

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519 Report Period Beginning: 9/1/2008 Ending: 8/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS					14

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ 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: 8/31/2009 Fiscal Year: 8/31/2009

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora # 0035519 Report Period Beginning: 9/1/2008 Ending: 8/31/2009

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	131,871	16,097	4,613	152,581		152,581		152,581		1
2	Food Purchase		46,748		46,748		46,748		46,748		2
3	Housekeeping	42,940	16,211		59,151		59,151		59,151		3
4	Laundry	114,192	2,670	28,437	145,299		145,299		145,299		4
5	Heat and Other Utilities			75,046	75,046	514	75,560		75,560		5
6	Maintenance	75,072	2,941	43,738	121,751	2,353	124,104		124,104		6
7	Other (specify):* Waste Removal			6,197	6,197		6,197		6,197		7
8	TOTAL General Services	364,075	84,667	158,031	606,773	2,867	609,640		609,640		8
	B. Health Care and Programs										
9	Medical Director			11,700	11,700		11,700		11,700		9
10	Nursing and Medical Records	257,431	47,050	128,361	432,842	597	433,439		433,439		10
10a	Therapy	680,145			680,145		680,145		680,145		10a
11	Activities	30,571	2,041	5,759	38,371		38,371		38,371		11
12	Social Services	70,799			70,799		70,799		70,799		12
13	CNA Training										13
14	Program Transportation		10,877	19,307	30,184	982	31,166	(20,942)	10,224		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,038,946	59,968	165,127	1,264,041	1,579	1,265,620	(20,942)	1,244,678		16
	C. General Administration										
17	Administrative	211,098		55,435	266,533	(55,435)	211,098		211,098		17
18	Directors Fees										18
19	Professional Services					118	118		118		19
20	Dues, Fees, Subscriptions & Promotions			965	965	1,235	2,200		2,200		20
21	Clerical & General Office Expenses	64,346	5,862	11,050	81,258	7,609	88,867		88,867		21
22	Employee Benefits & Payroll Taxes			482,007	482,007	32,433	514,440		514,440		22
23	Inservice Training & Education					1,364	1,364		1,364		23
24	Travel and Seminar			125	125	320	445		445		24
25	Other Admin. Staff Transportation			753	753	1,751	2,504		2,504		25
26	Insurance-Prop.Liab.Malpractice			27,969	27,969	567	28,536	(5,576)	22,960		26
27	Other (specify):*										27
28	TOTAL General Administration	275,444	5,862	578,304	859,610	(10,038)	849,572	(5,576)	843,996		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,678,465	150,497	901,462	2,730,424	(5,592)	2,724,832	(26,518)	2,698,314		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			141,279	141,279		141,279	(17,169)	124,110			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					5,592	5,592		5,592			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			141,279	141,279	5,592	146,871	(17,169)	129,702			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			151,286	151,286		151,286		151,286			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			151,286	151,286		151,286		151,286			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,678,465	150,497	1,194,027	3,022,989		3,022,989	(43,687)	2,979,302			45

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

Bethesda Lutheran Home-Aurora

ID# 0035519

Report Period Beginning: 9/1/2008

Ending: 8/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Program Transportation to/rom Workshop	\$ (20,942)	14	1
2	Insurance on Vehicle for Workshop Transportation	(5,576)	26	2
3	Depreciation on Vehicles or 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	(43,687)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519

Report Period Beginning:

9/1/2008

Ending:

8/31/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(20,942)	0	0	0	0	0	0	0	0	0	0	(20,942)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(20,942)	0	(20,942)	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	(5,576)	0	0	0	0	0	0	0	0	0	0	(5,576)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,576)	0	(5,576)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,518)	0	(26,518)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519

Report Period Beginning:

9/1/2008 Ending:

8/31/2009

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

	Capital Expense	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)	
	D. Ownership													
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	0	0	0	0	0	0	0	0	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(43,687)	0	0	0	0	0	0	0	0	0	0	(43,687)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethesda Lutheran Homes & Services Inc	100%	Bethesda Lutheran Homes & Services Inc	Watertown, WI			
		Bethesda Lutheran Homes & Services Inc	Montgomery, IL			
		Bethesda Lutheran Homes & Services Inc	Plainfield, IL			
		Bethesda Lutheran Homes & Services Inc	Sycamore, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Accounting Services	\$ 78,924		100.00%	\$ 78,924	\$	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		\$ 78,924			\$ 78,924	\$ *	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: 9/1/2008 Ending: 8/31/2009

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:

9/1/2008

Ending: 3/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Bethesda Lutheran Homes & Services Inc

Street Address

600 Hoffmann Dr

City / State / Zip Code

Watertown, WI 53094

Phone Number

(920) 206-4458

Fax Number

(920) 206-7711

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.

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	308,794	\$ 1,668,120	\$ 1,234,489	14,610	\$ 78,924	1
2	17	Central Region Office	Client Days	59,150	342,597	201,228	14,610	84,621	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				\$ 2,010,717	\$ 1,435,717		\$ 163,545	25

Facility Name & ID Number

Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2008

Ending:

8/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10						
		Name of Lender					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		Related**	YES											NO	Original			
	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.)

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2008

Ending:

8/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning:

9/1/2008

Ending:

8/31/2009

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	\$	\$ 1,255,019	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Accoustical Ceiling		1991	8,725	291	30	291		5,238	9
10		Multi-purpose Room		1991	169,382	5,646	30	5,646		101,628	10
11		Replace Roof (Partial)		1994	4,681	156	30	156		2,340	11
12		Shower Stalls		1994	2,950	98	30	98		1,470	12
13		Safety Lighting		1994	3,450	115	30	115		1,725	13
14		Replace Roof (Partial)		1995	7,950	265	30	265		3,710	14
15		Wall Covering		1995	5,140	171	30	171		2,394	15
16		Fire Door		1995	699	23	30	23		322	16
17		Chair Rails		1998	6,253	208	30	208		2,288	17
18		Remodel Bathroom (Repairs)		2001	2,730	91	30	91		819	18
19		Paint Wings		2001	6,000	200	30	200		1,800	19
20		Paint Wings		2002	9,150	305	30	305		2,440	20
21		Carpeting		2004	3,600	120	30	120		720	21
22		Replace Roof (Partial)		2004	6,120	204	30	204		1,224	22
23		New Air Hanndler		2005	9,450	315	30	315		1,575	23
24		Flooring		2005	4,878	163	30	163		815	24
25		Reroof Wing		2006	6,732	224	30	224		896	25
26		Plans for Remodeling		2006	6,250	1,876	3	1,876		6,250	26
27		Retile Shower Room		2006	9,280	309	30	309		1,236	27
28		Fire Sprinkler-Partial Replacement		2007	9,653	322	30	322		966	28
29		Plans for Remodeling		2007	7,000	2,333	30	2,333		6,999	29
30		Replace Roof (One Wing)		2007	8,400	280	30	280		840	30
31		Heater A/C Unit		2007	16,153	538	30	538		1,614	31
32		Remodel Shower Room		2007	9,660	322	30	322		966	32
33		Walls-Painting, Tiling,Wainscoat,Chair Rails		2008	163,062	5,435	30	5,435		10,870	33
34		Remodel Bathroom		1995	2,036	68	30	68		952	34
35		Emergency Generator Upgrade		1999	8,700	290	30	290		5,558	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:

9/1/2008

Ending:

8/31/2009

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	2002	\$ 6,998	\$ 233	30	\$ 233	\$	\$ 1,553	37
38	2006	5,000		2			5,000	38
39	2007	6,190	206	30	206		618	39
40	2009	7,691	256	30	256		256	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)		\$ 2,443,046	\$ 85,032		\$ 85,032	\$ 1,430,101	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 309,165	\$ 30,917	\$ 30,917	\$	10 yr	\$ 433,212	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	164,167						73
74								74
75	TOTALS	\$ 473,332	\$ 30,917	\$ 30,917	\$		\$ 433,212	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	\$	\$	\$	5	\$ 23,248	76
77	Transport Clients	2006 Ford Starcraft	2006	40,794	8,159	8,159		5	32,636	77
78	Transport Clients									78
79										79
80	TOTALS			\$ 64,042	\$ 8,159	\$ 8,159	\$		\$ 55,884	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)	\$ 3,324,817	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,108	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,108	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)	\$ 1,919,197	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	8,567	42,827	87
88	2000 ord Bus/Acquired 2000	45,508		45,508	88
89	2006 ord Champion/Acquired 2006	43,019	8,604	25,812	89
90					90
91	TOTALS	\$ 176,936	\$ 17,171	\$ 159,729	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ 24,001

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>5</u>
2. From other facilities (f)	<u>15</u>
DROP-OUTS	
1. From this facility	<u>6</u>
2. From other facilities (f)	
TOTAL TRAINED	26

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

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

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

	Service	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		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**# **0035519**Report Period Beginning: **9/1/2008**Ending: **8/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **8/31/2009**

(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	\$ 45,441	\$ 28,922,890	1
2	Cash-Patient Deposits		1,104,002	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>190,000</u>)	1,056,664	11,340,434	3
4	Supply Inventory (priced at <u>Cost</u>)		307,500	4
5	Short-Term Investments			5
6	Prepaid Insurance		310,366	6
7	Other Prepaid Expenses		408,632	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest,Legacies,Pledges</u>		21,009,975	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,102,105	\$ 63,403,799	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		132,737,766	12
13	Land	344,397	17,593,724	13
14	Buildings, at Historical Cost	2,443,046	90,687,155	14
15	Leasehold Improvements, at Historical Cost		756,579	15
16	Equipment, at Historical Cost	714,310	35,709,362	16
17	Accumulated Depreciation (book methods)	(2,078,926)	(65,184,573)	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>		4,749,520	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,422,827	\$ 217,049,533	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,524,932	\$ 280,453,332	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 234,808	\$ 5,408,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		829,731	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		1,811,965	30
31	Accrued Taxes Payable (excluding real estate taxes)		48,386	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		27,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Accrued Fringe Benefits</u>		18,834,997	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 234,808	\$ 26,960,991	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		832,013	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>LT Lease</u>		754	43
44	<u>Due to Beneficiaries</u>		15,266,573	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,099,340	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 234,808	\$ 43,060,331	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,290,124	\$ 237,393,001	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,524,932	\$ 280,453,332	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,905,326	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,905,326	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(479,193)	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)	\$ (479,193)	17
	B. Transfers (Itemize):		
18	Transfer Capital to Home Office	(1,136,009)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,136,009)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,290,124	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethesda Lutheran Home-Aurora

0035519

Report Period Beginning: 9/1/2008

Ending: 8/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,923,334	1
2	Discounts and Allowances for all Levels	(438,251)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,485,083	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	24,001	11
12	Gift and Coffee Shop	196	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)	\$ 24,197	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	34,516	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,516	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,543,796	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	606,773	31
32	Health Care	1,264,041	32
33	General Administration	859,610	33
B. Capital Expense			
34	Ownership	141,279	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	151,286	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,022,989	40
41	Income before Income Taxes (line 30 minus line 40)**	(479,193)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (479,193)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NA 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:

9/1/2008

Ending:

8/31/2009

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	2,024	2,360	\$ 72,510	\$ 30.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,285	2,338	71,172	30.44	3
4	Licensed Practical Nurses	2,744	3,020	73,869	24.46	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,734	1,840	30,571	16.61	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,055	2,320	37,135	16.01	13
14	Head Cook	3,997	4,529	54,214	11.97	14
15	Cook Helpers/Assistants	4,461	4,617	40,522	8.78	15
16	Dishwashers					16
17	Maintenance Workers	5,151	6,011	75,072	12.49	17
18	Housekeepers	4,061	4,480	42,940	9.58	18
19	Laundry	9,150	9,150	114,192	12.48	19
20	Administrator	3,872	4,160	102,988	24.76	20
21	Assistant Administrator					21
22	Other Administrative	4,044	4,455	108,110	24.27	22
23	Office Manager					23
24	Clerical	3,759	4,163	64,346	15.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,826	4,157	70,799	17.03	28
29	Resident Services Coordinator	1,612	2,045	39,880	19.50	29
30	Habilitation Aides (DD Homes)	50,345	55,670	680,145	12.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,120	115,315	\$ 1,678,465 *	\$ 14.56	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	104	\$ 4,613	1-3	35
36	Medical Director	9	11,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	487	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				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatric Consultar</u>	6	1,200	10-3	46
47	<u>Behavioral Consultant</u>	11	18,176	10-3	47
48					48
49	TOTAL (lines 35 - 48)	142	\$ 36,176		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	795	\$ 30,155	10-3	50
51	Licensed Practical Nurses	1,326	58,500	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,121	\$ 88,655		53

Facility Name & ID Number Bethesda Lutheran Home-Aurora# 0035519Report Period Beginning: 9/1/2008Ending: 8/31/2009**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. \$ 151,286
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? 75%
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. \$ 34,516
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly Virchow Krause
- (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.