

Ohio Department of Job and Family Services
MEDICAID ICF-MR COST REPORT

Type of Cost Report Filing pursuant to Ohio Administrative Code (Please check one of the following)			
<input checked="" type="checkbox"/> 4.1 Year-End	<input type="checkbox"/> 4.3 Change of Operator	<input type="checkbox"/> 4.5 Final	<input type="checkbox"/> 4.7 Capital
<input type="checkbox"/> 4.2 New Facility	<input type="checkbox"/> 4.4 Rate Reconsideration	<input type="checkbox"/> 4.6 Amended	

INSTRUCTIONS: This cost report must be received or postmarked pursuant to Ohio Administrative Code except for state operated ICFs-MR. Failure to file timely will result in reduction of the current prospective rate by two dollars (\$2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with Ohio Revised Code. Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit to Ohio Department of Job and Family Services Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414

Provider Name (DBA) Luther Home of Mercy	National Provider Identifier	Medicaid Provider Number 0035287	Medicare Provider Number 36-G023
Complete Facility Address Address(1) 5810 N Main St Address(2) P O Box 187 City Williston State of Ohio Zip Code 43468		Federal Tax ID Number 34-4441788	Period Covered by Cost Report
		ODH ID Number 1575	From 01/01/2005
		County OTTAWA	Through 12/31/2005

TYPE OF CONTROL OF PROVIDER- (Please check one of the following:)	PROVIDER LEGAL ENTITY IDENTIFICATION
For Profit <input type="checkbox"/> Sole Proprietorship (1.1) <input type="checkbox"/> Partnership (1.2) 1. General 2. Limited 3. Limited Liability Partnership <input type="checkbox"/> Corporation (1.3) <input type="checkbox"/> Limited Liability Company (1.5) <input type="checkbox"/> Business Trust (1.6) <input type="checkbox"/> Real Estate Investment Trust (REIT) (1.7) <input type="checkbox"/> Other: Specify _____ (1.4)	Name Of Legal Entity Luther Home of Mercy Address(1) 5810 N Main St Address(2) P O Box 187 City Williston State OH Zip Code 43468
	NAME AND ADDRESS OF OWNER OF REAL ESTATE
	Name Luther Home of Mercy Address(1) 5810 N Main St Address(2) P O Box 187 City Williston State OH Zip Code 43468

Location Of Entity, Organization, or Incorporation: If facility has a For Profit type of control, check one below <input type="checkbox"/> Domestic (1.8) <input type="checkbox"/> Foreign (1.9) Location: _____	
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Non-Profit <input type="checkbox"/> Domestic Non-Profit Corporation (2.4) <input type="checkbox"/> Foreign Non-Profit Corporation : Location _____ (2.5) <input type="checkbox"/> Other (non defined "non profit" entity): Specify _____ (2.6)	CARE SETTING Check all that apply <input type="checkbox"/> a. Rehab Hospital Based <input type="checkbox"/> b. General/Acute Hospital Based <input type="checkbox"/> c. Home For the Aging <input type="checkbox"/> d. Continuing Care Retirement Center (CCRC) <input type="checkbox"/> e. Other Assisted Living/Nursing Home Combo <input type="checkbox"/> f. Religious Non-Medical Health Care Institution <input type="checkbox"/> g. Free Standing <input type="checkbox"/> h. Combined with NF and/or Outlier Unit <input checked="" type="checkbox"/> i. Other: Specify: ICF/MR
Non-Federal Government <input type="checkbox"/> State (3.1) <input type="checkbox"/> County (3.2) <input checked="" type="checkbox"/> City (3.3) <input type="checkbox"/> City-County (3.4) <input type="checkbox"/> County - MR/DD Board (3.5) <input type="checkbox"/> Other (Specify Control) _____ <input type="checkbox"/> 2.1 Church (3.6)	

ALL PATIENTS	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
1. Licensed beds at beginning of period	129.0	129.0
** 2. Licensed beds at end of period	129.0	129.0
3. Total bed days available	47,085.0	47,085.0
4. Total inpatient days	42,533.0	42,533.0
5. Percentage of occupancy (line 4 divided by line 3 X 100)	90.33	90.33
6.1. Indirect allowable days (greater of line 4 or .85 X line 3)	42,533.0	42,533.0
6.2. Capital allowable days (greater of line 4 or .95 X line 3)	44,731.0	44,731.0

OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS	
7. Total patient days (from Schedule A-1, line 13, column 5)	42,521.0
8. Utilization Rate (line 7 divided by line 4, col. 1 X 100)	99.97

** If line 2 is different from col. 1, line 1, note date of change _____ and number of beds involved _____
 ** If line 2 is different from col. 1, line 1, note date of change _____ and number of beds involved _____
 ** If line 2 is different from col. 1, line 1, note date of change _____ and number of beds involved _____

CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through 12/31/2005
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CHAIN HOME OFFICE INFORMATION

This section is to be completed with information about the "HOME OFFICE" for those providers that are members of, or are joining, a chain organization

A. If this section does not apply check here X

B. Chain Home Office Information Change Effective Date: _____

1. Name Of Home Office As reported To The IRS _____ Federal Tax ID Number _____

2. Home Office Business Street Address Line 1 _____

Home Office Business Street Address Line 2 _____

City _____ State _____ Zip Code _____

C. Provider's Affiliation To The Chain Home Office Change Effective Date: _____

Check the appropriate box:

1. <input type="checkbox"/> Joint venture / Partnership	3. <input type="checkbox"/> Managed / Related	5. <input type="checkbox"/> Leased
2. <input type="checkbox"/> Operated / Related	4. <input type="checkbox"/> Wholly Owned	6. <input type="checkbox"/> Other (Specify): _____

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, REV. (10/05), all cost reports submitted to ODJFS will be certified as follows:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) **LUTHER HOME OF MERCY**, Medicaid Provider Number **0035287** for the cost report period beginning **1/1/2005** and ending **12/31/2005** and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider		Date of Signature
		03/27/2006
Print or Type Name of Owner, Officer, or Authorized Representative of Provider		
(Last) Wukotich	(First) Donald	(M.I.)
Title	Telephone Number	Fax Number
Executive Director	Area Code (419) 836-7741	Area Code (419) 836-9238

Report Prepared by (Company)		
Report Prepared by (Individual)		Title
(Last) Christophono	(First) Mark (M.I.)	Director Fiscal Services
Address 5810 N Main St P O Box 187		
City, State, Zip Code	Williston OH 43468	
Telephone Number of Person Preparing Cost Report	Fax Number	
Area Code (419) 725-5225	Area Code (419) 836-9238	
Location of Records or Probable Audit Site		Telephone Number for Audit Contact Person
Address 5810 N Main St P O Box 187		Area Code (419) 725-5225
		County OTTAWA
City	State	Zip Code
Williston	OH	43468

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this _____ day of _____ 20____ at _____, county of _____, and state of _____

Signature of Notary

SUMMARY OF INPATIENT DAYS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through: 12/31/2005
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INSTRUCTIONS: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January.

Month	Number of Medicaid Certified Beds (1)	Medicaid Patients				Non-Medicaid Patients			Total Inpatient Days (sum of cols. 5-8) (9)
		Authorized Days (2)	Hospital Leave Days (3)	Therapeutic Leave Days (4)	Total Medicaid Days (sum of cols. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January	129	3,531	31.0	22.0	3,584.0	12	0	0	3,596.0
2. February	129	3,185	29.0	2.0	3,216.0	0	0	0	3,216.0
3. March	129	3,444	36.0	26.0	3,506.0	0	0	0	3,506.0
4. April	129	3,435	17.0	10.0	3,462.0	0	0	0	3,462.0
5. May	129	3,609	3.0	15.0	3,627.0	0	0	0	3,627.0
6. June	129	3,525	0.0	0.0	3,525.0	0	0	0	3,525.0
7. July	129	3,602	22.0	34.0	3,658.0	0	0	0	3,658.0
8. August	129	3,637	8.0	13.0	3,658.0	0	0	0	3,658.0
9. September	129	3,499	14.0	24.0	3,537.0	0	0	0	3,537.0
10. October	129	3,583	14.0	14.0	3,611.0	0	0	0	3,611.0
11. November	129	3,451	13.0	46.0	3,510.0	0	0	0	3,510.0
12. December	129	3,573	4.0	50.0	3,627.0	0	0	0	3,627.0
13. TOTAL (sum of lines 1 through 12)		42,074	191.0	256.0	42,521.0	12	0	0	42,533.0
						Schedule A, page 1, line 7, column 2			Schedule A, page 1, line 4, column 1

4.1

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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INSTRUCTIONS: Enter gross charges for resident days reported in Schedule A-1 and Attachment 4. These gross charges must be reported from a uniform charge structure applicable to all residents.

Description SECTION A: REVENUES (1)	Medicare Part B Primary Payer is		Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
	Medicaid (2)	Other (3)					
1a. Medical Supplies Revenue	0	0	0	0	0	0	0
1b. Percentage (line 1a, each col. 2-7 divided by total on line 1a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
2a. Medical Minor Equipment	0	0	0	0	0	0	0
2b. Percentage (line 2a, each col. 2-7 divided by total on line 2a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3a. Enteral Feeding Revenue	0	0	0	0	0	0	0
3b. Percentage (line 3a, each col. 2-7 divided by total on line 3a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
4. TOTAL (Sum of 1a through 3a)	0	0	0	0	0	0	0

Description SECTION B: COSTS (1)	MEDICARE PART B OFFSET CALCULATIONS			
	Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)
5. Percentage of Medicare Part B Charges where primary payer is Medicaid (from Sch A-2, col. 2, applicable line b)	0.00%	0.00%	0.00%	
6. Costs (from Schedule B-1, column 3, lines 1 and 4 and Schedule C, column 3, line 10)	0	0	0	
7. Costs to be offset (line 5 times line 6). Offset costs in col. 4 on applicable cost report lines identified in line 6 of this section.	0	0	0	0

SECTION C: INDIRECT COST - OFFSET	
8. Indirect costs (Schedule C Line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col. 3)	1,918.027
9. Total costs (total of Sch. B-1 line 26, B-2 line 43, C line 63, D lines 11 and 13.)	13,393,628
10. Line 8 divided by line 9	0.1432
11. Costs offset (from line 7 column 5 above)	0
12. Indirect cost to be offset (line 10 times line 11) offset costs on Schedule C line 47 column 4	0

SUMMARY OF COSTS

Provider Name	Medicaid Provider Number	Reporting Period			
LUTHER HOME OF MERCY	0035287	From	01/01/2005	Through	12/31/2005
REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (Col 3 / 4) (5)
OTHER PROTECTED COSTS					
1. Other Protected Costs use allowable patient days Sch A line 4 Col 1	B1 line 26 Col 7		928,078	42,533.0	21.82
DIRECT CARE COST CENTER					
2. Direct Care Cost Use allowable patient days Sch A line 4 col 1	B2 line 43 Col 7		7,807,998	42,533.0	183.58
INDIRECT CARE COST CENTER					
3. Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7		3,844,073	42,533.0	90.38
CAPITAL COST CENTER					
COST OF OWNERSHIP					
4. Assets Acquired	D line 11 Col 7	622,801			
RENOVATIONS COST CENTER					
5. Renovations	D line 13 Col 7	112,523			
6. TOTAL Capital Cost (sum of lines 4 and 5) use allowable patient days Sch A line 6.2 Col 1			735,324	44,731.0	16.44
EQUITY					
7. Return on Equity	E1 line 36 Col 5				0.00
8. TOTAL REIMBURSABLE COSTS (sum of lines 1, 2, 3 and 6) Col 3			13,315,473		
9. TOTAL FILED COST PER DIEM (sum of lines 1, 2, 3, 6 and 7) Col 5					312.22

RECONCILIATION OF COSTS

Schedule/ Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt) Allocated Adjusted Total (4)
10. B1/26	col 3 928,078	col 4 0	col 5 928,078	col 7 928,078
11. B2/43	col 3 7,830,549	col 4 -22,551	col 5 7,807,998	col 7 7,807,998
12. C/80	col 3 7,294,833	col 4 -46,825	col 5 7,248,008	col 7 7,248,008
13. D *	col 3 748,894	col 4 -13,570	col 5 735,324	col 7 735,324
14. Totals	\$ 16,802,354 ^(A)	\$ -82,946 ^(B)	\$ 16,719,408	\$ 16,719,408
15. Less Non-Reimbursable from Schedule C Page 3 line 79			col 5 (3,403,935)	col 7 (3,403,935)
16. Total Reimbursable			\$ 13,315,473 ^(C)	\$ 13,315,473 ^(C)

* Summary of Schedule D lines 11 and 13.

(A) Agrees to Total Expenses per Working Trial Balance.

(B) Agrees to Attachment 2, line 21, Column 4, and Schedule A-2, lines 7 and 12, column 5.

(C) Agrees to Schedule A-3, line 8, Column 3.

NOTE: All cost data should be rounded to the nearest whole dollar.

OTHER PROTECTED COSTS

Schedule B-1

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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OTHER PROTECTED COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
MEDICAL SUPPLIES								
1. Medical Supplies - medicare billable	6000		0	0	0	0	1.0000	0
2. Medical Supplies - medicare non-billable	6001		46,113	46,113	0	46,113	1.0000	46,113
3. Oxygen - Emergency stand-by	6003		0	0	0	0	1.0000	0
4. Medical Minor Equip. - medicare billable	6005		0	0	0	0	1.0000	0
5. Medical Minor Equip. - medicare non-billable	6006		2,740	2,740	0	2,740	1.0000	2,740
6. TOTAL Medical Supplies (sum of lines 1 through 5)			48,853	48,853	0	48,853		48,853
UTILITY COSTS								
7. Heat, Light, Power	6020		270,421	270,421	0	270,421	1.0000	270,421
8. Water and Sewage	6030	2,341	136,457	138,798	0	138,798	1.0000	138,798
9. Trash and Refuse Removal	6040		12,846	12,846	0	12,846	1.0000	12,846
10. Hazardous Medical Waste Collection	6050		992	992	0	992	1.0000	992
11. TOTAL Utility Costs (sum of lines 7 through 10)		2,341	420,716	423,057	0	423,057		423,057
PROPERTY TAXES								
12. Real Estate Taxes	6060		2,739	2,739	0	2,739	1.0000	2,739
13. Personal Property Taxes	6070		0	0	0	0	1.0000	0
14. Franchise Tax (Attach FT 1120)	6080		0	0	0	0	1.0000	0
15. Commercial Activity Tax (CAT)	6085		0	0	0	0	1.0000	0
16. TOTAL Property Taxes (sum of line 12 through 15)			2,739	2,739	0	2,739		2,739
FRANCHISE PERMIT FEES								
17. Franchise Permit Fees	6091		453,429	453,429	0	453,429	1.0000	453,429
HOME OFFICE COSTS								
18. Home Office Costs/Other Protected**	6095		0	0	0	0	1.0000	0
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT								
19. Payroll Taxes - Other Protected	6054		0	0	0	0	1.0000	0
20. Workers Compensation - Other Protected	6055		0	0	0	0	1.0000	0
21. Employee Fringe Benefits - Other Protected	6056		0	0	0	0	1.0000	0
22. EAP Administrator - Other Protected	6057	0	0	0	0	0	1.0000	0
23. Self Funded Programs Adm. - Other Protected	6058	0	0	0	0	0	1.0000	0
24. Staff Development - Other Protected	6059	0	0	0	0	0	1.0000	0
25. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 19 thru 24)		0	0	0	0	0		0
26. TOTAL Other Protected Costs (sum of lines 6,11,16,17,18, and 25)		2,341	925,737	928,078	0	928,078		928,078

** Home office costs are to be entered on line 18 only. They are not be distributed to any other line on this schedule.

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
NURSING AND HABILITATION/REHABILITATION								
1. Medical Director	6100	0	80,400	80,400	-22,551	57,849	1.0000	57,849
2. Director of Nursing	6105	63,398	0	63,398	0	63,398	1.0000	63,398
3. RN Charge Nurse	6110	94,704	0	94,704	0	94,704	1.0000	94,704
4. LPN Charge Nurse	6115	0	0	0	0	0	1.0000	0
5. Registered Nurse	6120	425,628	0	425,628	0	425,628	1.0000	425,628
6. Licensed Practical Nurse	6125	623,374	0	623,374	0	623,374	1.0000	623,374
7. Nurse Aides	6130	0		0	0	0	1.0000	0
8. Activity Director	6135	31,096	0	31,096	0	31,096	1.0000	31,096
9. Activity Staff	6140	87,704	0	87,704	0	87,704	1.0000	87,704
10. Program Specialist	6150	0	0	0	0	0	1.0000	0
11. Program Director	6155	105,959	0	105,959	0	105,959	1.0000	105,959
12. Habilitation Supervisor	6165	401,518	0	401,518	0	401,518	1.0000	401,518
13. Habilitation Staff	6170	2,997,840	344,188	3,342,028	0	3,342,028	1.0000	3,342,028
14. Psychologist	6175	0	1,680	1,680	0	1,680	1.0000	1,680
15. Psychology Assistant	6180	0	0	0	0	0	1.0000	0
16. Respiratory Therapist	6185	0	0	0	0	0	1.0000	0
17. Social Work/Counseling	6190	75,366	0	75,366	0	75,366	1.0000	75,366
18. Social Services/Pastoral Care	6195	39,624	0	39,624	0	39,624	1.0000	39,624
19. Qualified Mental Retardation Professional	6200	267,654	2,061	269,715	0	269,715	1.0000	269,715
20. Quality Assurance	6205	0	0	0	0	0	1.0000	0
21. Consulting and Management Fees-Direct Care	6210		15,265	15,265	0	15,265	1.0000	15,265
22. Other Direct Care - Specify Below	6220	0	2,538	2,538	0	2,538	1.0000	2,538
23. Home Office Costs/Direct Care	6230	0	0	0	0	0	1.0000	0
24. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 23)		5,213,865	446,132	5,659,997	-22,551	5,637,446		5,637,446
PURCHASED NURSING SERVICES								
25. Registered Nurse - Purchased Nursing	6300		0	0	0	0	1.0000	0
26. Licensed Practical Nurse - Purchased Nursing	6310		0	0	0	0	1.0000	0
27. Nurse Aides - Purchased Nursing	6320		0	0	0	0	1.0000	0
28. TOTAL Purchased Nursing (sum of lines 25 through 27)			0	0	0	0		0

Line 22 Other Direct Care

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 22, Columns 1 and 2	0	2,538

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Provider Name LUTHER HOME OF MERCY		Medicaid Provider Number 0035287		Reporting Period From: 1/1/2005 Through: 12/31/2005				
DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
DIRECT CARE THERAPIES								
29. Physical Therapist	6600	58,400	2,465	60,865	0	60,865	1.0000	60,865
30. Physical Therapy Assistant	6605	103,112	0	103,112	0	103,112	1.0000	103,112
31. Occupational Therapist	6610	0	0	0	0	0	1.0000	0
32. Occupational Therapy Assistant	6615	168,733	0	168,733	0	168,733	1.0000	168,733
33. Speech Therapist	6620	122,063	42,350	164,413	0	164,413	1.0000	164,413
34. Audiologist	6630	0	0	0	0	0	1.0000	0
35. TOTAL Direct Care Therapies (sum of lines 29 through 34)		452,308	44,815	497,123	0	497,123		497,123
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT (No Purchased Nursing)								
36. Payroll Taxes - Direct Care	6510		452,434	452,434	0	452,434	1.0000	452,434
37. Workers' Compensation - Direct Care	6520		196,696	196,696	0	196,696	1.0000	196,696
38. Employee Fringe Benefits - Direct Care	6530		992,448	992,448	0	992,448	1.0000	992,448
39. EAP Administrator - Direct Care	6535	0	0	0	0	0	1.0000	0
40. Self Funded Programs Admin. - Direct Care	6540	0	0	0	0	0	1.0000	0
41. Staff Development - Direct Care	6550	27,235	4,616	31,851	0	31,851	1.0000	31,851
42. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 36 thru 41)		27,235	1,646,194	1,673,429	0	1,673,429		1,673,429
43. TOTAL Reimbursable Direct Care Cost (sum of lines 24, 28, 35 and 42)		5,693,408	2,137,141	7,830,549	-22,551	7,807,998		7,807,998

Note: All cost data should be rounded to the nearest whole dollar.

INDIRECT CARE COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
DIETARY COST								
1. Dietitian	7000	0	0	0	0	0	1.0000	0
2. Food Service Supervisor	7005	27,440	0	27,440	0	27,440	1.0000	27,440
3. Dietary Personnel	7015	402,652	1,234	403,886	0	403,886	1.0000	403,886
4. Dietary Supplies and Expenses	7025		35,667	35,667	0	35,667	1.0000	35,667
5. Dietary Minor Equipment	7030		249	249	0	249	1.0000	249
6. Dietary Maintenance and Repair	7035		6,086	6,086	0	6,086	1.0000	6,086
7. Food In-Facility	7040		271,246	271,246	-634	270,612	1.0000	270,612
8. Employee Meals	7045		0	0	0	0	1.0000	0
9. Contract Meals/Contract Meals Personnel	7050		0	0	0	0	1.0000	0
10. Enterals: Medicare Billable	7055		0	0	0	0	1.0000	0
11. Enterals: Medicare Non-Billable	7056		3,341	3,341	0	3,341	1.0000	3,341
12. Payroll Taxes - Dietary	7060		34,936	34,936	0	34,936	1.0000	34,936
13. Workers' Compensation - Dietary	7065		16,295	16,295	0	16,295	1.0000	16,295
14. Employee Fringe Benefits - Dietary	7070		94,115	94,115	0	94,115	1.0000	94,115
15. EAP Administrator - Dietary	7075	0	0	0	0	0	1.0000	0
16. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	1.0000	0
17. Staff Development - Dietary	7090	0	1,764	1,764	0	1,764	1.0000	1,764
18. TOTAL Dietary (sum of lines 1 through 17)		430,092	464,933	895,025	-634	894,391		894,391
MEDICAL, HABILITATION, PHARMACY AND INCONTINENCE SUPPLIES								
19. Habilitation Supplies	7100		1,291	1,291	0	1,291	1.0000	1,291
20. Medical/Habilitation Records	7105	38,244	0	38,244	0	38,244	1.0000	38,244
21. Pharmaceutical Consultant	7110	0	0	0	0	0	1.0000	0
22. Incontinence Supplies	7115		62,459	62,459	0	62,459	1.0000	62,459
23. Personal Care - Supplies	7120		48,211	48,211	0	48,211	1.0000	48,211
24. Program Supplies	7125		4,101	4,101	0	4,101	1.0000	4,101
25. TOTAL Habilitation, Pharmacy and Incontinence Supplies (sum of lines 19 through 24)		38,244	116,062	154,306	0	154,306		154,306
ADMINISTRATIVE & GENERAL SERVICES								
26. Administrator	7200	108,734	0	108,734	0	108,734	1.0000	108,734
27. Other Administrative Personnel	7210	376,729	0	376,729	-41,400	335,329	1.0000	335,329
28. Consulting and Management Fees - Indirect	7215		226,012	226,012	0	226,012	1.0000	226,012
29. Office and Administrative Supplies	7220		27,989	27,989	0	27,989	1.0000	27,989
30. Communications	7225		33,347	33,347	0	33,347	1.0000	33,347
31. Security Services	7230	0	52,736	52,736	0	52,736	1.0000	52,736
32. Travel and Entertainment	7235		0	0	0	0	1.0000	0
33. SUB-TOTAL (sum of lines 26 through 32)		485,463	340,084	825,547	-41,400	784,147		784,147

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

INDIRECT CARE COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
ADMINISTRATIVE & GENERAL SERVICES								
34. Laundry/Housekeeping Supervisor	7240	50,868	0	50,868	0	50,868	1.0000	50,868
35. Housekeeping	7245	358,339	39,519	397,858	0	397,858	1.0000	397,858
36. Laundry and Linen	7250	160,463	32,079	192,542	0	192,542	1.0000	192,542
37. Universal Precaution Supplies	7255		15,421	15,421	0	15,421	1.0000	15,421
38. Legal Services	7260		76,045	76,045	0	76,045	1.0000	76,045
39. Accounting	7265	131,809	43,006	174,815	0	174,815	1.0000	174,815
40. Dues, Subscriptions and Licenses	7270		70,958	70,958	0	70,958	1.0000	70,958
41. Interest - Other	7275		0	0	0	0	1.0000	0
42. Insurance	7280		129,482	129,482	0	129,482	1.0000	129,482
43. Data Services	7285	38,448	24,838	63,286	0	63,286	1.0000	63,286
44. Help Wanted/Informational Advertising	7290		4,977	4,977	0	4,977	1.0000	4,977
45. Amortization of Start-Up Costs	7295		0	0	0	0	1.0000	0
46. Amortization of Organizational Costs	7300		0	0	0	0	1.0000	0
47. Other Indirect Care - Specify below	7305	0	0	0	0	0	1.0000	0
48. Home Office Costs/Indirect Care **	7310	0	0	0	0	0	1.0000	0
49. TOTAL Administrative and General Services (sum of lines 34 thru 48 and 33)		1,225,390	776,409	2,001,799	-41,400	1,960,399		1,960,399
MAINTENANCE AND MINOR EQUIPMENT								
50. Plant Operations/Maintenance Supervisor	7320	39,624	0	39,624	0	39,624	1.0000	39,624
51. Plant Operations and Maintenance	7330	101,257		101,257	0	101,257	1.0000	101,257
52. Repair and Maintenance	7340		123,368	123,368	0	123,368	1.0000	123,368
53. Minor Equipment	7350		13,232	13,232	0	13,232	1.0000	13,232
54. Leased Equipment	7400		0	0	0	0	1.0000	0
55. TOTAL Maintenance and Minor Equipment (sum of lines 50 through 54)		140,881	136,600	277,481	0	277,481		277,481
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT								
56. Payroll Taxes - Indirect Care	7500		90,747	90,747	0	90,747	1.0000	90,747
57. Workers' Compensation - Indirect Care	7510		31,316	31,316	0	31,316	1.0000	31,316
58. Employee Fringe Benefits - Indirect Care	7520		417,758	417,758	0	417,758	1.0000	417,758
59. EAP Administrator - Indirect Care	7525	0	0	0	0	0	1.0000	0
60. Self Funded Prog. Admin. - Indirect Care	7530	0	0	0	0	0	1.0000	0
61. Staff Development - Indirect Care	7535	0	17,675	17,675	0	17,675	1.0000	17,675
62. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 56 thru 61)		0	557,496	557,496	0	557,496		557,496
63. TOTAL Reimbursable Indirect Care Cost (sum of lines 18, 25, 49, 55 and 62)		1,834,607	2,051,500	3,886,107	-42,034	3,844,073		3,844,073

Line 47 Other Indirect Care - Specify Below

Account Title	Salary Column 1	Other Column 2
Totals (must tie to line 47, Columns 1 and 2)		

*** If allocation is used, limit the precision to four places to the right of the decimal.
 Note: All cost data should be rounded to the nearest whole dollar.

INDIRECT CARE COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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NON-REIMBURSABLE EXPENSES	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
NON-REIMBURSABLE EXPENSES								
64. Legend Drugs	9705		21,566	21,566	0	21,566	1.0000	21,566
65. Radiology	9710		0	0	0	0	1.0000	0
66. Laboratory	9715		0	0	0	0	1.0000	0
67. Oxygen	9720		0	0	0	0	1.0000	0
68. Other Non-Reimbursable - Specify Below	9725	1,884,745	943,649	2,828,394	-4,791	2,823,603	1.0000	2,823,603
69. Late Fees, Fines or Penalties	9730		0	0	0	0	1.0000	0
70. Federal Income Tax	9735		0	0	0	0	1.0000	0
71. State Income Tax	9740		0	0	0	0	1.0000	0
72. Local Income Tax	9745		0	0	0	0	1.0000	0
73. Insurance - Officer's Life	9750		0	0	0	0	1.0000	0
74. Promotional Advertising and Marketing	9755	57,222	55,007	112,229	0	112,229	1.0000	112,229
75. Contributions and Donations	9760		32,440	32,440	0	32,440	1.0000	32,440
76. Bad Debt	9765		0	0	0	0	1.0000	0
77. Parenteral Nutrition Therapy	9770		0	0	0	0	1.0000	0
78. Active Treatment Off-site Day Programming	9775	78,400	335,697	414,097	0	414,097	1.0000	414,097
79. TOTAL Non-Reimbursable (sum of lines 64 thru 78)		2,020,367	1,388,359	3,408,726	-4,791	3,403,935		3,403,935
80. TOTAL Indirect Care Cost Reimbursable and Non-Reimbursable (sum of lines 63 and 79)		3,854,974	3,439,859	7,294,833	-46,825	7,248,008		7,248,008

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ADMINISTRATORS COMPENSATION

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through: 12/31/2005
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SECTION A:

First Name of Administrator Donald	Last Name of Administrator Wukotich	Administrator License Number* XXXXXXXXXXXX	Social Security No. XXX-XX-XXXX
Relationship to Provider: Is the administrator an owner/relative? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
1. Base percentage allowance			100%
2. Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years)			
		<u>10</u>	Times 4 = <u>40%</u>
3. Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate is not obtained)			
		<u>6</u>	Times 5 = <u>30%</u>
3.1 Was baccalaureate degree obtained? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
4. Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)			
a. Accounting		0	
b. Maintenance		0	
c. Housekeeping		0	
d. Other, specify		0	
d. Other, specify		0	
Total Duties		0	Times 4 = <u>0%</u>
5. County Adjustment (see instructions)			0%
6. Ownership Points (see instructions)			0%
7. Subtotal of lines 1 through 6			170%
8. Allowance Percentage (enter line 7, not to exceed 150%)			150%

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Paid Weekly		Compensation		
Beginning Date (MMDDYY)	Ending Date (MMDDYY)	Hrs. **	%	Account Number ***	Column Number	Amount
(1)	(2)	(3)	(4)	(5)	(6)	(7)
01/01/2005	12/31/2005	40.00	100.00	7200	7	108.734
TOTAL COMPENSATION						108.734

* QMRPS AND ADMINISTRATORS OF HOSPITAL BASED ICFs-MR REPORT SOCIAL SECURITY NUMBER.

** REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN (7) IS ALLOCATED, HOURS PAID MUST BE ALLOCATED USING THE SAME RATIO.

*** THIS SCHEDULE MUST BE COMPLETED FOR ALL ADMINISTRATORS REGARDLESS OF WHETHER THE ADMINISTRATOR'S SALARY IS REPORTED IN ACCOUNT NUMBER 7200 OR ACCOUNT NUMBER 7310. (USE ONLY ACCOUNT NUMBER 7200 OR 7310 WHICHEVER IS APPROPRIATE.)

OWNERS'/RELATIVES' COMPENSATION
OTHER THAN COMPENSATION FOR FACILITY ADMINISTRATOR DUTIES

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through: 12/31/2005
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Instructions: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed.

Detail owners and/or relatives compensation included on JFS 02524, Schedules B-1, B-2 and C net of applicable column 4 adjustments.

Individual's Name (1)	Social Security Number (2)	Position Number ** (3)	Relationship to Owner (4)	Years of Exper. (5)	Dates of Employment During this Reporting Period		Paid Weekly		Compensation		
					Beginning (6)	Ending (7)	Hrs. * (8)	% (9)	Account Number (10)	Col. No. (11)	Amount (12)

* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 12 IS ALLOCATED, HOURS PAID MUST BE ALLOCATED THE SAME WAY.
** SEE COST REPORT INSTRUCTIONS PAGES 22, 23, 24 AND 25 FOR POSITION NUMBERS.

COST OF SERVICES FROM RELATED PARTIES

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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1. In the amount of costs to be reimbursed by the Ohio Medicaid Program, are any costs included which are a result of transactions with a related party? *
 ___ Yes X No If Yes, complete item 2

2. Does this cost report include payments to related parties in excess of the costs to the related party?
 ___ Yes X No If Yes, complete the table below

Name of Owner (1)	Social Security No. (2)	Name of Related Party (3)	Federal ID. No. (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Party (9)

* FOR FURTHER EXPLANATION PLEASE SEE OHIO ADMINISTRATIVE CODE

COST OF SERVICES FROM RELATED PARTIES

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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3. List each individual, partner, related corporation, or related LLC which owns, in whole or in part, any mortgage or deed of trust, of the facility or of any property or asset of the provider.
(All individuals owning greater than 10% of the land or building, and/or greater than 5% of non real estate business, etc., must be identified by name and Social Security number.) *

Name	Title/Position (if applicable)	% Ownership	SSN or Fed ID #	Address	State	Zip Code

4. List all persons performing the duties of officer, director or equivalence (President, VP, Secretary, or other related positions).

Name	Social Security Number	Job Title
Lyle Schulte	XXX-XX-XXXX	President
James Van Brussell	XXX-XX-XXXX	First Vice President
Terri Hetrick	XXX-XX-XXXX	Second Vice President
Bonnie Newby	XXX-XX-XXXX	Secretary
Mark Storer	XXX-XX-XXXX	Treasurer

5. List all other facilities that have related ownership as set forth in Section 5111.20 of the ORC.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

* FOR FURTHER EXPLANATION PLEASE SEE OHIO ADMINISTRATIVE CODE

COST OF SERVICES FROM RELATED PARTIES

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?

Yes No If yes, list names below:

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Job and Family Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, the Ohio Department of Commerce, or the Ohio Department of Industrial Commission within the previous twelve months?

Yes No If yes, list names below:

Name	Social Security Number	Name	Social Security Number

8. List all contracts in effect during the cost report period for which the imputed value or cost of the service from any individual or organization is ten thousand dollars or more in a twelve month period.

Contractor Name	Contract Amount	Goods or Services Provided
ESSN	279,372	Contract Nursing/Direct Care
Aramark Service Master	205,997	Management Services
Neiman Odeh	80,400	Medical Director
Noslars	42,350	Speech Therapy
Plante & Moran	45,945	Auditing
Spengler Nathanson	61,339	Legal

CAPITAL COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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ASSETS ACQUIRED

COST OF OWNERSHIP (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 - Col 4) (5)	Alloc. *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
1. Depreciation - Building	8010	363,195	0	363,195	1.0000	363,195
2. Amortization - Land Improvements	8020	11,263	0	11,263	1.0000	11,263
3. Amortization - Leasehold Improvements	8030	0	0	0	1.0000	0
4. Depreciation - Equipment	8040	115,202	-103	115,099	1.0000	115,099
5. Depreciation - Transportation Equipment	8050	14,679	0	14,679	1.0000	14,679
6. Lease and Rent - Building	8060	0	0	0	1.0000	0
7. Lease and Rent - Equipment	8065	20,656	0	20,656	1.0000	20,656
8. Interest Exp. - Prop., Plant and Equip.	8070	92,765	-13,467	79,298	1.0000	79,298
9. Amortization of Financing Costs	8080	18,611	0	18,611	1.0000	18,611
10. Home Office Costs/Capital Cost **	8090	0	0	0	1.0000	0
11. TOTAL Cost of Ownership (sum of lines 1 through 10)		636,371	-13,570	622,801		622,801

** Home Office Costs are to be entered on line 10 only. They are not to be distributed to any other line in Cost of Ownership.

RENOVATIONS

INSTRUCTIONS: Complete for renovations in use during cost report period reimbursable under Ohio Administrative Code.

RENOVATIONS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
12. Depreciation/Amortization and Interest	8500,8570,8580	112,523	0	112,523	1.0000	112,523
13. Total Renovations		112,523	0	112,523		112,523

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

4.1

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Schedule D-1

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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ASSETS ACQUIRED

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 - Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
1. Land		261,774	-15,325	246,449		246,449	
2. Buildings		9,432,429	28,568	9,460,997	4,830,215	4,630,782	363,195
3. Land Improvements		367,142	6,328	373,470	282,659	90,811	11,263
4. Leasehold Improvements		0	0	0	0	0	0
5. Equipment		2,792,369	81,289	2,873,658	2,303,502	570,156	115,202
6. Transportation		264,942	7,744	272,686	238,319	34,367	14,679
7. Financing Costs		274,415	0	274,415	192,839	81,576	18,611
8. TOTAL		13,393,071	108,604	13,501,675	7,847,534	5,654,141	522,950

Has there been any change in the original historical cost of capital assets?

YES

NO X

If yes, submit complete detail.

RENOVATIONS

INSTRUCTIONS: Complete for renovations in use during cost report period reimbursable under Ohio Administrative Code.

ACCOUNT	Cost at Beginning of Period (1)	Additions or Reductions (2)	Project Cost End of Period (Col 1 + Col 2) (3)	Accumulated Depreciation End of Period (4)	Net Book Value End of Period (Col 3 - Col 4) (5)	Depreciation/ Amortization this Period (6)	Interest this Period (7)	Total Columns 6 and 7 (8) **
9. Depreciation/Amortization and Interest	2,127,437	0	2,127,437	1,221,491	905,946	85,662	26,861	112,523
10. TOTAL	2,127,437	0	2,127,437	1,221,491	905,946	85,662	26,861	112,523

** Transfer TOTAL of column 8 to Schedule D, column 3, line 12.

BALANCE SHEET

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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CURRENT ASSETS	Chart of Acct. No.	BALANCE PER BOOKS	
		Beginning of Period	End of Period
1. Petty Cash	1001	850	850
2. Cash In Banks - General Account	1010	193,723	393,666
3. Accounts Receivable	1030	1,233,152	1,396,213
4. Allowance For Uncollectible Accounts	1040	0	0
5. Notes Receivable	1050	0	0
6. Allowance For Uncollectible Notes Receivable	1060	0	0
7. Other Receivables	1070	70,474	30,196
8. Cost Settlement	1080	0	0
9. Inventories	1090	22,638	22,638
10. Prepaid Expenses	1100	37,164	40,118
11. Short-Term Investments	1110	0	0
12. Special Expenses	1120	0	0
13. Total Current Assets (sum of lines 1 through 12)		1,558,001	1,883,681
PROPERTY, PLANT AND EQUIPMENT			
14. Property, Plant and Equipment	1200	13,393,070	13,501,675
15. Accumulated Depreciation and Amortization	1250	-7,332,399	-7,847,535
16. Renovations	1300	2,127,437	2,127,437
17. Accumulated Depreciation and Amortization - Renovations	1350	-1,139,887	-1,221,491
18. Total Property, Plant and Equipment (sum of lines 14 through 17)		7,048,221	6,560,086
OTHER ASSETS			
19. Non-Current Investments	1400	9,293,178	11,773,188
20. Deposits	1410	543,550	458,732
21. Due From Owners / Officers (to Sch. E-1, pg. 1 of 2, line 2)	1420	0	0
22. Deferred Charges and Other Assets	1430	0	0
23. Notes Receivable - Long-Term	1440	0	0
24. Total Other Assets (sum of lines 19 through 23)		9,836,728	12,231,920
25. Total Assets (sum of lines 13, 18 and 24)		18,442,950	20,675,687
CURRENT LIABILITIES (Report credit balances as positive amounts)			
26. Accounts Payable	2010	588,495	392,419
27. Cost Settlements	2020	0	0
28. Notes Payable	2030	80,000	0
29. Current Portion of Long-Term Debt	2040	0	0
30. Accrued Compensation	2050	953,586	1,077,293
31. Payroll Related Withholdings and Liabilities	2060	139,479	170,580
32. Taxes Payable	2080	16,381	15,557
33. Other Liabilities - Specify below	2090	161,115	140,579
34. Total Current Liabilities (sum of lines 26 through 33)		1,939,056	1,796,428
LONG-TERM LIABILITIES (Report credit balances as positive amounts)			
35. Long-Term Debt	2410	3,895,000	3,675,000
36. Related Party Loans - Interest Allowable	2420	0	0
37. Related Party Loans - Interest Non-Allowable (to Sch E-1, pg 1 of 2, line 3)	2430	0	0
38. Non-Interest Bearing Loans From Owners (to Sch E-1, pg1 of 2, line 4)	2440	0	0
39. Deferred Liabilities	2450	0	0
40. Total Long-Term Liabilities (sum of lines 35 through 39)		3,895,000	3,675,000
41. Total Liabilities (sum of lines 34 and 40)		5,834,056	5,471,428
42. Capital (line 25 less line 41) (to Sch E-1, pg. 1 of 2, line 1)	3000	12,608,894	15,204,259
43. Total Liabilities and Capital (must equal line 25)		18,442,950	20,675,687

Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
Accrued Interest	-46,826.00	-26,290.00
Franchise permit fee	-114,289.00	-114,289.00
TOTALS (must tie to line33)	-46,826.00	-26,290.00

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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REIMBURSABLE EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch E, line 42)	12,608,894	15,204,259
2. Due From Owners/Officers (from Sch E, line 21)	0	0
3. Related Party Loans - Interest Non-Allowable (from Sch E, line 37)	0	0
4. Non-Interest Bearing Loans From Related Party (from Sch E, line 38)	0	0
5. Equity in Assets Leased From Related Party (attach detail)		
6. Home Office Equity (attach detail)		
7. Cash Surrender Value of Life Insurance Policy		
8. Other, Specify		
9. Other, Specify		
10. Other, Specify		
11. Other, Specify		
12. Other, Specify		
13. Other, Specify		
14. Other, Specify		
15. Other, Specify		
16. Other, Specify		
17. Other, Specify		
18. Other, Specify		
19. Other, Specify		
20. Other, Specify		
21. Other, Specify		
22. Total Reimbursable Equity (column 1 to E-1, page 2 of 2, line 23, column 2) (column 2 to E-1, page 2 of 2, line 34, column 8)	12,608,894	15,204,259

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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Month (1)	Reimbursable Equity Beginning of Period (2)	Capital Investments During Period (3)	Gain (Loss) On Disposal of Assets (4)	Withdrawals, or Dividend Distribution (5)	Other Increase / (Decrease) (6)	Increases or (Decreases) Due to Operations (7)	Reimbursable Equity Capital End of Month (net total of columns 2-7) (8) *
23. January	0	0	0	(0)	0	0	0
24. February	0	0	0	(0)	0	0	0
25. March	0	0	0	(0)	0	0	0
26. April	0	0	0	(0)	0	0	0
27. May	0	0	0	(0)	0	0	0
28. June	0	0	0	(0)	0	0	0
29. July	0	0	0	(0)	0	0	0
30. August	0	0	0	(0)	0	0	0
31. September	0	0	0	(0)	0	0	0
32. October	0	0	0	(0)	0	0	0
33. November	0	0	0	(0)	0	0	0
34. December	0	0	0	(0)	0	0	0
35. TOTAL							0

	1	2	3	4	5**
36. Return on Equity	0	12	X 0.06047	44,731	= 0.00
	(Ref. Sch. A-3, line 7 col. 5)				

* If the result in Column 8, lines 23 - 34 is a negative figure, enter "0" on lines 23 - 34. Do not enter less than zero.

** Maximum Return on Equity as specified in Ohio Administrative Code

INSTRUCTIONS FOR COMPLETING LINE NUMBER 36

Column # 1 Enter amount from Schedule E-1 line 35 column 8.

Column # 2 Enter number of months in reporting period.

Column # 3 Enter Rate of Return Ratio, use 5 decimal places to the right of the decimal.

Column # 4 Enter allowable capital days from Schedule A line 6.2 column 1.

Column # 5 Enter result of the previous calculations or the maximum return on equity, whichever is less.

REVENUE TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
ROUTINE SERVICE - ROOM AND BOARD				
1. Private	5010	3,240	0	3,240
2. Medicare	5011	0	0	0
3. Medicaid	5012	13,580,186	0	13,580,186
4. Veterans	5013	0	0	0
5. Other	5014	0	0	0
6. TOTAL (lines 1 through 5)		13,583,426	0	13,583,426
DEDUCTIONS FROM REVENUES				
7. Contractual Allowance-Medicare	5710	0	0	0
8. Contractual Allowance-Medicaid	5720	0	0	0
9. Contractual Allowance-Other	5730	0	0	0
10. Charity Allowance	5740	0	0	0
11. TOTAL (lines 7 through 10)		0	0	0
THERAPY SERVICES				
12. Physical Therapy	5020	0	0	0
13. Occupational Therapy	5030	0	0	0
14. Speech Therapy	5040	0	0	0
15. Audiology Therapy	5050	0	0	0
16. Respiratory Therapy	5060	0	0	0
17. TOTAL (lines 12 through 16)		0	0	0
MEDICAL SUPPLIES				
18. Medicare B - Medicaid (To Sch A-2, Line 1a, Col.2)	5070-1	0	0	0
19. Medicare B - Other (To Sch A-2, Line 1a, Col.3)	5070-2	0	0	0
20. Private (To Sch A-2, Line 1a, Col.4)	5070-3	0	0	0
21. Medicare A (To Sch A-2, Line 1a, Col.5)	5070-4	0	0	0
22. Veterans (To Sch A-2, Line 1a, Col.6)	5070-5	0	0	0
23. Other (To Sch A-2, Line 1a, Col.6)	5070-6	0	0	0
24. Medicaid (To Sch A-2, Line 1a, Col.7)	5070-7	0	0	0
25. Medical Supplies-Routine	5080	0	0	0
26. TOTAL (lines 18 through 25)		0	0	0
MEDICAL MINOR EQUIPMENT				
27. Medicare B - Medicaid (To Sch. A-2, Line 2a, Col. 2)	5090-1	0	0	0
28. Medicare B - Other (To Sch. A-2, Line 2a, Col. 3)	5090-2	0	0	0
29. Private (To Sch. A-2, Line 2a, Col. 4)	5090-3	0	0	0
30. Medicare A (To Sch. A-2, Line 2a, Col. 5)	5090-4	0	0	0
31. Veterans (To Sch. A-2, Line 2a, Col. 6)	5090-5	0	0	0
32. Other (To Sch. A-2, Line 2a, Col. 6)	5090-6	0	0	0
33. Medicaid (To Sch. A-2, Line 2a, Col. 7)	5090-7	0	0	0
34. Medical Minor Equipment-Routine	5100	0	0	0
35. TOTAL (Lines 27 through 34)		0	0	0

REVENUE TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
ENTERAL NUTRITION THERAPY				
36. Medicare B - Medicaid (To Sch. A-2, Line 3a, Col. 2)	5110-1	0	0	0
37. Medicare B - Other (To Sch. A-2, Line 3a, Col. 3)	5110-2	0	0	0
38. Private (To Sch. A-2, Line 3a, Col. 4)	5110-3	0	0	0
39. Medicare A (To Sch. A-2, Line 3a, Col. 5)	5110-4	0	0	0
40. Veterans (To Sch. A-2, Line 3a, Col. 6)	5110-5	0	0	0
41. Other (To Sch. A-2, Line 3a, Col. 6)	5110-6	0	0	0
42. Medicaid (To Sch. A-2, Line 3a, Col. 7)	5110-7	0	0	0
43. Enteral Nutrition Therapy - Routine	5120	0	0	0
44. TOTAL (lines 36 through 43)		0	0	0
OTHER ANCILLARY SERVICE				
45. Habilitation Supplies	5130	0	0	0
46. Incontinence Supply	5140	0	0	0
47. Personal Care	5150	0	0	0
48. Laundry Service - Routine	5160	0	0	0
49. TOTAL (lines 45 through 48)		0	0	0
OTHER SERVICES				
50. Dry Cleaning Service	5310	0	0	0
51. Communications	5320	0	0	0
52. Meals	5330	634	-634	0
53. Barber and Beauty	5340	0	0	0
54. Personal Purchases - Residents	5350	0	0	0
55. Radiology	5360	0	0	0
56. Laboratory	5370	0	0	0
57. Oxygen	5380	0	0	0
58. Legend Drugs	5390	0	0	0
59. Other - Specify Below	5400	2,545,319	-27,342	2,517,977
60. TOTAL (lines 50 through 59)		2,545,953	-27,976	2,517,977

Line 59 Other

Account Title	Amount
	2,545,319
Total (must tie to line 59, column 2)	2,545,319

REVENUE TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
NON-OPERATING				
61. Management Services	5510	41,400	-41,400	0
62. Cash Discounts	5520	0	0	0
63. Rebates and Refunds	5530	0	0	0
64. Gift Shop	5540	0	0	0
65. Vending Machine Revenues	5550	0	0	0
66. Vending Machine Commissions	5555	0	0	0
67. Rental - Space	5560	0	0	0
68. Rental - Equipment	5570	0	0	0
69. Rental - Other	5580	25,405	0	25,405
70. Interest Income - Working Capital	5590	13,467	-13,467	0
71. Interest Income - Restricted Funds	5600	0	0	0
72. Interest Income - Funded Depreciation	5610	0	0	0
73. Interest Income - Related Party Revenue	5620	0	0	0
74. Interest Income - Contributions	5625	0	0	0
75. Endowments	5630	0	0	0
76. Gain/Loss on Disposal of Assets	5640	75,550	-103	75,447
77. Gain/Loss on Sale of Investments	5650	2,550,742	0	2,550,742
78. Contributions	5670	753,022	0	753,022
79. TOTAL Non-operating (lines 61 through 78)		3,459,586	-54,970	3,404,616
80. TOTAL (SUM OF LINES 6, 11, 17, 26, 35, 44, 49, 60 AND 79)		19,588,965	-82,946	19,506,019

ADJUSTMENT TO TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through: 12/31/2005
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Description	Revenue Chart of Account # (1)	Salary Increase (Decrease) (2)	Other Increase (Decrease) (3)	Total Increase (Decrease) (Col. 2 + Col. 3) (4)	Expense Chart of Account # (5)	Revenue Reference Attachment 1 Line (6)
1. Meals	5330	0	-634	-634	7040	
2. Management Services	5510	-41,400	0	-41,400	7210	
3. Physician's Group	5400	0	-4,791	-4,791	9725	
4. Physican's Group	5400	0	-22,551	-22,551	6100	
5. Gain/Loss on Disposal	5640	0	-103	-103	8040	
6. Interest/Investment Income	5590	0	-13,467	-13,467	8070	
7. A-2 Offset (Line 7, Col 2)		0	0	0	6000	
8. A-2 Offset (Line 7, Col 3)		0	0	0	6005	
9. A-2 Offset (Line 7, Col 4)		0	0	0	7055	
10. A-2 Offset (Line 12, Col 5)		0	0	0	7305	
11. TOTAL		-41,400	-41,546	-82,946		

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Provider Name	Medicaid Provider Number	Reporting Period
LUTHER HOME OF MERCY	0035287	From 1/1/2005 Through: 12/31/2005

As per the cost report instructions, any documentation (required by the Department, or needed to clarify individual line items or groupings) must be submitted as hard copy and labeled as an exhibit. To facilitate the reporting and review process of the submitted cost report (including exhibits) ODJFS requires that exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and shall be labeled accordingly. Exhibits 3 and 4, if needed, shall also be labeled accordingly. In certain situations, if exhibits 3 and 4 are not applicable, the corresponding exhibit number shall not be used. Any other additional exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

Please attach one copy of the following:

- Exhibit 1. Facility trial balance that details the general ledger account names as of December 31, 2005
IF THE RECOMMENDED CHART OF ACCOUNTS PER OHIO ADMINISTRATIVE CODE IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT. (One copy with each cost report is required.)
- Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)
- Exhibit 3. Home office trial balances and the allocation work sheets that show how the home office trial balance is allocated to each individual facility's cost report. Include the account groupings for each home office account. The allocation procedures are pursuant to "CMS Publication 15-1," (REV. 11/05) (If applicable - One copy with each cost report is required.)
- Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported. (If applicable - One copy with each cost report is required)
- Exhibit 5. Any other documentation which is necessary to explain costs
Identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8 col. 4.

Failure to cross-reference exhibits, to the applicable cost report schedule, line, and column qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to Ohio Administrative Code.

PAID NON-MEDICAID LEAVE DAYS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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INSTRUCTIONS:

Record monthly the Non-Medicaid leave days paid for by payers other than ODJFS. Paid Non-Medicaid leave days are hospital, therapeutic, or any other leave day paid for on behalf of a Non-Medicaid resident. Non-Medicaid leave days are counted as inpatient days proportionate to the Non-Medicaid per diem rate paid.

MONTH	TOTAL PAID NON-MEDICAID LEAVE DAYS
JANUARY	0
FEBRUARY	0
MARCH	0
APRIL	0
MAY	0
JUNE	0
JULY	0
AUGUST	0
SEPTEMBER	0
OCTOBER	0
NOVEMBER	0
DECEMBER	0
TOTAL	0

Percentage of per diem rate paid by Non-Medicaid residents for leave days

0.00

WAGE AND HOURS SURVEY

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2005 Through: 12/31/2005
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INSTRUCTIONS: REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED.

Column (C): Enter wages (net of adjustments) paid to facility personnel (This must agree with the sum of column 1 on schedules B1, B-2, C and attachment 2, column2).

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with Schedule C-2).

Column (E): Column (C) minus Column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus Column (G).

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
OTHER PROTECTED COSTS							
1. Water and Sewage (salary only)	6030	2,341	0	2,341	168	0	168
1a. EAP Administrator - Other Protected	6057	0	0	0	0	0	0
1b. Self Funded Programs Adm. - Other Protected	6058	0	0	0	0	0	0
1c. Staff Development - Other Protected	6059	0	0	0	0	0	0
1d. TOTAL Other Protected (Sum of lines 1 - 1c)		2,341	0	2,341	168	0	168
DIRECT CARE NURSING AND HABILITATION/REHABILITATION							
2. Medical Director	6100	0	0	0	0	0	0
3. Director of Nursing	6105	63,398	0	63,398	2,172	0	2,172
4. RN Charge Nurse	6110	94,704	0	94,704	3,671	0	3,671
5. LPN Charge Nurse	6115	0	0	0	0	0	0
6. Registered Nurse	6120	425,628	0	425,628	17,906	0	17,906
7. Licensed Practical Nurse	6125	623,374	0	623,374	32,189	0	32,189
8. Nurse Aides	6130	0	0	0	0	0	0
9. Activity Director	6135	31,096	0	31,096	2,080	0	2,080
10. Activity Staff	6140	87,704	0	87,704	7,557	0	7,557
11. Program Specialist	6150	0	0	0	0	0	0
12. Program Director	6155	105,959	0	105,959	5,484	0	5,484
13. Habilitation Supervisor	6165	401,518	0	401,518	29,832	0	29,832
14. Habilitation Staff	6170	2,997,840	0	2,997,840	249,378	0	249,378
15. Psychologist	6175	0	0	0	0	0	0
16. Psychology Assistant	6180	0	0	0	0	0	0
17. Respiratory Therapist	6185	0	0	0	0	0	0
18. Social Work/Counseling	6190	75,366	0	75,366	4,251	0	4,251
19. Social Services/Pastoral Care	6195	39,624	0	39,624	2,080	0	2,080
20. Qualified Mental Retardation Professional	6200	267,654	0	267,654	15,856	0	15,856
21. Quality Assurance	6205	0	0	0	0	0	0
22. Other Direct Care (salary)	6220	0	0	0	0	0	0
23. Home Office Costs/Direct Care (salary)	6230	0	0	0	0	0	0
24. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 2 through 23)		5,213,865	0	5,213,865	372,456	0	372,456
25. TOTAL Page 1 (sum of lines 1d and 24)		5,216,206	0	5,216,206	372,624	0	372,624

WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
LUTHER HOME OF MERCY		0035287		From: 1/1/2005		Through: 12/31/2005	
WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
DIRECT CARE THERAPIES							
26. Physical Therapist	6600	58,400	0	58,400	2,080	0	2,080
27. Physical Therapy Assistant	6605	103,112	0	103,112	4,160	0	4,160
28. Occupational Therapist	6610	0	0	0	0	0	0
29. Occupational Therapy Assistant	6615	168,733	0	168,733	7,108	0	7,108
30. Speech Therapist	6620	122,063	0	122,063	3,487	0	3,487
31. Audiologist	6630	0	0	0	0	0	0
32. TOTAL Direct Care Therapies (sum of lines 26 through 31)		452,308	0	452,308	16,835	0	16,835
PAYROLL TAX, FRINGE BENEFITS AND STAFF DEVELOPMENT (No Purchased Nursing)							
33. EAP Administrator - Direct Care	6535	0	0	0	0	0	0
34. Self Funded Programs Adm. - Direct Care	6540	0	0	0	0	0	0
35. Staff Development - Direct Care	6550	27,235	0	27,235	2,080	0	2,080
36. TOTAL Payroll Tax, Fringe Benefits and Staff Development(sum of lines 33 through 35)		27,235	0	27,235	2,080	0	2,080
DIETARY COST							
37. Dietitian	7000	0	0	0	0	0	0
38. Food Service Supervisor	7005	27,440	0	27,440	2,220	0	2,220
39. Dietary Personnel	7015	402,652	0	402,652	33,905	0	33,905
40. EAP Administrator - Dietary	7075	0	0	0	0	0	0
41. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	0
42. Staff Development - Dietary	7090	0	0	0	0	0	0
43. TOTAL Dietary Cost (sum of lines 37 through 42)		430,092	0	430,092	36,125	0	36,125
HABILITATION AND PHARMACEUTICAL							
44. Medical/Habilitation Records	7105	38,244	0	38,244	3,022	0	3,022
45. Pharmaceutical Consultant	7110	0	0	0	0	0	0
46. TOTAL Habilitation, Pharmaceutical (sum of lines 44 and 45)		38,244	0	38,244	3,022	0	3,022
47. TOTAL Page 2 (sum of lines 32, 36, 43 and 46)		947,879	0	947,879	58,062	0	58,062

WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
LUTHER HOME OF MERCY		0035287		From: 1/1/2005 Through: 12/31/2005			
WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
ADMINISTRATIVE & GENERAL SERVICES							
48. Administrator	7200	108,734	0	108,734	2,080	0	2,080
49. Other Administrative Personnel	7210	335,329	0	335,329	19,518	0	19,518
50. Security Services (salary only)	7230	0	0	0	0	0	0
51. Laundry/Housekeeping Supervisor	7240	50,868	0	50,868	4,072	0	4,072
52. Housekeeping	7245	358,339	0	358,339	31,027	0	31,027
53. Laundry and Linen	7250	160,463	0	160,463	13,601	0	13,601
54. Accounting	7265	131,809	0	131,809	8,592	0	8,592
55. Data Services (salary only)	7285	38,448	0	38,448	2,080	0	2,080
56. Other Indirect Care (salary)	7305	0	0	0	0	0	0
57. Home Office Costs/Indirect Care (salary)	7310	0	0	0	0	0	0
58. TOTAL Administrative and General Services (sum of lines 48 through 57)		1,183,990	0	1,183,990	80,970	0	80,970
MAINTENANCE AND MINOR EQUIPMENT							
59. Plant Operations/Maintenance Supervisor	7320	39,624	0	39,624	2,080	0	2,080
60. Plant Operations and Maintenance	7330	101,257	0	101,257	8,152	0	8,152
61. TOTAL Maintenance and Minor Equipment (sum of lines 59 and 60)		140,881	0	140,881	10,232	0	10,232
PAYROLL TAXES, FRINGE BENEFITS & STAFF DEVELOPMENT							
62. EAP Administrator - Indirect Care	7525	0	0	0	0	0	0
63. Self Funded Prog. Admin. - Indirect Care	7530	0	0	0	0	0	0
64. Staff Development - Indirect Care	7535	0	0	0	0	0	0
65. TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 62 thru 64)		0	0	0	0	0	0
66. TOTAL Page 3 (sum of lines 58, 61 and 65)		1,324,871	0	1,324,871	91,202	0	91,202
67. TOTAL Attachment 6 Pages 1, 2 and 3(sum of lines 25, 47 and 66)		7,488,956	0	7,488,956	521,888	0	521,888

ADDENDUM FOR DISPUTED COSTS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2005 Through: 12/31/2005
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INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code, that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From:" columns, the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To:" columns, the schedule, line number, and reason you believe these costs should be reclassified.

Reclassification From:					Reclassification To:		
CURRENT COST CENTERS	Chart of Acct.	Salary Facility Employed (1)	Other/Contract Wages (2)	Adjusted/Allocated Total (3)	Schedule (4)	Line (5)	Reason (6)
OTHER PROTECTED COSTS							
1.		0	0	0			
2.		0	0	0			
3.		0	0	0			
4.		0	0	0			
5. TOTAL Other Protected Costs (sum of lines 1 through 4)		0	0	0			
DIRECT CARE COST CENTER							
6.		0	0	0			
7.		0	0	0			
8.		0	0	0			
9.		0	0	0			
10. TOTAL Direct Care Costs (sum of lines 6 through 9)		0	0	0			
INDIRECT CARE COST CENTER							
11.		0	0	0			
12.		0	0	0			
13.		0	0	0			
14.		0	0	0			
15. TOTAL Indirect Care Costs (sum of lines 11 through 14)		0	0	0			
NON-REIMBURSABLE EXPENSES							
16.		0	0	0			
17.		0	0	0			
18.		0	0	0			
19.		0	0	0			
20. TOTAL Non-Reimbursable Expenses (sum of lines 16 through 19)		0	0	0			
CAPITAL COST CENTER							
21.		0	0	0			
22.		0	0	0			
23.		0	0	0			
24.		0	0	0			
25. TOTAL Capital Cost (sum of lines 21 through 24)		0	0	0			
26. TOTAL COST CENTERS (sum of lines 5, 10, 15, 20, and 25)		0	0	0			