(3,442)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,582)	43		24
25	Fund Raising, Advertising and Promotional	(13,922)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(771,096)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (807,448)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (807,448)</b>		<b>37</b>

\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

ID# 0025023  
 Report Period Beginning: 10/01/2007  
 Ending: 09/30/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Medicare Lab Expense	\$ (3,212)	43	1
2	Disallow Medicare X-Ray Expense	(3,206)	43	2
3	Disallow Medicare Outpatient Expense	(7,053)	43	3
4	Disallow personal purchases	(416)	43	4
5	Offset dietary fund income against related expense	(2,555)	2	5
6	Offset various misc. revenues against misc. expense	(4,273)	21	6
7	Offset telephone income against telephone expense	(248)	21	7
8	Disallow non-allowable dues & charges	(125)	20	8
9	Disallow promotional advertising	(1,889)	20	9
10	Offset uniform income against uniform expense	(7,103)	22	10
11	Offset activities income against activities expens	(463)	11	11
12	Disallow non-care related real estate tax	(547)	33	12
13	Reclass EE Background Checks	(512)	22	13
14	Reclass EE Background Checks	512	20	14
15	Reclass Resident Background Checks	(1,088)	21	15
16	Reclass Resident Background Checks	1,088	20	16
17				17
18				18
19	Disallow non-care related salaries	(351,488)	43	19
20	Disallow non-care related supplies	(80,442)	43	20
21	Disallow non-care related expenses	(308,076)	43	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(771,096)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(21,065)	0	0	0	0	0	0	0	0	0	0	(21,065)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(21,065)</b>	<b>0</b>	<b>(21,065)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(463)	0	0	0	0	0	0	0	0	0	0	(463)	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	<b>TOTAL Health Care and Programs</b>	<b>(463)</b>	<b>0</b>	<b>(463)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(414)	0	0	0	0	0	0	0	0	0	0	(414)	20
21	Clerical & General Office Expenses	(5,609)	0	0	0	0	0	0	0	0	0	0	(5,609)	21
22	Employee Benefits & Payroll Taxes	(7,615)	0	0	0	0	0	0	0	0	0	0	(7,615)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(13,638)</b>	<b>0</b>	<b>(13,638)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(35,166)</b>	<b>0</b>	<b>(35,166)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/01/2007 Ending:

09/30/2008

## 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	21,762	0	0	0	0	0	0	0	0	0	0	21,762	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,442)	0	0	0	0	0	0	0	0	0	0	(3,442)	32
33	Real Estate Taxes	(547)	0	0	0	0	0	0	0	0	0	0	(547)	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	<b>TOTAL Ownership</b>	<b>17,773</b>	<b>0</b>	<b>17,773</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(790,055)	0	0	0	0	0	0	0	0	0	0	(790,055)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(790,055)</b>	<b>0</b>	<b>(790,055)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(807,448)</b>	<b>0</b>	<b>(807,448)</b>	<b>45</b>									

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	N/A		\$	\$	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		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

## 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	See attached schedule of Board of Directors										5
6	Note: No members of the Board of Directors provided services to the nursing home nor owned business entities that provided services to the nursing home.										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

# 0025023 Report Period Beginning: 10/01/2007 Ending: 9/30/2008

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

## 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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Midlands State Bank		X	Construction Loan	\$3,163.09	06/19/07	\$ 400,000	\$ 388,459	06/19/12	0.7250	\$ 28,609	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	First Mid-IL Bank & Trust		X	Line of Credit		06/18/07	225,000		demand	0.0750	8,879	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$3,163.09		\$ 625,000	\$ 388,459			\$ 37,488	9						
<b>B. Non-Facility Related*</b>																		
10	First Mid-IL Bank & Trust		X	Luther Terrace Mortgage	\$6,994.00	06/16/97	1,000,000	51,884	06/15/27	0.0750	4,594	10						
11												11						
12									Disallow nonallowable interest expense		(4,594)	12						
13									Interest Income Offset		(3,442)	13						
14	<b>TOTAL Non-Facility Related</b>				\$6,994.00		\$ 1,000,000	\$ 51,884			\$ (3,442)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,625,000	\$ 440,343			\$ 34,046	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2007 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.)		\$	N/A
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	N/A	12
<b>This entity is a not-for-profit facility and does not pay real estate taxes.</b>			
	<b>FOR BHF USE ONLY</b>		
	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 Lutheran Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0025023

CONTACT PERSON REGARDING THIS REPORT Karen Hille

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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. <u>                    </u>	<u>Vacant Lot</u>	<u>\$ 547.00</u>	<u>\$</u>
2. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
3. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
4. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
5. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
6. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
7. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
8. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
9. <u>                    </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
10. <u>                   </u>	<u>                                    </u>	<u>\$</u>	<u>\$</u>
<b>TOTALS</b>		<u>\$ 547.00</u>	<u>\$</u>

**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?  X  YES        NO

**NOTE: TAX IS FOR VACANT LAND. DISALLOWED ON SCH V, COL. 7.**

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007 Ending:

09/30/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,884 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

**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	96	1980	1969	\$ 867,500	\$	25	\$	\$	\$ 867,500	4
5		1980	1969	12,000		25			12,000	5
6		1980	1974	141,000		25			141,000	6
7		1980	1969	10,000		25			10,000	7
8		1980	1977	1,000		25			1,000	8
	<b>Improvement Type**</b>									
9	Therapy Room		1981	3,764		25			3,764	9
10	Land Improvements		1980	28,500		25			28,500	10
11	Land Improvements		1986	2,000	80	25	80		1,726	11
12	Land Improvements		1987	2,143	86	25	86		1,866	12
13	Land Improvements		1991	491	20	25	20		415	13
14	Building Improvements		1981	3,486		5			3,486	14
15	Building Improvements		1982	6,557		20			6,557	15
16	Building Improvements		1982	163		10			163	16
17	Building Improvements		1985	940		10			940	17
18	Building Improvements		1985	2,512		20			2,512	18
19	Building Improvements		1986	955		10			955	19
20	Building Improvements		1986	1,949		20			1,949	20
21	Building Improvements		1987	2,150		10			2,150	21
22	Building Improvements		1987	1,023		20			1,023	22
23	Building Improvements		1988	1,500		10			1,500	23
24	Building Improvements		1989	16,021		10			16,021	24
25	Building Improvements		1989	241		15			241	25
26	Building Improvements		1989	14,979		20			14,979	26
27	Building Improvements		1990	6,315		5			6,315	27
28	Building Improvements		1990	20,381		10			20,381	28
29	Building Improvements		1990	10,176		15			10,176	29
30	Building Improvements		1990	1,656	83	20	83		1,512	30
31	Building Improvements		1991	6,000		10			6,000	31
32	Building Improvements		1992	7,122		7			7,122	32
33	Building Improvements		1992	4,345		10			4,345	33
34	Misc Flooring/ Wallpaper		1993	3,762		5			3,762	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007 Ending: 09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room	1993	\$ 82,632	\$ 2,623	31.5	\$ 2,623	\$	\$ 39,019	37
38	Sprinkler System	1994	31,932	798	40	798		11,346	38
39	Additional Patio Work	1994	1,725	43	40	43		609	39
40	Dining Room Floor	1994	2,788	70	40	70		991	40
41	Breakroom Wallpaper	1994	302	8	40	8		113	41
42	Admin Office Wallpaper	1994	381	10	40	10		140	42
43	Lobby Wall Covering	1994	2,759	69	40	69		978	43
44	Floor Tile	1994	683	17	40	17		241	44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		496	45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		2,835	46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		300	47
48	Misc. Land Improvements	1994	1,279	32	40	32		456	48
49	Building Improvements	1995	7,804	195	40	195		2,672	49
50	Carpet for Lobby	1995	1,465		10			1,465	50
51	Office Wallpaper	1995	622		10			622	51
52	Front Office Wallpaper	1995	825		10			825	52
53	Activity Office Counter Top	1995	1,575		10			1,575	53
54	Flooring North Hall	1996	717		10			717	54
55	Air Conditioner Unit	1996	8,400		10			8,400	55
56	Air Conditioner Unit	1996	940		10			940	56
57	Air Conditioner Unit	1996	560		10			560	57
58	Gas Line	1996	947		10			947	58
59	Flooring Halls	1995	1,822		10			1,822	59
60	Flooring Halls	1994	1,267		10			1,267	60
61	Fire Alarm System	1996	2,429		10			2,429	61
62	Building Improvements	1996	697		10			697	62
63	Parking lot improvements	1997	1,500	75	20	75		863	63
64	Parking lot improvements	1997	2,510		10			2,510	64
65	Electrical wiring	1997	1,171		10			1,171	65
66	5 ton air conditioner unit	1997	5,330		10			5,330	66
67	Front entrance awning	1997	2,867		10			2,867	67
68	Electrical wiring	1997	966		10			966	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,359,743	\$ 4,464		\$ 4,464	\$	\$ 1,276,029	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007 Ending: 09/30/2008

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,359,743	\$ 4,464		\$ 4,464	\$	\$ 1,276,029	1
2	New administrative offices	1997	77,471		40	2,905	2,905	22,833	2
3	Dietary refrigeration system	1997	18,095		10			18,095	3
4	Cabinets & counter tops	1997	11,664		10			11,664	4
5	Roof	1998	178,417	8,921	20	8,921		93,670	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms)	1998	2,445	122	20	122		1,282	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms)	1998	384		10			384	7
8	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	834	45	10	45		834	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Rooms)	1998	3,548	175	10	175		3,548	9
10	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Medicare R	1998	2,576		10			2,576	10
11	Parking lot improvements	1998	1,298	64	10	64		1,298	11
12									12
13	Building Improvements - per 1994 audit	1981	1,140		10			1,140	13
14	Building Improvements - per 1994 audit	1982	2,159		10			2,159	14
15	Building Improvements - per 1994 audit	1984	1,677		10			1,677	15
16									16
17	Landscaping	1999	4,080	204	20	204		1,938	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295	30	10	30		283	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196	20	10	20		189	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474		10			1,474	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms)	1999	652	65	10	65		618	21
22	Cove base (Medicare room remodeling)	1999	77	10	10	10		77	22
23	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		1,500	23
24	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		3,354	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		2,159	25
26	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		1,284	26
27	Air Conditioner Improvements	1999	677		5			677	27
28	Wallcoverings, hand rails, chair rails (Remodeling - Medicare Rooms)	2000	1,684	168	10	168		1,429	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056	206	10	206		1,750	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59	6	10	6		54	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853	885	10	885		7,538	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59	6	10	6		51	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,699,093	\$ 16,264		\$ 19,169	\$ 2,905	\$ 1,461,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007 Ending: 09/30/2008

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,699,093	\$ 16,264		\$ 19,169	\$ 2,905	\$ 1,461,564	1
2	Sidewalk	2000	2,300	115	20	115		978	2
3	Flooring	2002	6,306	631	10	631		4,049	3
4	Windows	2002	3,635	364	10	364		2,245	4
5	Seed for lawn	2001	425	43	20	43		274	5
6	Chapel	2002	414,840	10,371	40	10,371		63,091	6
7	Windows	2002	26,539	2,654	10	2,654		16,145	7
8	Sidewalk	2002	2,083	208	10	208		1,265	8
9	Cabinets	2002	9,246	925	10	925		5,627	9
10	Wiring	2002	5,107	511	10	511		3,109	10
11	Landscaping	2002	6,280	628	10	628		3,820	11
12	Screen	2002	1,716	172	10	172		1,046	12
13	Cable	2002	7,954	795	10	795		4,836	13
14	Door guard	2002	4,955	496	10	496		3,017	14
15									15
16	Driveway & parking lot	2002	87,004	8,700	10	8,700		47,850	16
17	Plants/Rocks/Stone	2003	853	85	10	85		468	17
18	Window replacement project	2003	14,285	1,429	10	1,429		7,859	18
19	Laundry replacement	2002	1,983	198	10	198		1,089	19
20	Painting - hallways & west wing	2003	6,347	635	10	635		3,492	20
21	Painting - hallways	2003	2,230	223	10	223		1,227	21
22	Paintings - hallways	2003	5,000		10	500	500	2,500	22
23	Counter tops & cabinets	2003	696	99	7	99		545	23
24									24
25	Garage Expansion	2004	15,214	761	20	761		3,424	25
26	Room Painting and Wallpaper	2004	17,526	1,753	10	1,753		7,875	26
27	Painting building, trim, & eaves	2004	1,978	198	10	198		808	27
28	Generator	2004	160,787	16,078	10	16,078		65,653	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,504,382	\$ 64,336		\$ 67,741	\$ 3,405	\$ 1,713,856	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007 Ending: 09/30/2008

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,504,382	\$ 64,336		\$ 67,741	\$ 3,405	\$ 1,713,856	1
2	Paint	2004	371	37	10	37		145	2
3	Window Coverings	2004	3,307	331	10	331		1,296	3
4	Wiring	2004	11,383	569	20	569		2,181	4
5	Garage Expansion	2005	373	19	20	19		68	5
6	Window Tint	2005	510	51	10	51		183	6
7	Rocks	2005	116	12	10	12		37	7
8									8
9	Review fee to IDPH for Therapy Building Plans	2006	6,000	240	25	240		600	9
10	Architecture Fees for Therapy building	2006	26,205	1,048	25	1,048		2,620	10
11									11
12	Physical Therapy/Activity Room Addition	2007	365,881	18,294	20	18,294		27,473	12
13	Fire Sprinklers	2006	12,201	1,220	10	1,220		1,871	13
14	Gutters & Awnings	2007	4,840	484	10	484		710	14
15	Architecture Fees for Therapy building	2007	14,956	748	20	748		1,065	15
16	A/C Unit for Kitchen	2007	4,863	486	10	486		729	16
17	Cabinets	2007	4,741	474	10	474		731	17
18	Bath Tub w/ Lift	2007	16,560	1,656	10	1,656		2,139	18
19	Blinds/Wallpaper	2007	3,999	400	10	400		600	19
20									20
21	Seal Concrete	2008	2,951	105	7	211	106	211	21
22	Kitchen	2008	57,030	1,286	10-20	1,901	615	1,901	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,040,669	\$ 91,796		\$ 95,922	\$ 4,126	\$ 1,758,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lutheran Care Center

# 0025023

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

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	\$ 369,111	\$ 24,107	\$ 42,275	\$ 18,168	5-25	\$ 358,856	71
72	Current Year Purchases	49,879	5,520	4,988	(532)		4,988	72
73	Fully Depreciated Assets	383,758				5-7	383,758	73
74								74
75	TOTALS	\$ 802,748	\$ 29,627	\$ 47,263	\$ 17,636		\$ 747,602	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	2001 Dodge E250 van	2001	\$ 39,825	\$	\$	\$	5	\$ 39,825	76
77	Facility use	1990 Oldsmobile wagon	2001	3,340				3	3,340	77
78	Facility use	Chevy Lumina	2004	5,675	1,135	1,135		5	5,140	78
79										79
80	TOTALS			\$ 48,840	\$ 1,135	\$ 1,135	\$		\$ 48,305	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)	\$ 3,956,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,320	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,762	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,554,323	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		\$	\$	\$	86
87	Luther Villas & Luther Terrace	2,088,729	56,346	582,805	87
88					88
89	Child Enrichment Center	511,154	8,356	24,803	89
90					90
91	TOTALS	\$ 2,599,883	\$ 64,702	\$ 607,608	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Lutheran Care Center	\$ 71,079	92
93	CIP - Lutheran Villas	7,000	93
94			94
95		\$ 78,079	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

This amount was calculated by dividing the total amount to be amortized N/A  
by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 1,939 Description: Dishwasher Lease - \$489; Nursing Equipment - \$1,450

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1)	340 hrs	\$ 7,951		\$		340	\$ 7,951	1
2	Licensed Speech and Language Development Therapist	10A(1)	218 hrs	5,102				218	5,102	2
3	Licensed Recreational Therapist	10A(1,2,3)	3189 hrs	74,556	4	261	2,093	3,193	76,910	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	39(2)	# of prescripts				46,226		46,226	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			\$ 87,609	4	\$ 261	\$ 48,319	3,751	\$ 136,189	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lutheran Care Center

# 0025023

Report Period Beginning: 10/01/2007

Ending:

09/30/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 490,689	\$ 490,689	1
2	Cash-Patient Deposits	3,375	3,375	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,001 )	454,405	454,405	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	150,000	150,000	5
6	Prepaid Insurance	27,269	27,269	6
7	Other Prepaid Expenses	20,061	20,061	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,145,799	\$ 1,145,799	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	2,796,276	2,879,882	14
15	Leasehold Improvements, at Historical Cost	160,787	160,787	15
16	Equipment, at Historical Cost	856,690	851,588	16
17	Accumulated Depreciation (book methods)	(2,424,032)	(2,554,323)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (see Sch 17A)	83,423	83,423	22
23	Other(specify): <u>Net F/A Villas, Terrace &amp; CEC</u>	1,988,372	1,999,710	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,525,226	\$ 3,484,967	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,671,025	\$ 4,630,766	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 59,796	\$ 59,796	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,375	3,375	28
29	Short-Term Notes Payable	62,013	62,013	29
30	Accrued Salaries Payable	215,778	215,778	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,246	23,246	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,736	2,736	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Employee Withholdings</u>	3,185	3,185	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 373,044	\$ 373,044	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	378,330	378,330	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Lutheran Villas - Endowment Fund</u>	516,845	516,845	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 895,175	\$ 895,175	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,268,219	\$ 1,268,219	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,402,806	\$ 3,362,547	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,671,025	\$ 4,630,766	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lutheran Care Center  
Provider #: 0025023  
10/1/2007 to 9/30/2008

Schedule 17A

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

Line 22 Other Long Term Care Assets (specify):

Description	Operating	After Consolidation
LCC CIP - LCC Renovations	71,079	71,079
LV CIP - Villa in Process	7,000	7,000
LT Mortgage Costs	5,344	5,344
<b>Total Other Long Term Care Assets</b>	<b>83,423</b>	<b>83,423</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,182,610</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(98)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,182,512</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>220,294</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>220,294</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,402,806</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,215,391	1
2	Discounts and Allowances for all Levels	146,285	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,361,676	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	248,656	4
5	Other Care for Outpatients		5
6	Therapy	171,889	6
7	Oxygen	17,525	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 438,070	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,525	13
14	Non-Patient Meals	18,510	14
15	Telephone, Television and Radio	526	15
16	Rental of Facility Space		16
17	Sale of Drugs	69,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,010	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,870	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 168,780	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	417,770	24
25	Interest and Other Investment Income***	3,669	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 421,439	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	503,889	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 503,889	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,893,854	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	951,271	31
32	Health Care	1,625,131	32
33	General Administration	1,026,070	33
	<b>B. Capital Expense</b>		
34	Ownership	162,532	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	855,420	35
36	Provider Participation Fee	53,136	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,673,560	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	220,294	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 220,294	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No - NFP If not, please attach a reconciliation.

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

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

Lutheran Care Center  
Provider #: 0025023  
10/1/2007 to 9/30/2008

Schedule 19A

XVII. INCOME STATEMENT

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

Line 28

Description	Amount
Activity Fund Income	463
Dietary Fund Income	2,555
Personal Purchase Income	10,988
Employee Uniform Income	8,265
Miscellaneous Income	10,000
LV Rent Income - Luther Villas	125,262
Miscellaneous Income - LV	6,053
LT Rent Income	339,344
LT Employee Uniform Income - Terrace	564
LT Misc Income - Terrace	135
CEC Misc Income - CEC	77
CEC Employee Uniform Income	183
<b>Total Other Revenue</b>	<b>503,889</b>

Facility Name & ID Number Lutheran Care Center

# 0025023

Report Period Beginning: 10/01/2007

Ending: 09/30/2008

**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	1,881	2,093	\$ 52,737	\$ 25.20	1
2	Assistant Director of Nursing	2,112	2,168	46,807	21.59	2
3	Registered Nurses	6,075	7,098	140,993	19.86	3
4	Licensed Practical Nurses	16,116	18,457	279,188	15.13	4
5	CNAs & Orderlies	60,638	68,945	648,594	9.41	5
6	CNA Trainees					6
7	Licensed Therapist	3,527	3,748	87,609	23.37	7
8	Rehab/Therapy Aides	3,753	4,189	56,743	13.55	8
9	Activity Director	1,894	2,103	27,247	12.96	9
10	Activity Assistants	7,205	7,850	65,836	8.39	10
11	Social Service Workers	2,135	2,376	41,432	17.44	11
12	Dietician	1,833	2,104	31,529	14.99	12
13	Food Service Supervisor	1,936	2,180	21,549	9.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,145	28,683	246,445	8.59	15
16	Dishwashers					16
17	Maintenance Workers	3,267	3,844	46,710	12.15	17
18	Housekeepers	9,704	11,222	91,117	8.12	18
19	Laundry	8,563	9,907	94,667	9.56	19
20	Administrator	1,819	2,091	67,544	32.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,201	7,958	103,731	13.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	5,450	5,976	89,352	14.95	32
33	Other(specify) See Sch 20A	36,985	40,230	351,488	8.74	33
34	TOTAL (lines 1 - 33)	207,239	233,222	\$ 2,591,318 *	\$ 11.11	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	141	\$ 6,372	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	1,725	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	540	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	561	11(3)	44
45	Social Service Consultant	37	561	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	215	\$ 15,759		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lutheran Care Center**

**Provider #: 0025023**

**10/1/2007 to 9/30/2008**

**Schedule 20A**

XVIII. A: STAFFING AND SALARY COSTS

Line 32: Other Health Care (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Care Plan Nurse	1,931	2,175	42,266	19.43
Quality Assurance Coordinator	1,475	1,635	25,088	15.34
Ward Clerk	2,044	2,166	21,998	10.16
	<u>5,450</u>	<u>5,976</u>	<u>89,352</u>	<u>14.95</u>

Line 33: Other (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Independent Living Facility	14,613	16,688	141,500	8.48
Child Enrichment Center	22,372	23,542	209,988	8.92
	<u>36,985</u>	<u>40,230</u>	<u>351,488</u>	<u>8.74</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **Lutheran Care Center**

# **0025023**

Report Period Beginning: **10/01/2007**

Ending: **09/30/2008**

**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	
Karen Hille	Administrator	0	\$ 67,544	Workers' Compensation Insurance	\$ 136,597	IDPH License Fee	\$	
				Unemployment Compensation Insurance	9,811	Advertising: Employee Recruitment	1,153	
				FICA Taxes	160,206	Health Care Worker Background Check		
				Employee Health Insurance	317,052	(Indicate # of checks performed <u>32</u> )	512	
				Employee Meals		Patient Background Checks	68	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	4,700	
				Employee Physicals	1,505	MediaComm	1,054	
				Other Employee Benefits	22,949	Miscellaneous Dues/Fees & Subs	5,194	
						Promotional Advertising	1,889	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 67,544			Less: Public Relations Expense	(125)	
(List each licensed administrator separately.)						Non-allowable advertising	(1,889)	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 648,120	
N/A			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
				Description	Line #	Amount		
				N/A		\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)				Description			Amount	
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount	Out-of-State Travel			\$	
Taylor Law Offices	Legal		\$ 555					
McGladrey & Pullen LLP	Accounting		34,937	In-State Travel				
RSM McGladrey	Accounting		3,915					
ADP	Payroll Services		16,151	Seminar Expense				
Achieve	Computer Consulting		7,473	See Attached Schedules			3,322	
				Entertainment Expense			( )	
				TOTAL (agree to Sch. V, line 24, col. 8)			\$ 3,322	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 63,031	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023Report Period Beginning: 10/01/2007Ending: 09/30/2008**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. LSN - \$4700
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,636 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,136  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,510
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, 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? No If no, please explain. Audit not yet completed
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees