

Facility Name & ID Number Lutheran Care Center

0025023 Report Period Beginning: 10/01/2008 Ending: 09/30/2009

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 N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,246	16,257	3,464	28,967	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,246	16,257	3,464	28,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.67%

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

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 3,464

Medicare Intermediary Wisconsin Provider Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/2009 Fiscal Year: 09/30/2009

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

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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	303,411	32,876	6,742	343,029		343,029		343,029		1
2	Food Purchase		183,330		183,330		183,330	(19,976)	163,354		2
3	Housekeeping	96,493	20,383		116,876		116,876		116,876		3
4	Laundry	97,186	16,718		113,904		113,904		113,904		4
5	Heat and Other Utilities			122,038	122,038		122,038		122,038		5
6	Maintenance	46,756	5,205	23,311	75,272		75,272		75,272		6
7	Other (specify):*										7
8	TOTAL General Services	543,846	258,512	152,091	954,449		954,449	(19,976)	934,473		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,270,590	68,500	2,652	1,341,742		1,341,742	180	1,341,922		10
10a	Therapy	162,580	328	166	163,074		163,074		163,074		10a
11	Activities	99,273	1,781	51,098	152,152		152,152	(49,763)	102,389		11
12	Social Services	43,747	556	619	44,922		44,922		44,922		12
13	CNA Training										13
14	Program Transportation		2,123		2,123		2,123		2,123		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,576,190	73,288	60,535	1,710,013		1,710,013	(49,583)	1,660,430		16
	C. General Administration										
17	Administrative	71,923			71,923		71,923		71,923		17
18	Directors Fees										18
19	Professional Services			64,251	64,251		64,251	(921)	63,330		19
20	Dues, Fees, Subscriptions & Promotions			17,048	17,048		17,048	(368)	16,680		20
21	Clerical & General Office Expenses	110,425	4,979	21,638	137,042		137,042	(6,191)	130,851		21
22	Employee Benefits & Payroll Taxes			853,139	853,139		853,139	(7,678)	845,461		22
23	Inservice Training & Education			707	707		707		707		23
24	Travel and Seminar			2,273	2,273		2,273	(290)	1,983		24
25	Other Admin. Staff Transportation		4,096		4,096		4,096		4,096		25
26	Insurance-Prop.Liab.Malpractice			77,534	77,534		77,534		77,534		26
27	Other (specify):*										27
28	TOTAL General Administration	182,348	9,075	1,036,590	1,228,013		1,228,013	(15,448)	1,212,565		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,302,384	340,875	1,249,216	3,892,475		3,892,475	(85,007)	3,807,468		29

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

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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	
	D. Ownership											
30	Depreciation			123,897	123,897		123,897	26,202	150,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,679	35,679		35,679	(10,113)	25,566			32
33	Real Estate Taxes			376	376		376	(376)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			609	609		609		609			35
36	Other (specify):*											36
37	TOTAL Ownership			160,561	160,561		160,561	15,713	176,274			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,528		59,528		59,528		59,528			39
40	Barber and Beauty Shops			17,878	17,878		17,878		17,878			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):* Non-allowable cost	331,517	74,567	354,892	760,976		760,976	(760,976)				43
44	TOTAL Special Cost Centers	331,517	134,095	425,330	890,942		890,942	(760,976)	129,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,633,901	474,970	1,835,107	4,943,978		4,943,978	(830,270)	4,113,708			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.

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,976)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,388)	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	26,202	30		9
10	Interest and Other Investment Income	(10,113)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,668)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(805,327)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (830,270)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (830,270)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Medicare Lab Expense	\$ (10)	43	1
2	Disallow Medicare X-Ray Expense	(4,902)	43	2
3	Disallow Medicare Outpatient Expense	(6,372)	43	3
4	Disallow personal purchases	(690)	43	4
5	Offset various misc. revenues against misc. expense	(4,907)	21	5
6	Offset telephone income against telephone expense	(244)	21	6
7	Offset uniform income against uniform expense	(6,790)	22	7
8	Offset activities income against activities expense	(49,763)	11	8
9	Disallow promotional advertising	(2,257)	20	9
10	Disallow non-allowable dues & charges	(125)	20	10
11	Disallow non-allowable dues & charges	(24)	22	11
12	Disallow non-care real estate tax	(376)	33	12
13	Disallow non-care related salaries	(316,315)	43	13
14	Disallow non-care related supplies	(314,128)	43	14
15	Disallow non-care related expenses	(97,503)	43	15
16	Collections	(921)	19	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	(805,327)		49

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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.

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5	See attached schedule of Board of Directors									
6	Note: No members of the Board of Directors provided services to the nursing home nor owned business entities that provided services to the nursing home.									
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5			N/A						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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Midlands State Bank		X	Construction Loan	\$3,163.09	06/19/07	\$ 400,000	\$ 378,330	06/19/12	0.7250	\$ 27,828	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	First Mid-IL Bank & Trust		X	Line of Credit		06/18/08	275,000		06/18/10	0.0725	7,851	6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,163.09		\$ 675,000	\$ 378,330			\$ 35,679	9								
B. Non-Facility Related*																				
10	First Mid-IL Bank & Trust		X	Luther Terrace Mortgage	\$6,994.00	6/16/97	1,000,000		6/15/27	0.0750	277	10								
11												11								
12											Disallow nonallowable interest expense	(277)	12							
13											Interest Income Offset	(10,113)	13							
14	TOTAL Non-Facility Related				\$6,994.00		\$ 1,000,000	\$			\$ (10,113)	14								
15	TOTALS (line 9+line14)						\$ 1,675,000	\$ 378,330			\$ 25,566	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.)

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

(See instructions.)

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (cont)
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 2008 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.)		2008	\$	376	2
3. Under or (over) accrual (line 2 minus line 1).			\$	376	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND	\$	For		Tax Year.	
			\$	Non-Care Real Estate tax (376)	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:	2004			8	
	2005			9	
	2006			10	
	2007			11	
	2008	N/A		12	
This entity is a not-for-profit and does not pay real estate taxes					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

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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	TOTALS	436,500		\$ 63,900	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96	1980	1969	\$ 867,500	\$	25	\$	\$	\$ 867,500	4
5		1980	1969	12,000		25			12,000	5
6		1980	1974	141,000		25			141,000	6
7		1980	1969	10,000		25			10,000	7
8		1980	1977	1,000		25			1,000	8
Improvement Type**										
9	Therapy Room		1981	3,764		25			3,764	9
10	Land Improvements		1980	28,500		25			28,500	10
11	Land Improvements		1986	2,000	80	25	80		1,806	11
12	Land Improvements		1987	2,143	86	25	86		1,952	12
13	Land Improvements		1991	491	20	25	20		435	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		1,595	30
31	Building Improvements		1991	6,000		10			6,000	31
32	Building Improvements		1992	7,122		7			7,122	32
33	Building Improvements		1992	4,345		10			4,345	33
34	Misc Flooring/ Wallpaper		1993	3,762		5			3,762	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2008 Ending: 09/30/2009

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	
	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	\$	\$ 41,642	37
38	Sprinkler System	1994	31,932	798	40	798		12,144	38
39	Additional Patio Work	1994	1,725	43	40	43		652	39
40	Dining Room Floor	1994	2,788	70	40	70		1,061	40
41	Breakroom Wallpaper	1994	302	8	40	8		121	41
42	Admin Office Wallpaper	1994	381	10	40	10		150	42
43	Lobby Wall Covering	1994	2,759	69	40	69		1,047	43
44	Floor Tile	1994	683	17	40	17		258	44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		531	45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		3,034	46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		321	47
48	Misc. Land Improvements	1994	1,279	32	40	32		488	48
49	Building Improvements	1995	7,804	195	40	195		2,867	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		938	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	TOTAL (lines 4 thru 69)		\$ 1,359,743	\$ 4,464		\$ 4,464	\$	\$ 1,280,493	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/01/2008 Ending: 09/30/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,359,743	\$ 4,464		\$ 4,464	\$	\$ 1,280,493	1
2	New administrative offices	1997	77,471		40	2,905	2,905	25,738	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		102,591	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms)	1998	2,445	122	20	122		1,404	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms)	1998	384		10			384	7
8	Plumbing, paint, lumber (Remodeling-Medicare Rooms)	1998	834		10			834	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Rooms)	1998	3,548		10			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		10			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		2,142	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295	12	10	12		295	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196	7	10	7		196	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474		10			1,474	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms)	1999	652	34	10	34		652	21
22	Cove base (Medicare room remodeling)	1999	77		10			77	22
23	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		1,658	23
24	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		3,707	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		2,386	25
26	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		1,419	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		1,597	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056	206	10	206		1,956	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59	6	10	6		59	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853	885	10	885		8,423	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59	6	10	6		57	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,699,093	\$ 15,908		\$ 18,813	\$ 2,905	\$ 1,480,376	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:

10/01/2008 Ending: 09/30/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,699,093	\$ 15,908		\$ 18,813	\$ 2,905	\$ 1,480,376	1
2	Sidewalk	2000	2,300	115	20	115		1,093	2
3	Flooring	2002	6,306	631	10	631		4,680	3
4	Windows	2002	3,635	364	10	364		2,609	4
5	Seed for lawn	2001	425	43	20	43		317	5
6	Chapel	2002	414,840	10,371	40	10,371		73,462	6
7	Windows	2002	26,539	2,654	10	2,654		18,799	7
8	Sidewalk	2002	2,083	208	10	208		1,473	8
9	Cabinets	2002	9,246	925	10	925		6,552	9
10	Wiring	2002	5,107	511	10	511		3,620	10
11	Landscaping	2002	6,280	628	10	628		4,448	11
12	Screen	2002	1,716	172	10	172		1,218	12
13	Cable	2002	7,954	795	10	795		5,631	13
14	Door guard	2002	4,955	496	10	496		3,513	14
15									15
16	Driveway & parking lot	2002	87,004	8,700	10	8,700		56,550	16
17	Plants/Rocks/Stone	2003	853	85	10	85		553	17
18	Window replacement project	2003	14,285	1,429	10	1,429		9,288	18
19	Laundry replacement	2002	1,983	198	10	198		1,287	19
20	Painting - hallways & west wing	2003	6,347	635	10	635		4,127	20
21	Painting - hallways	2003	2,230	223	10	223		1,450	21
22	Paintings - hallways	2003	5,000		10	500	500	3,000	22
23	Counter tops & cabinets	2003	696	99	7	99		644	23
24									24
25	Garage Expansion	2004	15,214	761	20	761		4,185	25
26	Room Painting and Wallpaper	2004	17,526	1,753	10	1,753		9,628	26
27	Painting building, trim, & eaves	2004	1,978	198	10	198		1,006	27
28	Generator	2004	160,787	16,078	10	16,078		81,731	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,504,382	\$ 63,980		\$ 67,385	\$ 3,405	\$ 1,781,240	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:

10/01/2008 Ending: 09/30/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,504,382	\$ 63,980		\$ 67,385	\$ 3,405	\$ 1,781,240	1
2	Paint	2004	371	37	10	37		182	2
3	Window Coverings	2004	3,307	331	10	331		1,627	3
4	Wiring	2004	11,383	569	20	569		2,750	4
5	Garage Expansion	2005	373	19	20	19		87	5
6	Window Tint	2005	510	51	10	51		234	6
7	Rocks	2005	116	12	10	12		49	7
8									8
9	Review fee to IDPH for Therapy Building Plans	2006	6,000	240	25	240		840	9
10	Architecture Fees for Therapy building	2006	26,205	1,048	25	1,048		3,668	10
11									11
12	Physical Therapy/Activity Room Addition	2007	365,881	18,294	20	18,294		45,767	12
13	Fire Sprinklers	2006	12,201	1,220	10	1,220		3,091	13
14	Gutters & Awnings	2007	4,840	484	10	484		1,194	14
15	Architecture Fees for Therapy building	2007	14,956	748	20	748		1,813	15
16	A/C Unit for Kitchen	2007	4,863	486	10	486		1,215	16
17	Cabinets	2007	4,741	474	10	474		1,205	17
18	Bath Tub w/ Lift	2007	16,560	1,656	10	1,656		3,795	18
19	Blinds/Wallpaper	2007	3,999	400	10	400		1,000	19
20									20
21	Seal Concrete	2008	2,951	422	7	422		633	21
22	Kitchen	2008	57,030	3,802	10-20	3,802		5,703	22
23									23
24	CIP (Get more detail)	2009	71,079		15	2,369	2,369	2,369	24
25	Curt Reardon - Installation	2009	2,510	84	15	84		84	25
26	Lobby - Paint/Furniture	2009	5,768	192	15	192		192	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,120,026	\$ 94,549		\$ 100,323	\$ 5,774	\$ 1,858,738	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:

10/01/2008

Ending:

09/30/2009

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	\$ 368,344	\$ 26,980	\$ 47,408	\$ 20,428	5-25	\$ 360,606	71
72	Current Year Purchases	35,203	1,833	1,833		6-10	1,833	72
73	Fully Depreciated Assets	434,404				5-7	434,404	73
74								74
75	TOTALS	\$ 837,951	\$ 28,813	\$ 49,241	\$ 20,428		\$ 796,843	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	535	535		5	5,675	78
79										79
80	TOTALS			\$ 48,840	\$ 535	\$ 535	\$		\$ 48,840	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)		\$ 4,070,717	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 123,897	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 150,099	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 26,202	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,704,421	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	2,110,125	57,046	639,851	87
88					88
89	Child Enrichment Center	511,154	8,356	33,159	89
90					90
91	TOTALS	\$ 2,621,279	\$ 65,402	\$ 673,010	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Lutheran Villas	\$ 7,000	92
93			93
94			94
95		\$ 7,000	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				N/A			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 _____.

N/A

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: \$ 609 Description: Dishwasher Lease - \$539, Nursing Equipment - \$70

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1)	347 hrs	\$ 8,242		\$		347	\$ 8,242	1
2	Licensed Speech and Language Development Therapist	10A(1)	291 hrs	6,902				291	6,902	2
3	Licensed Recreational Therapist	10A(1,2,3)	3846 hrs	147,436	3	166	328	3,849	147,930	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				59,528		59,528	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			\$ 162,580	3	\$ 166	\$ 59,856	4,487	\$ 222,602	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 & ID Number **Lutheran Care Center**
XV. BALANCE SHEET - Unrestricted Operating Fund.

0025023
 As of **09/30/2009**

Report Period Beginning: **10/01/2008**
 (last day of reporting year)

Ending: **09/30/2009**

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 447,120	\$ 447,120	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>16,000</u>)	518,950	518,950	3
4	Supply Inventory (priced at _____)	15,279	15,279	4
5	Short-Term Investments			5
6	Prepaid Insurance	68,294	68,294	6
7	Other Prepaid Expenses	1,723	1,723	7
8	Accounts Receivable (owners or related parties)	477,221	477,221	8
9	Other(specify): _____	340,778	340,778	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,869,365	\$ 1,869,365	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	2,875,634	2,959,239	14
15	Leasehold Improvements, at Historical Cost	160,787	160,787	15
16	Equipment, at Historical Cost	891,893	886,791	16
17	Accumulated Depreciation (book methods)	(2,547,930)	(2,704,421)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe LV CIP _____)	7,000	7,000	22
23	Other(specify): <u>Net F/A Villas,Terrace CEC</u>	1,908,041	2,021,064	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,359,135	\$ 3,394,360	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,228,500	\$ 5,263,725	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,114	\$ 61,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	378,330	378,330	29
30	Accrued Salaries Payable	272,491	272,491	30
31	Accrued Taxes Payable (excluding real estate taxes)	137,445	137,445	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	484,154	484,154	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,336,449	\$ 1,336,449	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Lutheran Villas-Endowment Fund</u>	432,002	432,002	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 432,002	\$ 432,002	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,768,451	\$ 1,768,451	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,460,049	\$ 3,495,274	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,228,500	\$ 5,263,725	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lutheran Care Center
Provider # 0025023
10/1/08-9/30/09

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

Line 36

<u>Description</u>	<u>Amount</u>
State of Illinois Payable	2,736
Miscellaneous Withholding	76
Miscellaneous deduction	670
Resident allowances	30
Resident funds	3,421
Due from Terrace	100,000
Due from villa	297,221
Due to CEC	80,000
	<u>484,154</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,402,806	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,402,806	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,243	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)	\$ 57,243	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,460,049	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,405,461	1
2	Discounts and Allowances for all Levels	246,229	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,651,690	3
	B. Ancillary Revenue		
4	Day Care	225,150	4
5	Other Care for Outpatients		5
6	Therapy	221,157	6
7	Oxygen	19,574	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 465,881	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,241	13
14	Non-Patient Meals	19,473	14
15	Telephone, Television and Radio	389	15
16	Rental of Facility Space		16
17	Sale of Drugs	89,126	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,417	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,181	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 186,827	23
	D. Non-Operating Revenue		
24	Contributions	78,046	24
25	Interest and Other Investment Income***	28,817	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 106,863	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	589,960	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 589,960	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,001,221	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	954,449	31
32	Health Care	1,710,013	32
33	General Administration	1,228,013	33
	B. Capital Expense		
34	Ownership	160,561	34
	C. Ancillary Expense		
35	Special Cost Centers	838,382	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,943,978	40
41	Income before Income Taxes (line 30 minus line 40)**	57,243	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,243	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
10/1/08-9/30/09

Schedule 19A

XVII. INCOME STATEMENT

E. Other Revenue

Line 28

<u>Description</u>	<u>Amount</u>
Telephone Income	244
Activity Fund Income	49,763
Dietary Fund Income	3,241
Personal Purchase Income	11,931
Employee Uniform Income	6,790
Miscellaneous Income	4,235
LV Rent Income	193,900
LT Rent Income	319,317
LT Employee Uniform Income	313
CEC Employee Uniform Income	226
	<u>589,960</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning: 10/01/2008

Ending: 09/30/2009

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	1,921	2,154	\$ 56,406	\$ 26.19	1
2	Assistant Director of Nursing	1,064	1,152	25,473	22.12	2
3	Registered Nurses	5,971	6,419	132,585	20.66	3
4	Licensed Practical Nurses	17,023	18,801	278,301	14.80	4
5	CNAs & Orderlies	65,432	69,949	680,232	9.72	5
6	CNA Trainees					6
7	Licensed Therapist	4,198	4,485	106,442	23.73	7
8	Rehab/Therapy Aides	3,436	3,839	56,138	14.62	8
9	Activity Director	1,903	1,974	28,361	14.36	9
10	Activity Assistants	7,506	8,016	70,912	8.85	10
11	Social Service Workers	2,127	2,369	43,747	18.47	11
12	Dietician	1,924	2,094	32,056	15.31	12
13	Food Service Supervisor	1,916	2,092	23,950	11.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,626	31,737	247,405	7.80	15
16	Dishwashers					16
17	Maintenance Workers	3,494	3,774	46,756	12.39	17
18	Housekeepers	10,142	11,156	96,493	8.65	18
19	Laundry	8,883	9,788	97,186	9.93	19
20	Administrator	1,805	2,094	71,923	34.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,436	8,190	110,425	13.48	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 page 20A	6,082	6,507	97,593	15.00	32
33	Other(specify) See page 20A	33,894	36,506	331,517	9.08	33
34	TOTAL (lines 1 - 33)	215,783	233,095	\$ 2,633,901 *	\$ 11.30	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	139	\$ 6,387	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	1,760	10(3)	37
38	Nurse Consultant	Monthly	397	10(3)	38
39	Pharmacist Consultant	Monthly	495	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	39	602	11(3)	44
45	Social Service Consultant	37	575	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	215	\$ 16,216		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	0	0		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

Provider #: 0025023
10/1/2008 to 9/30/2009

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	1,972	2,188	44,093	20.15
Quality Assurance Coordinator	1,590	1,609	27,602	17.15
Ward Clerk	2,519	2,709	25,898	9.56
	<u>6,082</u>	<u>6,507</u>	<u>97,593</u>	<u>15.00</u>

Line 33: Other (specify)

	# of Hrs Actually Worked	# of Hrs Paid and Accrued	Total Salary & Wages	Average Hourly Wage
Independent Living Facility	13,259	14,402	138,524	9.62
Child Enrichment Center	20,634	22,104	192,993	8.73
	<u>33,894</u>	<u>36,506</u>	<u>331,517</u>	<u>9.08</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center
Provider # 0025023
10/1/08-9/30/09

Schedule 21C

XIX. Support Schedules
C. Professional Services

Schedule V, line 19, col. 3	64,251
Less Collections	-921
Schedule V, line 19, col. 8	<u>63,330</u>

See Accountants' Compilation Report

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023Report Period Beginning: 10/01/2008Ending: 09/30/2009**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? Yes
If YES, give association name and amount. LSN - \$5687
- (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. \$ 9,049 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,560
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 16,735
- (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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No
- (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

SEE ACCOUNTANTS' COMPILATION REPORT