

Ohio Department of Job and Family Services

MEDICAID ICF-MR COST REPORT

Type of Cost Report Filing. (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) <b>LUTHER HOME OF MERCY</b>	National Provider Identifier <b>1538135173</b>	Medicaid Provider Number <b>0035287</b>	Medicare Provider Number <b>36-G023</b>
Complete Facility Address Address(1) <b>5810 N MAIN ST</b> Address(2) <b>P O BOX 187</b> City <b>WILLISTON</b> State of Ohio Zip Code <b>43468</b>	Federal Tax ID Number <b>34-4441788</b>	Period Covered by Cost Report	
	ODH ID Number <b>1575</b>	From: <b>01/01/2006</b>	
	County <b>OTTAWA</b>	Through: <b>12/31/2006</b>	

TYPE OF CONTROL OF PROVIDER- (Please check one of the following:)	PROVIDER LEGAL ENTITY IDENTIFICATION
<b>For Profit</b> <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 <b>LUTHER HOME OF MERCY</b> Address(1) <b>5810 N MAIN ST</b> Address(2) <b>P O BOX 187</b> City <b>WILLISTON</b> State <b>OH</b> Zip Code <b>43468</b>
<b>Location Of Entity, Organization, or Incorporation:</b> 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: _____	NAME AND ADDRESS OF OWNER OF REAL ESTATE Name <b>LUTHER HOME OF MERCY</b> Address(1) <b>5810 N MAIN ST</b> Address(2) <b>P O BOX 187</b> City <b>WILLISON</b> State <b>OH</b> Zip Code <b>43468</b>

<b>Non-Profit</b> <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)	<b>CARE SETTING</b> 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: <b>ICF/MR</b>
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<b>Non-Federal Government</b> <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): <b>CHURCH</b> (3.6)	
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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	42,984.0	42,984.0
5. Percentage of occupancy (line 4 divided by line 3 X 100)	91.29	91.29
6.1. Indirect allowable days (greater of line 4 or .85 X line 3)	42,984.0	42,984.0
6.2. Capital allowable days (greater of line 4 or .95 X line 3)	44,731.0	44,731.0

<b>OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS</b>	
7. Total patient days (from Schedule A-1, line 13, column 5)	42,984.0
8. Utilization Rate(line 7 divided by line 4, col. 1 X 100)	100.00

\*\* 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: 01/01/2006 Through: 12/31/2006
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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 **1/1/2006** and ending **12/31/2006** 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	03/22/2007
Print or Type Name of Owner, Officer, or Authorized Representative of Provider			
(Last) WUKOTICH	(First) DONALD	(M.I.)	
Title EXECUTIVE DIRECTOR	Telephone Number Area Code (419) 836-7741	Fax Number 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		OH	43468
Telephone Number of Person Preparing Cost Report		Fax Number	
Area Code (419) 836-7741		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) 836-7741
City WILLISTON		County	OTTAWA
State	OH	Zip Code	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
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SUMMARY OF INPATIENT DAYS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2006 Through: 12/31/2006
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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	3,581	29.0	17.0	3,627.0	0	0	0	3,627.0
2. February	129	3,244	45.0	2.0	3,291.0	0	0	0	3,291.0
3. March	129	3,640	16.0	2.0	3,658.0	0	0	0	3,658.0
4. April	129	3,490	24.0	26.0	3,540.0	0	0	0	3,540.0
5. May	129	3,607	34.0	17.0	3,658.0	0	0	0	3,658.0
6. June	129	3,538	1.0	1.0	3,540.0	0	0	0	3,540.0
7. July	129	3,616	5.0	37.0	3,658.0	0	0	0	3,658.0
8. August	129	3,621	12.0	11.0	3,644.0	0	0	0	3,644.0
9. September	129	3,468	27.0	17.0	3,512.0	0	0	0	3,512.0
10. October	129	3,609	12.0	37.0	3,658.0	0	0	0	3,658.0
11. November	129	3,493	13.0	34.0	3,540.0	0	0	0	3,540.0
12. December	129	3,578	3.0	77.0	3,658.0	0	0	0	3,658.0
13. TOTAL (sum of lines 1 through 12)		42,485	221.0	278.0	42,984.0	0	0	0	42,984.0
					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: 1/1/2006 Through: 12/31/2006
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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  <b>SECTION A: REVENUES</b>  (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%
<b>4. TOTAL (Sum of 1a through 3a)</b>	0	0	0	0	0	0	0

Description  <b>SECTION B: COSTS</b>  (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

<b>SECTION C: INDIRECT COST - OFFSET</b>	
8. Indirect costs (Schedule C Line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col. 3)	1,457,129
9. Total costs (total of Sch. B-1 line 26, B-2 line 44, C line 63, D lines 11 and 13.)	13,306,427
10. Line 8 divided by line 9	0.1095
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: 01/01/2006	Through	12/31/2006
REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (Col 3 / 4) (5)
<b>OTHER PROTECTED COSTS</b>					
1. Other Protected Costs use allowable patient days Sch A line 4 Col 1	B1 line 26 Col 7		971,513	42,984.0	22.60
<b>DIRECT CARE COST CENTER</b>					
2. Direct Care Cost Use allowable patient days Sch A line 4 col 1	B2 line 44 Col 7		8,067.737	42,984.0	187.69
<b>INDIRECT CARE COST CENTER</b>					
3. Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7		3,400.323	42,984.0	79.11
<b>CAPITAL COST CENTER</b>					
<b>COST OF OWNERSHIP</b>					
4. Assets Acquired	D line 11 Col 7	547,019			
<b>RENOVATIONS COST CENTER</b>					
5. Renovations	D line 13 Col 7	118,119			
6. <b>TOTAL Capital Cost (sum of lines 4 and 5)</b> use allowable patient days Sch A line 6.2 Col 1			665,138	44,731.0	14.87
<b>EQUITY</b>					
7. Return on Equity	E1 line 36 Col 5				0.00
8. <b>TOTAL REIMBURSABLE COSTS</b> (sum of lines 1, 2, 3 and 6 ) Col 3			13,104,711		
9. <b>TOTAL FILED COST PER DIEM</b> (sum of lines 1, 2, 3, 6 and 7) Col 5					304.27

RECONCILIATION OF COSTS

Schedule/ Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
10. B1/26	col 3 971,513	col 4 0	col 5 971,513	col 7 971,513
11. B2/44	col 3 8,087,945	col 4 -20,208	col 5 8,067,737	col 7 8,067,737
12. C/79	col 3 6,787,075	col 4 -65,002	col 5 6,722,073	col 7 6,722,073
13. D *	col 3 786,646	col 4 -121,508	col 5 665,138	col 7 665,138
14. Totals	\$ 16,633,179 <sup>(A)</sup>	\$ -206,718 <sup>(B)</sup>	\$ 16,426,461	\$ 16,426,461
15. Less Non-Reimbursable from Schedule C Page 3 line 78			col 5 (3,321,750)	col 7 (3,321,750)
16. Total Reimbursable			\$ 13,104,711 <sup>(C)</sup>	\$ 13,104,711 <sup>(C)</sup>

\* 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: 1/1/2006 Through: 12/31/2006
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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)
<b>MEDICAL SUPPLIES</b>								
1. Medical Supplies - medicare billable	6000		0	0	0	0	1.0000	0
2. Medical Supplies - medicare non-billable	6001		46,592	46,592	0	46,592	1.0000	46,592
3. Oxygen - Emergency stand-by	6003		78	78	0	78	1.0000	78
4. Medical Minor Equip. - medicare billable	6005		0	0	0	0	1.0000	0
5. Medical Minor Equip. - medicare non-billable	6006		7,433	7,433	0	7,433	1.0000	7,433
<b>6. TOTAL Medical Supplies (sum of lines 1 through 5)</b>			54,103	54,103	0	54,103		54,103
<b>UTILITY COSTS</b>								
7. Heat, Light, Power	6020		311,396	311,396	0	311,396	1.0000	311,396
8. Water and Sewage	6030	2,341	130,975	133,316	0	133,316	1.0000	133,316
9. Trash and Refuse Removal	6040		14,111	14,111	0	14,111	1.0000	14,111
10. Hazardous Medical Waste Collection	6050		1,031	1,031	0	1,031	1.0000	1,031
<b>11. TOTAL Utility Costs (sum of lines 7 through 10)</b>		2,341	457,513	459,854	0	459,854		459,854
<b>PROPERTY TAXES</b>								
12. Real Estate Taxes	6060		4,127	4,127	0	4,127	1.0000	4,127
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
<b>16. TOTAL Property Taxes (sum of line 12 through 15)</b>			4,127	4,127	0	4,127		4,127
<b>FRANCHISE PERMIT FEES</b>								
17. Franchise Permit Fees	6091		453,429	453,429	0	453,429	1.0000	453,429
<b>HOME OFFICE COSTS</b>								
18. Home Office Costs/Other Protected**	6095		0	0	0	0	1.0000	0
<b>PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT</b>								
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
<b>25. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 19 thru 24)</b>		0	0	0	0	0		0
<b>26. TOTAL Other Protected Costs (sum of lines 6,11,16,17,18, and 25)</b>		2,341	969,172	971,513	0	971,513		971,513

\*\* 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.

4.1

Schedule B-2

## DIRECT CARE COST CENTER

1 of 2

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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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)
<b>NURSING AND HABILITATION/REHABILITATION</b>								
1. Medical Director	6100	0	80,400	80,400	-20,208	60,192	1.0000	60.192
2. Director of Nursing	6105	109,774	0	109,774	0	109,774	1.0000	109.774
3. RN Charge Nurse	6110	77,218	0	77,218	0	77,218	1.0000	77.218
4. LPN Charge Nurse	6115	0	0	0	0	0	1.0000	0
5. Registered Nurse	6120	314,069	0	314,069	0	314,069	1.0000	314.069
6. Licensed Practical Nurse	6125	619,091	0	619,091	0	619,091	1.0000	619.091
7. Nurse Aides	6130	0	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	4,941	0	4,941	0	4,941	1.0000	4.941
10. Program Specialist	6150	0	0	0	0	0	1.0000	0
11. Program Director	6155	127,201	0	127,201	0	127,201	1.0000	127.201
12. Habilitation Supervisor	6165	364,116	0	364,116	0	364,116	1.0000	364.116
13. Habilitation Staff	6170	2,590,093	708,246	3,298,339	0	3,298,339	1.0000	3,298.339
14. Psychologist	6175	0	0	0	0	0	1.0000	0
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	47,976	0	47,976	0	47,976	1.0000	47.976
18. Social Services/Pastoral Care	6195	45,374	0	45,374	0	45,374	1.0000	45.374
19. Qualified Mental Retardation Professional	6200	253,406	0	253,406	0	253,406	1.0000	253.406
20. Quality Assurance	6205	0	0	0	0	0	1.0000	0
21. Consulting and Management Fees-Direct Care	6210	0	15,910	15,910	0	15,910	1.0000	15.910
22. Active Treatment Off-site Day Programming	6215	0	817,941	1,147,008	0	1,147,008	1.0000	1,147.008
23. Other Direct Care - Specify Below	6220	0	1,593	1,593	0	1,593	1.0000	1.593
24. Home Office Costs/Direct Care	6230	0	0	0	0	0	1.0000	0
<b>25. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 24)</b>		<b>4,913,422</b>	<b>1,624,090</b>	<b>6,537,512</b>	<b>-20,208</b>	<b>6,517,304</b>		<b>6,517,304</b>
<b>PURCHASED NURSING SERVICES</b>								
26. Registered Nurse - Purchased Nursing	6300	0	0	0	0	0	1.0000	0
27. Licensed Practical Nurse - Purchased Nursing	6310	0	0	0	0	0	1.0000	0
28. Nurse Aides - Purchased Nursing	6320	0	0	0	0	0	1.0000	0
<b>29. TOTAL Purchased Nursing (sum of lines 26 through 28)</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>		<b>0</b>

Line 23 Other Direct Care

Account Title	Salary Column 1	Other Column 2
OTHER PHYSICIAN SVS	0	1,593
Totals must tie to line 23, Columns 1 and 2	0	1,593

\*\*\* 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: 1/1/2006 Through: 12/31/2006				
<b>DIRECT CARE COSTS</b>	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)
<b>DIRECT CARE THERAPIES</b>								
30. Physical Therapist	6600	58,674	0	58,674	0	58,674	1.0000	58,674
31. Physical Therapy Assistant	6605	98,148	0	98,148	0	98,148	1.0000	98,148
32. Occupational Therapist	6610	0	6,220	6,220	0	6,220	1.0000	6,220
33. Occupational Therapy Assistant	6615	91,081	0	91,081	0	91,081	1.0000	91,081
34. Speech Therapist	6620	109,325	38,460	147,785	0	147,785	1.0000	147,785
35. Audiologist	6630	0	0	0	0	0	1.0000	0
<b>36. TOTAL Direct Care Therapies (sum of lines 30 through 35)</b>		357,228	44,680	401,908	0	401,908		401,908
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT (No Purchased Nursing)</b>								
37. Payroll Taxes - Direct Care	6510		402,533	402,533	0	402,533	1.0000	402,533
38. Workers' Compensation - Direct Care	6520		161,749	161,749	0	161,749	1.0000	161,749
39. Employee Fringe Benefits - Direct Care	6530		559,498	559,498	0	559,498	1.0000	559,498
40. EAP Administrator - Direct Care	6535	0	0	0	0	0	1.0000	0
41. Self Funded Programs Admin. - Direct Care	6540	0	0	0	0	0	1.0000	0
42. Staff Development - Direct Care	6550	16,345	8,400	24,745	0	24,745	1.0000	24,745
<b>43. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 37 thru 42)</b>		16,345	1,132,180	1,148,525	0	1,148,525		1,148,525
<b>44. TOTAL Reimbursable Direct Care Cost (sum of lines 25, 29, 36 and 43)</b>		5,286,995	2,800,950	8,087,945	-20,208	8,067,737		8,067,737

\*\*\* 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: 1/1/2006 Through: 12/31/2006
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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)
<b>DIETARY COST</b>								
1. Dietitian	7000	0	7,122	7,122	0	7,122	1.0000	7,122
2. Food Service Supervisor	7005	26,281	0	26,281	0	26,281	1.0000	26,281
3. Dietary Personnel	7015	389,891	0	389,891	0	389,891	1.0000	389,891
4. Dietary Supplies and Expenses	7025		47,475	47,475	0	47,475	1.0000	47,475
5. Dietary Minor Equipment	7030		169	169	0	169	1.0000	169
6. Dietary Maintenance and Repair	7035		5,280	5,280	0	5,280	1.0000	5,280
7. Food In-Facility	7040		304,995	304,995	0	304,995	1.0000	304,995
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		6,533	6,533	0	6,533	1.0000	6,533
12. Payroll Taxes - Dietary	7060		31,071	31,071	0	31,071	1.0000	31,071
13. Workers' Compensation - Dietary	7065		14,629	14,629	0	14,629	1.0000	14,629
14. Employee Fringe Benefits - Dietary	7070		55,936	55,936	0	55,936	1.0000	55,936
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	529	529	0	529	1.0000	529
18. TOTAL Dietary (sum of lines 1 through 17)		416,172	473,739	889,911	0	889,911		889,911
<b>MEDICAL, HABILITATION, PHARMACY AND INCONTINENCE SUPPLIES</b>								
19. Habilitation Supplies	7100		2,612	2,612	0	2,612	1.0000	2,612
20. Medical/Habilitation Records	7105	29,489	0	29,489	0	29,489	1.0000	29,489
21. Pharmaceutical Consultant	7110	0	0	0	0	0	1.0000	0
22. Incontinence Supplies	7115		71,637	71,637	0	71,637	1.0000	71,637
23. Personal Care - Supplies	7120		54,160	54,160	0	54,160	1.0000	54,160
24. Program Supplies	7125		6,280	6,280	0	6,280	1.0000	6,280
25. TOTAL Habilitation, Pharmacy and Incontinence Supplies (sum of lines 19 through 24)		29,489	134,689	164,178	0	164,178		164,178
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>								
26. Administrator	7200	108,734	0	108,734	0	108,734	1.0000	108,734
27. Other Administrative Personnel	7210	379,310	0	379,310	-60,000	319,310	1.0000	319,310
28. Consulting and Management Fees - Indirect	7215		365	365	0	365	1.0000	365
29. Office and Administrative Supplies	7220		35,022	35,022	0	35,022	1.0000	35,022
30. Communications	7225		36,762	36,762	0	36,762	1.0000	36,762
31. Security Services	7230	0	38,711	38,711	0	38,711	1.0000	38,711
32. Travel and Entertainment	7235		0	0	0	0	1.0000	0
33. SUB-TOTAL (sum of lines 26 through 32)		488,044	110,860	598,904	-60,000	538,904		538,904

\*\*\* 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: 1/1/2006 Through: 12/31/2006
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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)
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>								
34. Laundry/Housekeeping Supervisor	7240	50,968	0	50,968	0	50,968	1.0000	50,968
35. Housekeeping	7245	343,621	53,053	396,674	0	396,674	1.0000	396,674
36. Laundry and Linen	7250	165,414	30,981	196,395	0	196,395	1.0000	196,395
37. Universal Precaution Supplies	7255		22,998	22,998	0	22,998	1.0000	22,998
38. Legal Services	7260		24,267	24,267	0	24,267	1.0000	24,267
39. Accounting	7265	122,964	54,745	177,709	0	177,709	1.0000	177,709
40. Dues, Subscriptions and Licenses	7270		58,808	58,808	0	58,808	1.0000	58,808
41. Interest - Other	7275		0	0	0	0	1.0000	0
42. Insurance	7280		135,400	135,400	0	135,400	1.0000	135,400
43. Data Services	7285	41,840	27,045	68,885	0	68,885	1.0000	68,885
44. Help Wanted/Informational Advertising	7290		3,921	3,921	0	3,921	1.0000	3,921
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
<b>49. TOTAL Administrative and General Services (sum of lines 34 thru 48 and 33)</b>		<b>1,212,851</b>	<b>522,078</b>	<b>1,734,929</b>	<b>-60,000</b>	<b>1,674,929</b>		<b>1,674,929</b>
<b>MAINTENANCE AND MINOR EQUIPMENT</b>								
50. Plant Operations/Maintenance Supervisor	7320	40,253	0	40,253	0	40,253	1.0000	40,253
51. Plant Operations and Maintenance	7330	129,160		129,160	0	129,160	1.0000	129,160
52. Repair and Maintenance	7340		117,727	117,727	0	117,727	1.0000	117,727
53. Minor Equipment	7350		17,928	17,928	0	17,928	1.0000	17,928
54. Leased Equipment	7400		0	0	0	0	1.0000	0
<b>55. TOTAL Maintenance and Minor Equipment (sum of lines 50 through 54)</b>		<b>169,413</b>	<b>135,655</b>	<b>305,068</b>	<b>0</b>	<b>305,068</b>		<b>305,068</b>
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT</b>								
56. Payroll Taxes - Indirect Care	7500		100,027	100,027	0	100,027	1.0000	100,027
57. Workers' Compensation - Indirect Care	7510		26,932	26,932	0	26,932	1.0000	26,932
58. Employee Fringe Benefits - Indirect Care	7520		217,335	217,335	0	217,335	1.0000	217,335
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	21,943	21,943	0	21,943	1.0000	21,943
<b>62. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 56 thru 61)</b>		<b>0</b>	<b>366,237</b>	<b>366,237</b>	<b>0</b>	<b>366,237</b>		<b>366,237</b>
<b>63. TOTAL Reimbursable Indirect Care Cost (sum of lines 18, 25, 49, 55 and 62)</b>		<b>1,827,925</b>	<b>1,632,398</b>	<b>3,460,323</b>	<b>-60,000</b>	<b>3,400,323</b>		<b>3,400,323</b>

Home Office Costs are to be entered on line 48 only. They are not be distributed to any other line on this schedule. \*\*

Line 47 Other Indirect Care - Specify Below

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

\*\*\* 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: 1/1/2006 Through: 12/31/2006
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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)
<b>NON-REIMBURSABLE EXPENSES</b>								
64. Legend Drugs	9705		8,911	8,911	0	8,911	1.0000	8,911
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	2,081,050	1,151,298	3,232,348	-5,002	3,227,346	1.0000	3,227,346
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	35,915	49,235	85,150	0	85,150	1.0000	85,150
75. Contributions and Donations	9760		343	343	0	343	1.0000	343
76. Bad Debt	9765		0	0	0	0	1.0000	0
77. Parenteral Nutrition Therapy	9770		0	0	0	0	1.0000	0
78. <b>TOTAL Non-Reimbursable (sum of lines 64 thru 77)</b>		2,116,965	1,209,787	3,326,752	-5,002	3,321,750		3,321.750
79. <b>TOTAL Indirect Care Cost Reimbursable and Non-Reimbursable (sum of lines 63 and 78)</b>		3,944,890	2,842,185	6,787,075	-65,002	6,722,073		6,722.073

Line 68 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
OTHER PROGRAM	2,081,050	1,151,298
<b>Totals (must tie to line 68, Columns 1 and 2)</b>	2,081,050	1,151,298

\*\*\* 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: 01/01/2006 Through: 12/31/2006
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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)			
_____ 10 Times 4 =			40%
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)			
_____ 6 Times 5 =			30%
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 = 0%
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) (1)	Ending Date (MMDDYY) (2)	Hrs. ** (3)	% (4)	Account Number *** (5)	Column Number (6)	Amount (7)
01/01/2006	12/31/2006	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 <b>LUTHER HOME OF MERCY</b>	Medicaid Provider Number <b>0035287</b>	Reporting Period From: <b>01/01/2006</b> Through: <b>12/31/2006</b>
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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: 1/1/2006 Through: 12/31/2006
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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

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: 1/1/2006 Through: 12/31/2006
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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
NEIMAN ODEH	80,400	MEDICAL DIRECTOR
CHASE GOFF & BISHOP	21,745	LEGAL
ESSN	671,417	CONTRACT NURSING/DIRECT CARE
DAN HOUSEPIAN	15,770	BEHAVIOR MGMT CONSULTANT
MEDICARE	15,544	CONTRACT NURSING/DIRECT CARE
NW OHIO SPEECH	37,910	SPEECH THERAPY
OTTAWA COUNTY BOARD MRDD	536,276	DAY HAB
OTTAWA COUNTY TRANSPORTATION	24,141	RESIDENT TRANSPORTATION
PLANTE & MORAN	40,820	AUDIT

## CAPITAL COST CENTER

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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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	341,040	0	341,040	1.0000	341,040
2. Amortization - Land Improvements	8020	10,601	0	10,601	1.0000	10,601
3. Amortization - Leasehold Improvements	8030	0	0	0	1.0000	0
4. Depreciation - Equipment	8040	115,159	-85,190	29,969	1.0000	29,969
5. Depreciation - Transportation Equipment	8050	15,773	0	15,773	1.0000	15,773
6. Lease and Rent - Building	8060	0	0	0	1.0000	0
7. Lease and Rent - Equipment	8065	24,773	0	24,773	1.0000	24,773
8. Interest Exp. - Prop., Plant and Equip.	8070	148,543	-36,318	112,225	1.0000	112,225
9. Amortization of Financing Costs	8080	12,638	0	12,638	1.0000	12,638
10. Home Office Costs/Capital Cost **	8090	0	0	0	1.0000	0
<b>11. TOTAL Cost of Ownership (sum of lines 1 through 10)</b>		668,527	-121,508	547,019		547,019

\*\* 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	118,119	0	118,119	1.0000	118,119
<b>13. Total Renovations</b>		118,119	0	118,119		118,119

\*\*\* 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: 1/1/2006 Through: 12/31/2006
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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		246,449	0	246,449		246,449	
2. Buildings		9,460,997	104,299	9,565,296	5,106,430	4,458,866	341,040
3. Land Improvements		373,470	5,465	378,935	293,260	85,675	10,601
4. Leasehold Improvements		0	0	0	0	0	0
5. Equipment		2,873,658	-18,514	2,855,144	2,260,932	594,212	115,159
6. Transportation		272,686	16,033	288,719	252,892	35,827	15,773
7. Financing Costs		274,415	0	274,415	209,536	64,879	12,638
8. TOTAL		13,501,675	107,283	13,608,958	8,123,050	5,485,908	495,211

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

YES

NO

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	1,300,733	826,704	83,300	34,819	118,119
10. TOTAL	2,127,437	0	2,127,437	1,300,733	826,704	83,300	34,819	118,119

\*\* 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: 1/1/2006 Through: 12/31/2006	
CURRENT ASSETS	Chart of Acct. No.	BALANCE PER BOOKS		
		Beginning of Period	End of Period	
1. Petty Cash	1001	850	1,150	
2. Cash In Banks - General Account	1010	393,666	1,119,409	
3. Accounts Receivable	1030	1,396,213	1,351,588	
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	30,196	69,843	
8. Cost Settlement	1080	0	0	
9. Inventories	1090	22,638	22,638	
10. Prepaid Expenses	1100	40,118	40,184	
11. Short-Term Investments	1110	0	0	
12. Special Expenses	1120	0	0	
13. Total Current Assets (sum of lines 1 through 12)		1,883,681	2,604,812	
<b>PROPERTY, PLANT AND EQUIPMENT</b>				
14. Property, Plant and Equipment	1200	13,519,675	13,608,458	
15. Accumulated Depreciation and Amortization	1250	-7,847,535	-8,123,050	
16. Renovations	1300	2,124,737	2,127,437	
17. Accumulated Depreciation and Amortization - Renovations	1350	-1,221,491	-1,300,733	
18. Total Property, Plant and Equipment (sum of lines 14 through 17)		6,575,386	6,312,112	
<b>OTHER ASSETS</b>				
19. Non-Current Investments	1400	11,783,205	13,619,924	
20. Deposits	1410	458,732	473,763	
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)		12,241,937	14,093,687	
25. Total Assets (sum of lines 13, 18 and 24)		20,701,004	23,010,611	
<b>CURRENT LIABILITIES (Report credit balances as positive amounts)</b>				
26. Accounts Payable	2010	392,419	392,015	
27. Cost Settlements	2020	0	0	
28. Notes Payable	2030	0	0	
29. Current Portion of Long-Term Debt	2040	0	0	
30. Accrued Compensation	2050	1,077,293	1,044,998	
31. Payroll Related Withholdings and Liabilities	2060	170,580	164,295	
32. Taxes Payable	2080	15,557	20,800	
33. Other Liabilities - Specify below	2090	140,579	148,932	
34. Total Current Liabilities (sum of lines 26 through 33)		1,796,428	1,771,040	
<b>LONG-TERM LIABILITIES (Report credit balances as positive amounts)</b>				
35. Long-Term Debt	2410	3,675,000	3,445,000	
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, pg 1 of 2, line 4)	2440	0	0	
39. Deferred Liabilities	2450	0	0	
40. Total Long-Term Liabilities (sum of lines 35 through 39)		3,675,000	3,445,000	
41. Total Liabilities (sum of lines 34 and 40)		5,471,428	5,216,040	
42. Capital (line 25 less line 41) (to Sch E-1, pg. 1 of 2, line 1)	3000	15,229,576	17,794,571	
43. Total Liabilities and Capital (must equal line 25)		20,701,004	23,010,611	

## Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
FRANCHISE FEE PAYABLE	-140,579.00	-148,932.00
<b>TOTALS (must tie to line 33)</b>	-140,579.00	-148,932.00

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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REIMBURSABLE EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch E, line 42)	15,229,576	17,794,571
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)	15,229,576	17,794,571

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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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
<b>35. TOTAL</b>							<b>0</b>

	1	2	3	4	5**
36. Return on Equity	<u>0</u>	/	<u>12</u> X	<u>0.07235</u> /	<u>44,731</u> = <u>0.00</u>
	(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: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>ROUTINE SERVICE - ROOM AND BOARD</b>				
1. Private	5010	0	0	0
2. Medicare	5011	0	0	0
3. Medicaid	5012	14,419,039	0	14,419,039
4. Veterans	5013	0	0	0
5. Other	5014	0	0	0
6. TOTAL (lines 1 through 5)		14,419,039	0	14,419,039
<b>DEDUCTIONS FROM REVENUES</b>				
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
<b>THERAPY SERVICES</b>				
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
<b>MEDICAL SUPPLIES</b>				
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
<b>MEDICAL MINOR EQUIPMENT</b>				
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: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>ENTERAL NUTRITION THERAPY</b>				
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
<b>OTHER ANCILLARY SERVICE</b>				
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
<b>OTHER SERVICES</b>				
50. Dry Cleaning Service	5310	0	0	0
51. Communications	5320	0	0	0
52. Meals	5330	0	0	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	2,957,140	-25,210	2,931,930
60. TOTAL (lines 50 through 59)		2,957,140	-25,210	2,931,930

Line 59 Other

Account Title	Amount
OTHER PROGRAM INCOME	2,957,140
Total (must tie to line 59, column 2)	2,957,140

## REVENUE TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>NON-OPERATING</b>				
61. Management Services	5510	60,000	-60,000	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	24,268	0	24,268
70. Interest Income - Working Capital	5590	36,318	-36,318	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	85,190	-85,190	0
77. Gain/Loss on Sale of Investments	5650	1,367,415	0	1,367,415
78. Contributions	5670	274,121	0	274,121
79. TOTAL Non-operating (lines 61 through 78)		1,847,312	-181,508	1,665,804
80. TOTAL (SUM OF LINES 6, 11, 17, 26, 35, 44, 49, 60 AND 79)		19,223,491	-206,718	19,016,773

## ADJUSTMENT TO TRIAL BALANCE

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2006 Through: 12.31/2006
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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. MANAGEMENT SERVICES	5510	-60,000	0	-60,000	7210	
2. INTEREST/INVESTMENT INCOME	5590	0	-36,318	-36,318	8070	
3. GAIN/LOSS ON DISPOSAL	5640	0	-85,190	-85,190	8040	
4. PHYSICIAN'S GROUP	5400	0	-20,208	-20,208	6100	
5. PHYSICIAN'S GROUP	5400	0	-5,002	-5,002	9725	
6. A-2 Offset (Line 7, Col 2)		0	0	0	6000	
7. A-2 Offset (Line 7, Col 3)		0	0	0	6005	
8. A-2 Offset (Line 7, Col 4)		0	0	0	7055	
9. A-2 Offset (Line 12, Col 5)		0	0	0	7305	
10. TOTAL		-60,000	-146,718	-206,718		

## MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From 1/1/2006 Through: 12/31/2006
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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, 2006  
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: 1/1/2006 Through: 12/31/2006
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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

4.1

Attachment 6

## WAGE AND HOURS SURVEY

1 of 3

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 1/1/2006 Through: 12/31/2006
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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)
<b>OTHER PROTECTED COSTS</b>							
1. Water and Sewage (salary only)	6030	2,341	0	2,341	182	0	182
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
<b>1d. TOTAL Other Protected (Sum of lines 1 - 1c)</b>		2,341	0	2,341	182	0	182
<b>DIRECT CARE NURSING AND HABILITATION/REHABILITATION</b>							
2. Medical Director	6100	0	0	0	0	0	0
3. Director of Nursing	6105	109,774	0	109,774	4,074	0	4,074
4. RN Charge Nurse	6110	77,218	0	77,218	3,142	0	3,142
5. LPN Charge Nurse	6115	0	0	0	0	0	0
6. Registered Nurse	6120	314,069	0	314,069	13,911	0	13,911
7. Licensed Practical Nurse	6125	619,091	0	619,091	31,554	0	31,554
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	4,941	0	4,941	426	0	426
11. Program Specialist	6150	0	0	0	0	0	0
12. Program Director	6155	127,201	0	127,201	6,240	0	6,240
13. Habilitation Supervisor	6165	364,116	0	364,116	27,759	0	27,759
14. Habilitation Staff	6170	2,590,093	0	2,590,093	235,871	0	235,871
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	47,976	0	47,976	2,728	0	2,728
19. Social Services/Pastoral Care	6195	45,374	0	45,374	2,080	0	2,080
20. Qualified Mental Retardation Professional	6200	253,406	0	253,406	14,902	0	14,902
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
<b>24. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 2 through 23)</b>		4,584,355	0	4,584,355	344,767	0	344,767
<b>25. TOTAL Page 1 (sum of lines 1d and 24)</b>		4,586,696	0	4,586,696	344,949	0	344,949

## WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
LUTHER HOME OF MERCY		0035287		From: 1/1/2006		Through: 12/31/2006	
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)
<b>DIRECT CARE THERAPIES</b>							
26. Physical Therapist	6600	58,674	0	58,674	2,088	0	2,088
27. Physical Therapy Assistant	6605	98,148	0	98,148	4,160	0	4,160
28. Occupational Therapist	6610	0	0	0	0	0	0
29. Occupational Therapy Assistant	6615	91,081	0	91,081	4,889	0	4,889
30. Speech Therapist	6620	109,325	0	109,325	3,692	0	3,692
31. Audiologist	6630	0	0	0	0	0	0
<b>32. TOTAL Direct Care Therapies (sum of lines 26 through 31)</b>		<b>357,228</b>	<b>0</b>	<b>357,228</b>	<b>14,829</b>	<b>0</b>	<b>14,829</b>
<b>PAYROLL TAX, FRINGE BENEFITS AND STAFF DEVELOPMENT (No Purchased Nursing)</b>							
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	16,345	0	16,345	1,439	0	1,439
<b>36. TOTAL Payroll Tax, Fringe Benefits and Staff Development(sum of lines 33 through 35)</b>		<b>16,345</b>	<b>0</b>	<b>16,345</b>	<b>1,439</b>	<b>0</b>	<b>1,439</b>
<b>DIETARY COST</b>							
37. Dietitian	7000	0	0	0	0	0	0
38. Food Service Supervisor	7005	26,281	0	26,281	2,120	0	2,120
39. Dietary Personnel	7015	389,891	0	389,891	30,797	0	30,797
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
<b>43. TOTAL Dietary Cost (sum of lines 37 through 42)</b>		<b>416,172</b>	<b>0</b>	<b>416,172</b>	<b>32,917</b>	<b>0</b>	<b>32,917</b>
<b>HABILITATION AND PHARMACEUTICAL</b>							
44. Medical/Habilitation Records	7105	29,489	0	29,489	2,140	0	2,140
45. Pharmaceutical Consultant	7110	0	0	0	0	0	0
<b>46. TOTAL Habilitation, Pharmaceutical (sum of lines 44 and 45)</b>		<b>29,489</b>	<b>0</b>	<b>29,489</b>	<b>2,140</b>	<b>0</b>	<b>2,140</b>
<b>47. TOTAL Page 2 (sum of lines 32, 36, 43 and 46)</b>		<b>819,234</b>	<b>0</b>	<b>819,234</b>	<b>51,325</b>	<b>0</b>	<b>51,325</b>

## WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
LUTHER HOME OF MERCY		0035287		From: 1/1/2006		Through: 12/31/2006	
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)
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>							
48. Administrator	7200	108,734	0	108,734	2,160	0	2,160
49. Other Administrative Personnel	7210	319,310	0	319,310	19,897	0	19,897
50. Security Services (salary only)	7230	0	0	0	0	0	0
51. Laundry/Housekeeping Supervisor	7240	50,968	0	50,968	4,089	0	4,089
52. Housekeeping	7245	343,621	0	343,621	31,289	0	31,289
53. Laundry and Linen	7250	165,414	0	165,414	13,632	0	13,632
54. Accounting	7265	122,964	0	122,964	7,543	0	7,543
55. Data Services (salary only)	7285	41,840	0	41,840	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
<b>58. TOTAL Administrative and General Services (sum of lines 48 through 57)</b>		1,152,851	0	1,152,851	80,690	0	80,690
<b>MAINTENANCE AND MINOR EQUIPMENT</b>							
59. Plant Operations/Maintenance Supervisor	7320	40,253	0	40,253	2,113	0	2,113
60. Plant Operations and Maintenance	7330	129,160	0	129,160	9,531	0	9,531
<b>61. TOTAL Maintenance and Minor Equipment (sum of lines 59 and 60)</b>		169,413	0	169,413	11,644	0	11,644
<b>PAYROLL TAXES, FRINGE BENEFITS &amp; STAFF DEVELOPMENT</b>							
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
<b>65. TOTAL Payroll Taxes, Fringe Benefits, &amp; Staff Development (sum of lines 62 thru 64)</b>		0	0	0	0	0	0
<b>66. TOTAL Page 3 (sum of lines 58, 61 and 65)</b>		1,322,264	0	1,322,264	92,334	0	92,334
<b>67. TOTAL Attachment 6 Pages 1, 2 and 3(sum of lines 25, 47 and 66)</b>		6,728,194	0	6,728,194	488,608	0	488,608

ADDENDUM FOR DISPUTED COSTS

Provider Name LUTHER HOME OF MERCY	Medicaid Provider Number 0035287	Reporting Period From: 01/01/2006 Through: 12/31/2006
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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)
<b>OTHER PROTECTED COSTS</b>							
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			
<b>DIRECT CARE COST CENTER</b>							
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			
<b>INDIRECT CARE COST CENTER</b>							
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			
<b>NON-REIMBURSABLE EXPENSES</b>							
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			
<b>CAPITAL COST CENTER</b>							
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			