

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning: 1/1/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,738</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>71</u>	Intermediate (ICF)	<u>71</u>	<u>25,986</u>	3
4		Intermediate/DD			4
5	<u>14</u>	Sheltered Care (SC)	<u>14</u>	<u>5,124</u>	5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,848</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>3,931</u>		<u>3,931</u>	8
9	SNF/PED					9
10	ICF	<u>15,659</u>	<u>13,779</u>		<u>29,438</u>	10
11	ICF/DD					11
12	SC		<u>1,752</u>		<u>1,752</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,659</u>	<u>19,462</u>		<u>35,121</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.97%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/02/1953

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 43 and days of care provided 3,931

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 1/1/08 Ending: 12/31/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	301,922	45,564	6,373	353,859		353,859		353,859		1
2	Food Purchase		320,169		320,169		320,169	(12,014)	308,155		2
3	Housekeeping	113,551	28,585		142,136		142,136		142,136		3
4	Laundry	77,571	13,748		91,319		91,319		91,319		4
5	Heat and Other Utilities			165,396	165,396		165,396		165,396		5
6	Maintenance	67,300	18,755	6,780	92,835		92,835		92,835		6
7	Other (specify):*										7
8	TOTAL General Services	560,344	426,821	178,549	1,165,714		1,165,714	(12,014)	1,153,700		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,592,978	54,266	398,086	3,045,330		3,045,330		3,045,330		10
10a	Therapy										10a
11	Activities	84,855	5,401	2,000	92,256		92,256		92,256		11
12	Social Services	70,515	172	1,590	72,277		72,277		72,277		12
13	CNA Training		4,993		4,993		4,993	(15,565)	(10,572)		13
14	Program Transportation		2,740		2,740		2,740	(1,180)	1,560		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,748,348	67,572	401,676	3,217,596		3,217,596	(16,745)	3,200,851		16
	C. General Administration										
17	Administrative	77,912		25,729	103,641		103,641		103,641		17
18	Directors Fees										18
19	Professional Services			45,863	45,863		45,863		45,863		19
20	Dues, Fees, Subscriptions & Promotions			36,833	36,833		36,833	(22,944)	13,889		20
21	Clerical & General Office Expenses	174,260	13,056	9,668	196,984		196,984		196,984		21
22	Employee Benefits & Payroll Taxes			1,098,661	1,098,661		1,098,661		1,098,661		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,156	4,156		4,156		4,156		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			106,761	106,761		106,761		106,761		26
27	Other (specify):*			26,198	26,198		26,198	(14,399)	11,799		27
28	TOTAL General Administration	252,172	13,056	1,353,869	1,619,097		1,619,097	(37,343)	1,581,754		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,560,864	507,449	1,934,094	6,002,407		6,002,407	(66,102)	5,936,305		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home #0011593 Report Period Beginning: 1/1/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			216,130	216,130	216,130	(264)	215,866			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			183	183	183		183			32
33	Real Estate Taxes			(1,470)	(1,470)	(1,470)	1,470				33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			10,793	10,793	10,793		10,793			35
36	Other (specify):* Bad Debt exp.			69,248	69,248	69,248		69,248			36
37	TOTAL Ownership			294,884	294,884	294,884	1,206	296,090			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			603,213	603,213	603,213		603,213			39
40	Barber and Beauty Shops		24,386		24,386	24,386	(24,386)				40
41	Coffee and Gift Shops		981		981	981	(981)				41
42	Provider Participation Fee			62,586	62,586	62,586		62,586			42
43	Other (specify):*			44,653	44,653	44,653		44,653			43
44	TOTAL Special Cost Centers		25,367	710,452	735,819	735,819	(25,367)	710,452			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,560,864	532,816	2,939,430	7,033,110	7,033,110	(90,263)	6,942,847			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 1/1/08

Ending: 12/31/08

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,014)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,944)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(15,565)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,740)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,263)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (90,263)		37

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

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

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

BHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Mendota Lutheran Home

ID# 0011593

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bequest Expense	\$ (14,399)	27	1
2	Rental Prop Taxes	1,470	33	2
3	Barber/Beauty Shop	(24,386)	40	3
4	Gift Shop	(981)	41	4
5	Non care asset depr	(264)	30	5
6	Reim Van Usage	(1,180)	14	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,740)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,014)	0	0	0	0	0	0	0	0	0	0	(12,014)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,014)	0	0	0	0	0	0	0	0	0	0	(12,014)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(15,565)	0	0	0	0	0	0	0	0	0	0	(15,565)	13
14	Program Transportation	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(16,745)	0	0	0	0	0	0	0	0	0	0	(16,745)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,944)	0	0	0	0	0	0	0	0	0	0	(22,944)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(14,399)	0	0	0	0	0	0	0	0	0	0	(14,399)	27
28	TOTAL General Administration	(37,343)	0	0	0	0	0	0	0	0	0	0	(37,343)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,102)	0	0	0	0	0	0	0	0	0	0	(66,102)	29

STATE OF ILLINOIS

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(264)	0	0	0	0	0	0	0	0	0	0	(264)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	1,470	0	0	0	0	0	0	0	0	0	0	1,470	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,206	0	1,206	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(24,386)	0	0	0	0	0	0	0	0	0	0	(24,386)	40
41	Coffee and Gift Shops	(981)	0	0	0	0	0	0	0	0	0	0	(981)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(25,367)	0	(25,367)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(90,263)	0	(90,263)	45									

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

VII. RELATED PARTIES

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 1/1/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2007 report.		\$ 4,380	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 1,434	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,946)	3																				
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 1,476	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ (1,470)	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2003	3,829	8																				
	2004	3,987	9																				
	2005	4,098	10																				
	2006	4,663	11																				
	2007	1,434	12																				
	<table border="1"> <tr> <td colspan="4">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2007</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY				13	FROM R. E. TAX STATEMENT FOR 2007	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mendota Lutheran Home COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0011593

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-33-232-021</u>	<u>Lot</u>	\$ <u>1,433.36</u>	\$ _____
2. <u>ENS-110-30</u>	<u>Oil Well (gifted to home in bequest)</u>	\$ <u>372.48</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,805.84</u>	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning:

1/1/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,665 B. General Construction Type: Exterior Brick Frame Brick & Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Building Site</u>	<u>63,000</u>	<u>1951-1975</u>	<u>\$ 82,752</u>	<u>1</u>
2	<u>Building Site</u>	<u>53,760</u>	<u>1993</u>	<u>348,949</u>	<u>2</u>
3	TOTALS	116,760		\$ 431,701	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1953	1964	\$ 264,584	\$	Various	\$	\$	\$ 264,584	4
5			1971	1971	472,968		33			472,968	5
6			1975	1976	595,519		30			594,761	6
7			1976	1976	280,167		30			280,167	7
8			1995	1995	2,607,338	65,230	Various	65,230		883,575	8
Improvement Type**											
9		Night lights & door alarm		1971	1,244		10			1,244	9
10		Landscaping		1971	6,835		10			6,835	10
11		Bath tub ramp		1972	226		10			226	11
12		North entry alteration		1974	1,207		25			1,207	12
13		Emergency lights		1974	980		10			980	13
14		Emergency lights		1975	626		10			626	14
15		Landscaping		1976	1,086		10			1,086	15
16		Parking lot improvements		1977	3,177		10			3,177	16
17		Sprinkler system		1978	14,160		20			14,160	17
18		Building construction		1983	62,250	2,175	30	2,175		56,550	18
19		Water heater		1984	4,111		15			4,111	19
20		Cove molding		1985	2,457	98	25	98		2,340	20
21		Nurse call lights		1985	2,267		15			2,267	21
22		Heating system rev.		1985	11,343		20			11,343	22
23		Examination room		1985	5,869	196	30	196		4,617	23
24		Water heater booster		1985	782		15			782	24
25		Air Conditioner/furnace		1986	3,552		20			3,552	25
26		Water heater		1986	773		15			773	26
27		Replace roof		1987	98,780		20			98,780	27
28		Phone system		1987	3,811		20			3,811	28
29		Cupboards		1987	303		20			303	29
30		Water heater - kitchen		1988	2,805		15			2,805	30
31		Rebuild elevator		1988	19,831	162	20	162		19,831	31
32		Basement room		1988	529	22	20	22		529	32
33		Egress window		1989	810	31	26	31		607	33
34		Phase monitor		1989	348	17	20	17		336	34
35		Water heater		1989	1,298		16			1,298	35
36		Soffits & gutters		1989	9,890	380	26	380		7,414	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water heaters	1989	\$ 2,681	\$	16	\$	\$	\$ 2,681	37
38	Harris lounge light fixtures	1990	2,089		10			2,089	38
39	Replace roof south unit	1990	33,700	1,685	20	1,685		31,032	39
40	Getz hood	1990	870	44	20	44		827	40
41	Tub room	1990	3,478	116	30	116		2,184	41
42	Code alert system	1990	17,344		15			17,344	42
43	Office electrical wiring	1990	1,283	64	20	64		1,165	43
44	Ceiling in office/lounge	1990	5,181	199	26	199		3,593	44
45	Medication room	1991	18,286	610	30	610		10,975	45
46	Fire alarm system	1991	14,683	734	20	734		12,786	46
47	Doors monitor & nurse call	1991	2,971		15			2,971	47
48	Water heaters	1991	2,776		15			2,776	48
49	Shower room remodeling	1991	3,362	112	30	112		1,961	49
50	Blacktop parking lot	1991	3,180		15			3,180	50
51	Fire door in serving window	1993	3,373	87	16	87		3,373	51
52	Air Conditioner Compressor	1993	2,482		10			2,482	52
53	Air Conditioner Compressor	1993	2,072	81	15	81		2,072	53
54	Radiator covers	1993	6,405	320	20	320		4,963	54
55	Parking lot improvements	1994	1,962		10			1,962	55
56	Renovation of south unit	1994	4,551	228	20	228		3,320	56
57	Cross connectiong corrections	1994	10,878	544	20	544		7,887	57
58	Parking lot improvements	1994	141,458	9,431	15	9,431		133,601	58
59	Pressure back flow device	1995	5,567	223	25	223		3,081	59
60	South unit - laundry remodeling	1995	9,165	458	20	458		6,097	60
61	Landscaping	1996	2,841		10			2,841	61
62	Fence - west wing	1996	2,288		8			2,288	62
63	Water heater	1996	1,208	81	15	81		1,041	63
64	Lights in office	1996	2,632	132	20	132		1,701	64
65	2' water meter - west wing	1996	895	45	20	45		571	65
66	Light fixtures upstairs	1996	1,168	58	20	58		739	66
67	Vent in oxygen storage room	1996	685	46	20	46		578	67
68	Light fixture - dining room	1996	2,919	146	15	146		1,836	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,796,359	\$ 83,755		\$ 83,755	\$	\$ 3,023,642	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,796,359	\$ 83,755		\$ 83,755	\$	\$ 3,023,642	1
2	Ceiling tile - dining room	1996	982	65	20	65		818	2
3	Lights - rooms & hall center unit	1997	27,704		10			27,704	3
4	9 Zoneline heater/air conditioners	1997	6,299	53	10	53		6,299	4
5	Remodel/refurbish rooms & hall	1997	50,949	3,397	15	3,397		37,646	5
6	Fire annunciator panel	1997	2,718	181	15	181		2,008	6
7	Remodel nurses station	1997	13,762	917	15	917		10,092	7
8	Lights - rooms & hall north unit	1997	18,469		10			18,469	8
9	Water heater	1997	4,210	281	15	281		3,157	9
10	Remodel refurbish rooms & hall north unit	1997	53,073	3,538	15	3,538		39,215	10
11	Fire annunciator panel	1997	2,717	181	15	181		2,007	11
12	Windows & ceiling tile	1997	3,261	163	15	163		1,876	12
13	Corner guards	1997	473		10			473	13
14	Landscape garage	1997	200		10			200	14
15	Handicap sidewalk pad	1997	1,242	83	10	83		946	15
16	Garage for van	1997	19,744	987	15	987		11,270	16
17	Petroleum tank removal	1998	6,656	444	20	444		4,807	17
18	Windows south unit	1998	10,393	520	15	520		10,393	18
19	Windows & doors center unit	1998	9,632	482	10	482		9,632	19
20	Lights, handrails, & carpet	1998	16,378	819	10	819		16,378	20
21	New roof	1998	151,887	7,594	10	7,594		151,887	21
22	Code alert system	1998	35,360	1,768	10	1,768		35,360	22
23	Smoke alarms	1998	4,718	236	10	236		4,718	23
24	Fire alarm system upgrade	1998	6,902	345	10	345		6,902	24
25	Air conditioners	1998	6,299	315	10	315		6,299	25
26	Water heater	1998	4,197	280	15	280		2,938	26
27	Light north unit	1998	4,061	203	10	203		4,061	27
28	Water softner - west wing	1998	6,213	311	10	311		6,213	28
29	Outdoor wiring & installation	1999	10,529	526	20	526		5,177	29
30	Firesafing drywall	1999	27,134	1,809	15	1,809		17,185	30
31	Air conditioners	1999	1,899	190	10	190		1,804	31
32	Computer wiring	1999	2,154	108	20	108		996	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,306,574	\$ 109,551		\$ 109,551	\$	\$ 3,470,572	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,306,574	\$ 109,551		\$ 109,551	\$	\$ 3,470,572	1
2	Cabinet & Carpentry work	1999	10,239	683	15	683		6,485	2
3	Plumbing campbell lounge	1999	3,287	164	20	164		1,561	3
4	Electrical fixtures campbell lounge	1999	1,014	101	10	101		963	4
5	New drains south unit	2000	3,159	158	20	158		1,342	5
6	Water heater center unit	2000	7,933	793	10	793		6,743	6
7	Water heaters & plumbing	2000	2,141	214	10	214		1,820	7
8	Water valve west wing	2000	1,027	51	20	51		445	8
9	Roof replacement north unit	2001	167,190	8,360	20	8,360		59,213	9
10	Waer heater north unit	2001	4,298	430	10	430		3,224	10
11	Replace faucets north unit	2001	3,162	316	10	316		2,372	11
12	Sign	2001	2,010	201	10	201		1,508	12
13	Admin renovation & computer room	2001	2,337	234	10	234		1,753	13
14	Remodeling assisted living area	2001	77,634	3,882	20	3,882		30,268	14
15	Remodeling assisted living area	2001	36,991	3,699	10	3,699		27,743	15
16	Water heater	2001	382	38	10	38		287	16
17	Central wing lounge expansion	2001	56,597	2,830	20	2,830		20,752	17
18	Install eye wash station	2001	1,962	196	30	196		1,471	18
19	Bathroom flooring	2002	2,127	213	10	213		1,383	19
20	Remodeling & repair	2002	4,053	405	10	405		2,635	20
21	Roof top heating / cooling unit	2002	4,445	445	10	445		2,890	21
22	Dirt & seeding	2002	1,000	100	10	100		650	22
23	Water heater	2002	4,505	451	10	451		2,929	23
24	Landscaping	2002	6,822	341	20	341		2,189	24
25	Exenon heating and air conditioning system	2003	2,984	298	10	298		1,641	25
26	Exenon heating and air conditioning system	2003	2,984	298	10	298		1,641	26
27	PIV Supervisory switch	2004	1,446	145	10	145		651	27
28	Condenser/Air handler, Expansion valve	2004	8,606	403	10	403		6,239	28
29	New gas drver	2004	3,414	341	10	341		1,536	29
30	Kronos Payroll system	2004	23,494	4,699	5	4,699		21,145	30
31	Therm Unit Portable sure temp & cover	2004	910	91	10	91		409	31
32	2 recliners	2004	1,350	135	10	135		608	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,756,077	\$ 140,266		\$ 140,266	\$	\$ 3,685,068	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,756,077	\$ 140,266		\$ 140,266	\$	\$ 3,685,068	1
2	Water Meter repair chamber assembly labor	2004	1,386	139	10	139		624	2
3	Food processor, bowl & blades	2004	1,253	125	10	125		564	3
4	Garbage disposal	2004	814	81	10	81		366	4
5	Washer	2004	8,918	892	10	892		4,013	5
6	Diagnostics/call charge Hydrosound model rebuilt	2004	2,739	244	7	244		2,128	6
7	Carpet for breakroom	2005	622	72	5	72		515	7
8	Countertops breakroom	2005	1,208	44	27.5	44		167	8
9	Boilers	2006	57,281	2,083	27.5	2,083		4,860	9
10	Fire Alarm Panel	2006	11,295	411	27.5	411		958	10
11	Carpet for breakroom	2006	999	143	5	143		357	11
12	Fire Alarm Panel	2006	12,070	439	27.5	439		1,024	12
13	Labor/Materials for wall	2006	2,218	81	27.5	81		228	13
14	Carpet	2006	1,356	271	5	271		678	14
15	Abatement Disposal Asbestos	2006	8,883	592	15	592		1,431	15
16	Demo, Landfill	2006	15,000	1,000	15	1,000		2,333	16
17	Fire Alarm System	2007	16,767	1,677	10	1,677		2,515	17
18	Door protective screen	2007	650	65	10	65		98	18
19	Door frame fire door	2007	1,240	62	20	62		103	19
20	Fire Alarm System	2007	16,768	1,677	10	1,677		2,515	20
21	Building repairs & counter top	2007	14,833	742	20	742		1,236	21
22	Stein Heating unit	2007	2,950	197	15	197		213	22
23	Parking lot drainage	2007	5,841	389	15	389		617	23
24	Construction Document Preparation	2008	613	31	10	31		31	24
25	Fire Alarm Monitoring	2008	1,600	80	10	80		80	25
26	Installation of PO	2008	4,375	219	10	219		219	26
27	Survey /Recommendations for existing	2008	7,147	357	10	357		357	27
28	Cabinet & Counter Tops	2008	2,735	438	20	438		438	28
29	41 Ceiling Radiation Dampers	2008	10,746	224	20	224		23	29
30	Dual Line Dialer	2008	868	43	10	43		224	30
31	Module to Monitor Ansul System	2008	602	30	10	30		43	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,969,854	\$ 153,114		\$ 153,114	\$	\$ 3,714,026	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 709,071	\$ 59,798	\$ 59,798	\$		\$ 530,393	71
72	Current Year Purchases	65,369	2,954	2,954			2,954	72
73	Fully Depreciated Assets	615,143					615,143	73
74								74
75	TOTALS	\$ 1,389,583	\$ 62,752	\$ 62,752	\$		\$ 1,148,490	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Van	1996 Ford 8 Passenger	1993	\$ 38,350	\$	\$	\$		\$ 38,350	76
77	Resident Van	1998 Dodge Caravan SE	1999	16,593					16,593	77
78										78
79										79
80	TOTALS			\$ 54,943	\$	\$	\$		\$ 54,943	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,846,081	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 215,866	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 215,866	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,917,459	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Tree of Life	\$ 10,562	\$ 264	\$ 3,540	86
87	Lot 5/15/1990 (land)	5,500			87
88	Rental House NBV (Land) 1/1/07	17,865			88
89	Purchase & Demolition of House (land)	66,976			89
90					90
91	TOTALS	\$ 100,903	\$ 264	\$ 3,540	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 4,524 Description: KYOCERA AND COPYSTAR COPIERS FROM KYOCERA: GE CAPITAL SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>46</u>
		HOURS PER CNA <u>110</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,600		2,600
3	Classroom Wages (a)		1,067		1,067
4	Clinical Wages (b)		341		341
5	In-House Trainer Wages (c)		468		468
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,640		1,640
9	TOTALS	\$	\$ 6,116	\$	\$ 6,116
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,116		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home# 0011593Report Period Beginning: 1/1/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 426,750	\$	1
2	Cash-Patient Deposits	1,073		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	868,127		3
4	Supply Inventory (priced at)	35,905		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,277		6
7	Other Prepaid Expenses	5,057		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	5,571		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,356,760	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	854,865		12
13	Land	521,044		13
14	Buildings, at Historical Cost	5,803,327		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,622,613		16
17	Accumulated Depreciation (book methods)	(4,920,999)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,880,850	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,237,610	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 331,770	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,223		30
31	Accrued Taxes Payable (excluding real estate taxes)	119,049		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,476		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 565,518	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 565,518	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,672,092	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,237,610	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,182,324	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,182,324	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(510,232)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (510,232)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,672,092	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home# 0011593Report Period Beginning: 1/1/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,283,885	1
2	Discounts and Allowances for all Levels	(139,106)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,144,779	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,565	11
12	Gift and Coffee Shop	1,727	12
13	Barber and Beauty Care	23,716	13
14	Non-Patient Meals	12,014	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 53,022	23
D. Non-Operating Revenue			
24	Contributions	376,044	24
25	Interest and Other Investment Income***	(162,959)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 213,085	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	98,976	27
28	Royalty income	11,153	28
28a	Other revenue	1,863	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 111,992	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,522,878	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,165,714	31
32	Health Care	3,217,596	32
33	General Administration	1,619,097	33
B. Capital Expense			
34	Ownership	294,884	34
C. Ancillary Expense			
35	Special Cost Centers	673,233	35
36	Provider Participation Fee	62,586	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,033,110	40
41	Income before Income Taxes (line 30 minus line 40)**	(510,232)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (510,232)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 1/1/08

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,080	\$ 59,323	\$ 28.52	1
2	Assistant Director of Nursing	1,960	2,080	43,076	20.71	2
3	Registered Nurses	15,971	16,914	432,811	25.59	3
4	Licensed Practical Nurses	17,784	18,654	445,499	23.88	4
5	CNAs & Orderlies	134,988	139,908	1,518,001	10.85	5
6	CNA Trainees	160	160	1,640	10.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,900	4,125	61,459	14.90	8
9	Activity Director	1,960	2,080	28,086	13.50	9
10	Activity Assistants	4,076	4,363	56,769	13.01	10
11	Social Service Workers	5,145	5,386	70,515	13.09	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	34,640	16.65	13
14	Head Cook	5,861	6,246	65,621	10.51	14
15	Cook Helpers/Assistants	20,021	21,054	201,661	9.58	15
16	Dishwashers					16
17	Maintenance Workers	4,315	4,398	67,300	15.30	17
18	Housekeepers	10,370	11,386	113,551	9.97	18
19	Laundry	7,669	8,173	77,571	9.49	19
20	Administrator	1,960	2,080	77,912	37.46	20
21	Assistant Administrator					21
22	Other Administrative	1,960	2,080	43,715	21.02	22
23	Office Manager					23
24	Clerical	10,807	11,983	99,579	8.31	24
25	Vocational Instruction	640	640	15,098	23.59	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,624	2,885	31,169	10.80	31
32	Other Health C: <u>Clerical</u>	593	658	7,417	11.27	32
33	Other(specify) <u>Chaplain</u>	425	425	8,451	19.88	33
34	TOTAL (lines 1 - 33)	257,109	269,838	\$ 3,560,864 *	\$ 13.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	13,850	\$ 6,114	line 1 col 3	35
36	Medical Director	200	9,600	line 10 col 3	36
37	Medical Records Consultant	24	1,200	line 10 col 3	37
38	Nurse Consultant	645	5,225	line 10 col 3	38
39	Pharmacist Consultant		1,404	line 10 col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	814	line 11 col 3	44
45	Social Service Consultant	10	618	line 12 cold 3	45
46	Other(specify) <u>Administration</u>		32,120	line 17 col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	14,742	\$ 57,095		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,151	\$ 56,870	line 10 col 3	50
51	Licensed Practical Nurses	1,045	45,763	line 10 col 3	51
52	Certified Nurse Assistants/Aides	6,977	154,211	line 10 col 3	52
53	TOTAL (lines 50 - 52)	9,173	\$ 256,844		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

Report Period Beginning: 1/1/08

Ending:

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 20
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,266 Line 10 col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,586
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,014
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ None
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Lindgren, Callihan, Van Osdol & Co., Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule V Line 27 Column 3

Drug Testing	3879
Restricted gift expense	14399
Computer expense	7920
	<hr/>
	26198

Schedule V Line 43 Column 3

Radiology Expense	9052
Ancillary Expenses	13302
Laboratory Expense	22299
	<hr/>
	44653

2007 Long Term Care Real Estate Tax Statement B

The Oil Well was gifted to the Mendota Lutheran Home in Bequest

Schedule XVII Income Statement - Section E line 28 - Other Revenue

Offset to expense

Van usage income	Page 3 Line 24	1180
Vending Machine Income		683
		<hr/>
		1863

Schedule XIII (f) Expenses Related to Nurse Aid Training

Nurses aides trained at our facility for other homes:

Heritage Manor 1201 1st Ave., Mendota, IL 61342

Item e: The cost of dropouts and completed costs for home trained aides does not agree with Schedule V, line 13 col 8 because the home receives reimbursement from the IDPA for in house training of nurses aides. See Schedule XVII for total Nurses Aide training reimbursements of \$15,565.

Schedule XII - Rental Costs

Detail of leased equipment

Kyocera Mita Model No. KM 3060
Kyocera Mita Model No. CS 1820
Kyocera Mita Model No. CS 1820
Kyocera Mita Model No. CS 1820
Copy machines are leased from:

Kyocera
GE Capital
PO Box 740441
Atlanta, GA 30374-0441

Monthly Fee is 377.01 for all copiers

Schedule XX - General Information

Question 2 - General information

Life Services Network	3,434
AAHSA Membership	5,173
	<hr/>
	8,607

Question 12 - Schedule of allocation of salaries refer to Page 26