

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0011593</u></p> <p>Facility Name: <u>Mendota Lutheran Home</u></p> <p>Address: <u>500 Sixth Street</u> <u>Mendota</u> <u>61342</u> Number City Zip Code</p> <p>County: <u>LaSalle</u></p> <p>Telephone Number: <u>(815) 539 - 7439</u> Fax # <u>(815) 538 - 3400</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1952</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jeremy M. Brune, CPA</u> Telephone Number: <u>(779) 875 - 3979</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/13</u> to <u>12/31/13</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Jon Ragsdale</u> (Title) <u>Administrator</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u> (Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u> (Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jon Ragsdale</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u> (Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u> (Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	14	Sheltered Care (SC)	14	5,110	5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,245	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	13,757	11,789	4,616	30,162	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,564		1,564	12
13	DD 16 OR LESS					13
14	TOTALS	13,757	13,353	4,616	31,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.92%

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)

Outpatient Therapy

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 12/02/53

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 99 and days of care provided 4,522

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	360,390	46,831	7,523	414,744		414,744		414,744		1
2	Food Purchase		287,066		287,066		287,066	(13,326)	273,740		2
3	Housekeeping	157,504	26,142		183,646		183,646		183,646		3
4	Laundry	67,457	14,507		81,964		81,964		81,964		4
5	Heat and Other Utilities			129,009	129,009		129,009		129,009		5
6	Maintenance	77,673	4,913	68,442	151,028		151,028	12,239	163,267		6
7	Other (specify):*										7
8	TOTAL General Services	663,024	379,459	204,974	1,247,457		1,247,457	(1,087)	1,246,370		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	2,854,196	77,153	126,852	3,058,201		3,058,201		3,058,201		10
10a	Therapy										10a
11	Activities	78,656	10,637	1,444	90,737		90,737		90,737		11
12	Social Services	88,606	6,675	1,444	96,725		96,725		96,725		12
13	CNA Training										13
14	Program Transportation			1,742	1,742		1,742	(1,742)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,021,458	94,465	152,482	3,268,405		3,268,405	(1,742)	3,266,663		16
	C. General Administration										
17	Administrative	79,258			79,258		79,258		79,258		17
18	Directors Fees										18
19	Professional Services			145,474	145,474		145,474		145,474		19
20	Dues, Fees, Subscriptions & Promotions			39,507	39,507		39,507	(20,980)	18,527		20
21	Clerical & General Office Expenses	201,237	16,764	108,778	326,779		326,779	(96,017)	230,762		21
22	Employee Benefits & Payroll Taxes			922,343	922,343		922,343		922,343		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,277	10,277		10,277		10,277		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,001	67,001		67,001		67,001		26
27	Other (specify):*										27
28	TOTAL General Administration	280,495	16,764	1,293,380	1,590,639		1,590,639	(116,997)	1,473,642		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,964,977	490,688	1,650,836	6,106,501		6,106,501	(119,826)	5,986,675		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:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			286,954	286,954		286,954	(264)	286,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,461	14,461		14,461	(14,461)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			301,415	301,415		301,415	(14,725)	286,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		256,126	742,657	998,783		998,783		998,783			39
40	Barber and Beauty Shops			18,347	18,347		18,347	(18,244)	103			40
41	Coffee and Gift Shops			3,740	3,740		3,740		3,740			41
42	Provider Participation Fee			210,129	210,129		210,129		210,129			42
43	Other (specify):* Marketing	32,777	1,731		34,508		34,508	(34,508)				43
44	TOTAL Special Cost Centers	32,777	257,857	974,873	1,265,507		1,265,507	(52,752)	1,212,755			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,997,754	748,545	2,927,124	7,673,423		7,673,423	(187,303)	7,486,120			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

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	(13,326)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,902)	21		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	(14,461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,278)	21		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	(80,104)	21		24
25	Fund Raising, Advertising and Promotional	(20,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(53,252)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (187,303)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (187,303)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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 HomeID# 0011593Report Period Beginning: 01/01/13Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Beauty Shop Revenue	\$ (18,244)	40	1
2	Transportation Revenue	(1,742)	14	2
3	Miscellaneous Revenue	(5,963)	21	3
4	Bank Charges	(373)	21	4
5	Marketing Wages	(32,777)	43	5
6	Marketing Supplies	(1,731)	43	6
7	Loan Financing Fees	(4,397)	21	7
8	Non-Care Depreciation	(264)	30	8
9	Leasehold Improvements - Under \$2,500	2,200	06	9
10	Equipment - Under \$2,500	10,039	06	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
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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	(53,252)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,326)	0	0	0	0	0	0	0	0	0	0	(13,326)	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	12,239	0	0	0	0	0	0	0	0	0	0	12,239	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,087)	0	(1,087)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,742)	0	0	0	0	0	0	0	0	0	0	(1,742)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,742)	0	(1,742)	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	(20,980)	0	0	0	0	0	0	0	0	0	0	(20,980)	20
21	Clerical & General Office Expenses	(96,017)	0	0	0	0	0	0	0	0	0	0	(96,017)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(116,997)	0	(116,997)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(119,826)	0	(119,826)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(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	(14,461)	0	0	0	0	0	0	0	0	0	0	(14,461) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(14,725)	0	0	0	0	0	0	0	0	0	0	(14,725) 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	(18,244)	0	0	0	0	0	0	0	0	0	0	(18,244) 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(34,508)	0	0	0	0	0	0	0	0	0	0	(34,508) 43
44	TOTAL Special Cost Centers	(52,752)	0	0	0	0	0	0	0	0	0	0	(52,752) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(187,303)	0	0	0	0	0	0	0	0	0	0	(187,303) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Director Listing							1
2								2
3								3
4								4
5	Ken Kurth							5
6	Ginny Becker							6
7	Greta Bates							7
8	Gloria Cogdal							8
9	John Nielsen							9
10	Rev. Dale Peterson							10
11	Rev. Kevin Weeks							11
12	Rev. Mike Morrell							12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21	None of the above listed board							21
22	members received compensation nor							22
23	provided direct services to Mendota							23
24	Lutheran Home during 2013.							24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	N/A								\$	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:

01/01/13

Ending: 12/31/13

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	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Eureka Savings		X	Line of Credit						8,027	6							
7	Midland States Bank		X	Line of Credit			572,923			6,551	7							
8	Other		X							(117)	8							
9	TOTAL Facility Related					\$	\$ 572,923			\$ 14,461	9							
B. Non-Facility Related*																		
10	Interest Income		X							(14,461)	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ (14,461)	14							
15	TOTALS (line 9+line14)					\$	\$ 572,923			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2012 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (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.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2008	8
	2009	9
	2010	10
	2011	11
	2012	12

N/A - Non Profit Organization

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	\$	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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,665 B. General Construction Type: Exterior Brick Frame Brick and 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	63,000	1951 - 75	\$ 82,752	1
2	Facility	53,760	1993	348,949	2
3	TOTALS	116,760		\$ 431,701	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1953	1964	\$ 264,584	\$		\$	\$	\$	4
5			1971	1971	472,968						5
6			1975	1976	595,519						6
7			1976	1976	280,167						7
8			1995	1995	2,607,338						8
	Improvement Type**										
9	Various		1971		8,079						9
10	Various		1972		226						10
11	Various		1974		2,187						11
12	Various		1975		626						12
13	Various		1976		1,086						13
14	Various		1977		3,177						14
15	Various		1978		14,160						15
16	Various		1983		62,250						16
17	Various		1984		4,111						17
18	Various		1985		22,718						18
19	Various		1986		4,325						19
20	Various		1987		102,894						20
21	Various		1988		23,165						21
22	Various		1989		15,027						22
23	Various		1990		63,945						23
24	Various		1991		45,258						24
25	Various		1993		14,332						25
26	Various		1994		158,849						26
27	Various		1995		14,732						27
28	Various		1996		15,618						28
29	Various		1997		204,821						29
30	Various		1998		262,696						30
31	Various		1999		56,256						31
32	Various		2000		14,260						32
33	Various		2001		352,563						33
34	Various		2002		22,952						34
35	Various		2003		5,968						35
36	Various		2004		54,330						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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2005	\$ 1,830	\$		\$	\$	37
38	Various	2006	109,102					38
39	Various	2007	59,049					39
40	Various	2008	28,686					40
41	Various	2009	92,330					41
42	Dishwashing Room - Drywall and Flooring	2010	7,371					42
43	Sprinkler System	2010	94,500					43
44	Paint Rooms	2010	6,100					44
45	Automatic Doors	2010	4,061					45
46	Door Locks and Installation	2010	7,081					46
47	Fire Protection System	2011	24,424					47
48	Boiler	2011	20,757					48
49	Painting - Hallways and Wing Lounges	2011	7,040					49
50	Garage Construction	2011	50,300					50
51	Overhead Doors	2011	3,170					51
52	Electrical Wiring	2011	2,895					52
53	Painting - Hallways and Wing Lounges	2012	38,163					53
54	Flooring - Therapy Department / Lounge	2012	11,067					54
55	Concrete Sidewalk	2012	21,032					55
56	Roof	2012	100,640					56
57	Walk In Cooler	2013	44,657					57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 6,505,442	\$		\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 6,505,442	\$		\$	\$	\$	1
2									2
3	Leasehold Improvements - Disposals								3
4									4
5	Various	1964	(1,645)						5
6	Various	1972	(226)						6
7	Various	1984	(4,111)						7
8	Various	1985	(5,506)						8
9	Various	1986	(773)						9
10	Various	1987	(99,083)						10
11	Various	1989	(1,298)						11
12	Various	1990	(33,700)						12
13	Various	1991	(17,459)						13
14	Various	1993	(2,072)						14
15	Various	1995	(21,567)						15
16	Various	1996	(1,208)						16
17	Various	1997	(9,645)						17
18	Various	1998	(10,410)						18
19	Various	2000	(1,027)						19
20	Various	2001	(9,170)						20
21	Various	2002	(4,505)						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation			140,724		140,724		4,032,164	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,282,037	\$ 140,724		\$ 140,724	\$	\$ 4,032,164	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 Costs-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	\$ 2,234,082	\$ 126,066	\$ 126,066	\$	3 - 15	\$ 1,227,508	71
72	Current Year Purchases	11,403	1,766	1,766		3 - 15	1,766	72
73	Fully Depreciated Assets							73
74	Dispositions	(519,542)						74
75	TOTALS	\$ 1,725,943	\$ 127,832	\$ 127,832	\$		\$ 1,229,274	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Dodge Caravan - 1998	1999	\$ 16,583	\$	\$	\$	5	\$ 16,583	76
77	Facility	Ford Elkhard - 2010	2010	50,002	10,000	10,000		5	35,000	77
78	Facility	Dodge Caravan - 2012	2012	40,669	8,134	8,134		5	12,201	78
79										79
80	TOTALS			\$ 107,254	\$ 18,134	\$ 18,134	\$		\$ 63,784	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 8,546,935	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 286,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,690	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)	\$ 5,325,222	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	\$ 4,861	86
87	Land	5,500			87
88	Land (Including Demolition)	83,843			88
89					89
90					90
91	TOTALS	\$ 99,905	\$ 264	\$ 4,861	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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	263,772	\$		\$	263,772	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				62,043				62,043	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				383,041				383,041	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					115,374			115,374	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Supplemental</u>	39 - 02						140,752			140,752	12
13	Other (specify): <u>See Supplemental</u>	39 - 03					33,801				33,801	13
14	TOTAL			\$		\$	742,657	\$	256,126	\$	998,783	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

**Mendota Lutheran Home
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 16 Supplemental Schedule

<u>Description</u>	<u>Supplies</u>	<u>Other</u>
Medical Supplies	116,958	
Therapy Supplies	20,193	
Radiology		5,560
Laboratory		24,295
Other	3,601	3,946
Total	<u>140,752</u>	<u>33,801</u>

Facility Name & ID Number Mendota Lutheran Home# 0011593Report Period Beginning: 01/01/13Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 168,920	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>130,000</u>)	885,409		3
4	Supply Inventory (priced at)	41,269		4
5	Short-Term Investments			5
6	Prepaid Insurance	94,822		6
7	Other Prepaid Expenses	9,922		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	42,629		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,242,971	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,871,790		12
13	Land	521,044		13
14	Buildings, at Historical Cost	5,981,822		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,926,716		16
17	Accumulated Depreciation (book methods)	(5,330,083)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,971,289	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,214,260	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 687,976	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	572,923		29
30	Accrued Salaries Payable	270,794		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,768		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,492		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,546,953	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,546,953	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,667,307	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,214,260	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Mendota Lutheran Home
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Interest Receivable	6,639	
Estates Receivable	4,817	
Medicare Cost Report Settlement	31,173	
Total	42,629	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,427,437	1
2	Restatements (describe):		2
3	Audit Adjustments	(148,887)	3
4	Beneficial Interest In Trust	799,942	4
5	Rounding	(3)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,078,489	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(411,182)	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)	\$ (411,182)	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)	\$ 4,667,307	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,453,192	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,453,192	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,092	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 279,092	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,128	12
13	Barber and Beauty Care	18,244	13
14	Non-Patient Meals	13,326	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	55,938	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 90,636	23
D. Non-Operating Revenue			
24	Contributions	226,743	24
25	Interest and Other Investment Income***	199,738	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 426,481	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	12,841	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,841	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,262,241	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,247,457	31
32	Health Care	3,268,405	32
33	General Administration	1,590,639	33
B. Capital Expense			
34	Ownership	301,415	34
C. Ancillary Expense			
35	Special Cost Centers	1,055,378	35
36	Provider Participation Fee	210,129	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,673,423	40
41	Income before Income Taxes (line 30 minus line 40)**	(411,182)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (411,182)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,707,454	44
45	Private Pay - Net Inpatient Revenue	2,572,747	45
46	Medicare - Net Inpatient Revenue	2,172,991	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,453,192	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Mendota Lutheran Home
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Royalty Revenue	3,756	
Transportation Revenue	2,175	2,175
Vending Maching Revenue	948	
Miscellaneous Income	5,962	5,962
Total	<u>12,841</u>	<u>8,137</u>

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,732	2,080	\$ 69,261	\$ 33.30	1
2	Assistant Director of Nursing	1,792	2,080	61,839	29.73	2
3	Registered Nurses	19,132	21,536	612,264	28.43	3
4	Licensed Practical Nurses	22,526	25,379	641,340	25.27	4
5	CNAs & Orderlies	97,661	108,491	1,413,887	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	34,126	16.41	9
10	Activity Assistants	4,549	4,747	44,530	9.38	10
11	Social Service Workers	5,897	6,414	88,606	13.81	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,080	37,813	18.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,853	31,891	322,577	10.11	15
16	Dishwashers					16
17	Maintenance Workers	4,167	4,463	77,673	17.40	17
18	Housekeepers	12,421	13,545	157,504	11.63	18
19	Laundry	6,409	6,941	67,457	9.72	19
20	Administrator	1,848	2,080	79,258	38.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,818	17,802	201,237	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,749	4,163	55,605	13.36	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,411	1,554	32,777	21.09	33
34	TOTAL (lines 1 - 33)	233,765	257,326	\$ 3,997,754 *	\$ 15.54	34

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	163	\$ 7,523	01 - 03	35
36	Medical Director	312	21,000	09 - 03	36
37	Medical Records Consultant	18	1,200	10 - 03	37
38	Nurse Consultant		2,233	10 - 03	38
39	Pharmacist Consultant		5,525	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,444	11 - 03	44
45	Social Service Consultant	19	1,444	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	530	\$ 40,369		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses	791	30,456	10 - 03	51
52	Certified Nurse Assistants/Aides	3,838	87,439	10 - 03	52
53	TOTAL (lines 50 - 52)	4,629	\$ 117,895		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jon Ragsdale	Administrator	0	\$ 79,258	Workers' Compensation Insurance	\$ 92,515	IDPH License Fee	\$ 2,029	
				Unemployment Compensation Insurance	15,937	Advertising: Employee Recruitment	4,184	
				FICA Taxes	292,224	Health Care Worker Background Check	1,670	
				Employee Health Insurance	449,762	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	1,130	
				Illinois Municipal Retirement Fund (IMRF)*		Manuals and Subscriptions	2,092	
				401K Employee Match	33,705	Association Dues	7,422	
				Employee Recognition	27,250	Advertising and Public Relations	20,980	
				Physicals and Drug Testing	10,950			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,258	TOTAL (agree to Schedule V, line 22, col.8)		\$ 18,527		
B. Administrative - Other								
Description			Amount					
			\$					
			\$					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Description	Amount	
Guilfoyle Law Firm	Legal		\$ 40			Out-of-State Travel	\$	
Duane Morris	Legal		1,173					
Aplington, Kaurman, McClintock & Stelle	Collections		681			In-State Travel		
Wessels Sherman	HR Consultant		1,578					
Jeremy Brune & Associates, LLC	Accounting		20,245					
Echols & Associates, P.C.	Accounting		4,770			Seminar Expense	10,277	
Frost, Ruttenberg & Rothblatt	Accounting		385					
WIPFLI	Accounting		395					
Benefit Services Group	Accounting		100					
Nebo Systems	Data Processing		340					
See Supplemental Schedule			115,767			Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 145,474	TOTAL		TOTAL (agree to Sch. V, line 24, col. 8) \$ 10,277		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

**Mendota Lutheran Home
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Page 21 Supplemental Schedule - Other Professional Fees

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
ADP / Paylocity	Payroll Processing	45,629
Wecom Solutions	Data Processing	27,882
Cerner Corporation	Data Processing	11,792
Ability Ease	Data Processing	4,393
Verison	Data Processing	351
Carbonite Online Services	Data Processing	120
Yahoo Web Hosting	Data Processing	13
E Solutions	Data Processing	1,392
DC Computers	Data Processing	21,545
Other	Data Processing	2,650

Total	<u><u>115,767</u></u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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# 0011593

Report Period Beginning:

01/01/13Ending: 12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN / AAHSA - \$
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 71,188 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 210,129
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,326
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Jeremy Brune & Associates, LLC
- (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