

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	12,875	12,912	3,143	28,930	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		756		756	12
13	DD 16 OR LESS					13
14	TOTALS	12,875	13,668	3,143	29,686	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.97%

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)

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 2,735

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

* 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: 01/01/15 Ending: 12/31/15

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	356,234	54,654	8,235	419,123		419,123		419,123		1
2	Food Purchase		266,937		266,937		266,937	(15,057)	251,880		2
3	Housekeeping	118,103	20,895		138,998		138,998		138,998		3
4	Laundry	74,340	13,688		88,028		88,028		88,028		4
5	Heat and Other Utilities			140,390	140,390		140,390	(8,100)	132,290		5
6	Maintenance	78,521	2,960	42,655	124,136		124,136	2,230	126,366		6
7	Other (specify):* See Supplemental										7
8	TOTAL General Services	627,198	359,134	191,280	1,177,612		1,177,612	(20,927)	1,156,685		8
	B. Health Care and Programs										
9	Medical Director			21,360	21,360		21,360		21,360		9
10	Nursing and Medical Records	2,586,912	73,886	250,788	2,911,586		2,911,586		2,911,586		10
10a	Therapy										10a
11	Activities	86,015	13,132	942	100,089		100,089		100,089		11
12	Social Services	88,197	8,870	942	98,009		98,009		98,009		12
13	CNA Training										13
14	Program Transportation			3,184	3,184		3,184	(3,184)			14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	2,761,124	95,888	277,216	3,134,228		3,134,228	(3,184)	3,131,044		16
	C. General Administration										
17	Administrative	82,927			82,927		82,927		82,927		17
18	Directors Fees										18
19	Professional Services			164,728	164,728		164,728	(907)	163,821		19
20	Dues, Fees, Subscriptions & Promotions			20,229	20,229		20,229		20,229		20
21	Clerical & General Office Expenses	204,526	13,897	21,335	239,758		239,758	(10,153)	229,605		21
22	Employee Benefits & Payroll Taxes			703,900	703,900		703,900		703,900		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,375	6,375		6,375		6,375		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			68,184	68,184		68,184		68,184		26
27	Other (specify):* See Supplemental										27
28	TOTAL General Administration	287,453	13,897	984,751	1,286,101		1,286,101	(11,060)	1,275,041		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,675,775	468,919	1,453,247	5,597,941		5,597,941	(35,171)	5,562,770		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:

01/01/15

Ending:

12/31/15

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			283,665	283,665		283,665	(264)	283,401			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,367	25,367		25,367	(13,777)	11,590			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			309,032	309,032		309,032	(14,041)	294,991			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,897	534,612	754,509		754,509		754,509			39
40	Barber and Beauty Shops			20,993	20,993		20,993	(20,798)	195			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,778	212,778		212,778		212,778			42
43	Other (specify):* See Supplemental	33,642	39	25,452	59,133		59,133	(59,133)				43
44	TOTAL Special Cost Centers	33,642	219,936	793,835	1,047,413		1,047,413	(79,931)	967,482			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,709,417	688,855	2,556,114	6,954,386		6,954,386	(129,143)	6,825,243			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

**Mendota Lutheran Home
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Marketing	33,642	39	25,452
Total	33,642	39	25,452

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	(15,057)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,100)	05		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	(13,777)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,841)	21		24
25	Fund Raising, Advertising and Promotional				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	(84,368)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,143)		\$	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))	\$ (129,143)		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 Home

ID# 0011593

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Care Assets - Depreciation	\$ (264)	30	1
2	Beauty Shop Revenue	(20,798)	40	2
3	Transporation Revenue	(3,184)	14	3
4	Miscellaneous Revenue	(1,804)	21	4
5	Bank Charges	(138)	21	5
6	Other Admin Expenses	(370)	21	6
7	Marketing Expenses	(59,133)	43	7
8	Capitalized Asset FS < \$2,500	2,230	06	8
9	Legal Fees - Retainer and Collections	(907)	19	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	(84,368)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(15,057)	0	0	0	0	0	0	0	0	0	0	(15,057)	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	(8,100)	0	0	0	0	0	0	0	0	0	0	(8,100)	5
6	Maintenance	2,230	0	0	0	0	0	0	0	0	0	0	2,230	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,927)	0	0	0	0	0	0	0	0	0	0	(20,927)	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	(3,184)	0	0	0	0	0	0	0	0	0	0	(3,184)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,184)	0	0	0	0	0	0	0	0	0	0	(3,184)	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	(907)	0	0	0	0	0	0	0	0	0	0	(907)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(10,153)	0	0	0	0	0	0	0	0	0	0	(10,153)	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	(11,060)	0	0	0	0	0	0	0	0	0	0	(11,060)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,171)	0	0	0	0	0	0	0	0	0	0	(35,171)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(13,777)	0	0	0	0	0	0	0	0	0	0	(13,777) 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	(14,041)	0	0	0	0	0	0	0	0	0	0	(14,041) 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	(20,798)	0	0	0	0	0	0	0	0	0	0	(20,798) 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):*	(59,133)	0	0	0	0	0	0	0	0	0	0	(59,133) 43
44	TOTAL Special Cost Centers	(79,931)	0	0	0	0	0	0	0	0	0	0	(79,931) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(129,143)	0	0	0	0	0	0	0	0	0	0	(129,143) 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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
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 Directors							1
2								2
3								3
4	Rev. Kevin Weeks							4
5	Rev. Ann Hoflen							5
6	Rev. Tammy Anderson							6
7	Greta Bates							7
8	Lorraine Loomis							8
9	John Nielsen							9
10	Ed Bock							10
11	David Jones							11
12	Tim Munson							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 2015.							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: 01/01/15 Ending: 12/31/15

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:

01/01/15

Ending: 12/31/15

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 (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 2014 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 2015 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:	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

N/A - Non Profit Organization

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:

01/01/15 Ending:

12/31/15

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? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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).

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Rows include Facility, Facility, and TOTALS.

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	\$ 262,939	\$		\$	\$	\$	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								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								17
18	Various		1985		17,212						18
19	Various		1986		3,552						19
20	Various		1987		3,811						20
21	Various		1988		23,165						21
22	Various		1989		13,729						22
23	Various		1990		30,245						23
24	Various		1991		27,799						24
25	Various		1993		12,260						25
26	Various		1994		158,849						26
27	Various		1995								27
28	Various		1996		14,410						28
29	Various		1997		195,176						29
30	Various		1998		252,286						30
31	Various		1999		56,256						31
32	Various		2000		13,233						32
33	Various		2001		343,393						33
34	Various		2002		18,447						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	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	Various	2005	\$ 1,830	\$		\$	\$	\$	37
38	Various	2006	109,102						38
39	Various	2007	59,049						39
40	Various	2009	28,686						40
41	Various	2009	92,330						41
42	Various	2010	119,113						42
43	Various	2011	108,586						43
44	Painting - Hallways and Wing Lounges	2012	38,163						44
45	Flooring - Therapy Department / Lounge	2012	11,067						45
46	Concrete Sidewalk	2012	21,032						46
47	Roof	2012	100,640						47
48	Walk In Cooler	2013	44,657						48
49	Hot Water Heaters and Installation (2)	2014	23,115						49
50	Fire System - Backflow Valves	2015	3,246						50
51	10 Ton Rooftop AC Unit	2015	12,630						51
52	Side Walk - Expensed Under \$2,500	2015							52
53	Painting - Resident Rooms	2015	3,865						53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Depreciation - Financial Statements			135,402		135,402		4,312,728	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,331,728	\$ 135,402		\$ 135,402	\$	\$ 4,312,728	70

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	\$ 1,850,432	\$ 128,728	\$ 128,728	\$		\$ 1,479,310	71
72	Current Year Purchases	88,845	6,137	6,137			6,137	72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$ 1,939,277	\$ 134,865	\$ 134,865	\$		\$ 1,485,447	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	Patient Transportation	Dodge Caravan - 1998	1999	\$ 16,583	\$	\$	\$		\$ 16,583	76
77	Patient Transportation	Ford Elkhart - 2010	2010	50,002	5,000	5,000			50,002	77
78	Patient Transportation	Dodge Caravan - 2012	2012	40,669	8,134	8,134			28,468	78
79										79
80	TOTALS			\$ 107,254	\$ 13,134	\$ 13,134	\$		\$ 95,053	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)		\$ 8,809,960	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 283,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 283,401	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)		\$ 5,893,228	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	Land	\$ 5,000	\$	\$	86
87	Land (Including Demolition)	83,843			87
88	Tree of Life	10,562	264	5,411	88
89	Land	43,897			89
90					90
91	TOTALS	\$ 143,302	\$ 264	\$ 5,411	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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

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.	<u> </u> /2016	\$ <u> </u>
13.	<u> </u> /2017	\$ <u> </u>
14.	<u> </u> /2018	\$ <u> </u>

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: \$ 0 Description: _____

(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.

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	\$		\$	131,041	\$		\$	131,041	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				42,699				42,699	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				343,407				343,407	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					102,947			102,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						116,950			116,950	12
13	Other (specify): See Supplemental	39 - 03					17,465				17,465	13
14	TOTAL			\$		\$	534,612	\$	219,897	\$	754,509	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
01/01/15 - 12/31/15**

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	103,318	
Other	13,632	
Lab		11,613
Radiology		5,852
Total	<u>116,950</u>	<u>17,465</u>

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>40,000</u>)	771,046		3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)	43,183		4
5	Short-Term Investments	1,715,779		5
6	Prepaid Insurance	100,630		6
7	Other Prepaid Expenses	12,092		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	300,426		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,943,156	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	564,941		13
14	Buildings, at Historical Cost	6,021,223		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,145,735		16
17	Accumulated Depreciation (book methods)	(5,898,639)		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)	\$ 2,833,260	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,776,416	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 605,667	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	645,050		29
30	Accrued Salaries Payable	97,808		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,749		31
32	Accrued Real Estate Taxes(Sch.IX-B)	881		32
33	Accrued Interest Payable	1,860		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)	\$ 1,355,015	\$	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)	\$ 1,355,015	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,421,401	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,776,416	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Mendota Lutheran Home
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
401K Forfeitures	2,400	
Intransit & Interest Receivable	6,534	
Estates Receivable	291,492	
Total	300,426	-
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	\$ 4,498,007	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,498,007	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(76,606)	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)	\$ (76,606)	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)	\$ 4,421,401	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,285,016	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,285,016	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	205,467	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 205,467	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	1,001	12
13	Barber and Beauty Care	20,798	13
14	Non-Patient Meals	15,057	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)	\$ 36,856	23
D. Non-Operating Revenue			
24	Contributions	366,054	24
25	Interest and Other Investment Income***	13,777	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 379,831	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	(29,390)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (29,390)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,877,780	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,177,612	31
32	Health Care	3,134,228	32
33	General Administration	1,286,101	33
B. Capital Expense			
34	Ownership	309,032	34
C. Ancillary Expense			
35	Special Cost Centers	834,635	35
36	Provider Participation Fee	212,778	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,954,386	40
41	Income before Income Taxes (line 30 minus line 40)**	(76,606)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (76,606)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,645,942	44
45	Private Pay - Net Inpatient Revenue	3,153,421	45
46	Medicare - Net Inpatient Revenue	1,485,653	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>		47
48	Other-(specify) <u>Veterans and Hospice - Net Inpatient Revenue</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,285,016	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
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Transportation Revenue	12,900	3,184
Royalty Revenue	1,744	
Vending Machine Commissions	938	
Miscellaneous Revenue	1,804	1,804
Unrealized Losses on Investments	(46,776)	
Total	<u>(29,390)</u>	<u>4,988</u>

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2,080	2,271	\$ 74,151	\$ 32.65	1
2	Assistant Director of Nursing	1,109	1,370	41,171	30.05	2
3	Registered Nurses	23,990	25,050	688,005	27.47	3
4	Licensed Practical Nurses	14,596	15,868	406,400	25.61	4
5	CNAs & Orderlies	97,662	107,668	1,320,279	12.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,888	2,080	34,209	16.45	9
10	Activity Assistants	4,688	5,083	51,806	10.19	10
11	Social Service Workers	5,880	6,501	88,197	13.57	11
12	Dietician					12
13	Food Service Supervisor	1,843	2,100	38,883	18.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,291	31,740	317,351	10.00	15
16	Dishwashers					16
17	Maintenance Workers	4,086	4,561	78,521	17.22	17
18	Housekeepers	8,911	10,136	118,103	11.65	18
19	Laundry	6,977	7,650	74,340	9.72	19
20	Administrator	1,890	2,081	82,927	39.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,932	12,149	204,526	16.83	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	3,678	4,152	56,906	13.71	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,418	1,580	33,642	21.29	33
34	TOTAL (lines 1 - 33)	221,919	242,040	\$ 3,709,417 *	\$ 15.33	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	\$ 8,235	01 - 03	35
36	Medical Director	21,360	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant	42,783	10 - 03	38
39	Pharmacist Consultant	9,144	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	942	11 - 03	44
45	Social Service Consultant	942	12 - 03	45
46	Other(specify)			46
47	<u>Dental</u>	5,047	10 - 03	47
48				48
49	TOTAL (lines 35 - 48)	\$ 88,453		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 10,910	10 - 03	50
51	Licensed Practical Nurses	49,559	10 - 03	51
52	Certified Nurse Assistants/Aides	133,945	10 - 03	52
53	TOTAL (lines 50 - 52)	\$ 194,414		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

**Mendota Lutheran Home
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 21 Supplemental Schedule - Seminar Schedule

Payee	Course	Attendee	Location	Cost
Mather Life Ways	Ways to Understand Resident Sexuality	Kari Lazzarotto	MLH	49
Mather Life Ways	Ways to Understand Resident Sexuality	Lorena Lemus	MLH	-
All Risk Training & Safety	CPR & AED Class	See Attached Listing	MLH	336
All Risk Training & Safety	CPR & AED Class	See Attached Listing	MLH	336
Leading Age	ICD-10	See Attached Listing	MLH	250
NADONALTC	Renewal of Membership	Mary Wren		210
IVCC	Neuro Through The Ages	Sheri Bowne	IVCC Oglesby IL	112
INHAA	INHAA Convention	Sheri Bowne	Springfield IL	144
INHAA	INHAA Convention	Kari Lazzarotto	Springfield IL	125
Pathway	Infection Prevention & Control - System Check	Amber Badgett	MLH	89
Mather Life Ways	Ways to Understand Resident Sexuality	Jon Ragsdale	MLH	-
NHRMA	Workers Compensation 2015 Regional Training	Jon Ragsdale	Dekalb IL	51
Leading Age	Medicare Updates 2015	Sue Wujek	MLH	50
Leading Age	Medicare Updates 2015	Anita Matuszewski	MLH	50
INHAA	Latest Trends in Great Clinical Care	Jon Ragsdale	Bloomington IL	188
INHAA		Jon Ragsdale	Bloomington IL	95
AANAC	Medicare University	Anita Matuszewski	Mokena IL	917
INHAA	Surviving in a Data-Driven World	Jon Ragsdale	East Peoria IL	84
NHRMA	2015 Regional Training	Jon Ragsdale	Dekalb IL	51
US Foods	Food Fanatics	Jon Ragsdale	Schaumburg, IL	99
INHAA	2015 Annual Convention	Sue Wujek	Springfield IL	427
Wessels Sherman	Legal Winds Blow Through the City	Marylee Simpson	Chicago IL	466
NHRMA		Marylee Simpson	Dekalb IL	63
Mather Life Ways	Ways to Understand Resident Sexuality	Becky Deming	MLH	-
Mather Life Ways	Ways to Understand Resident Sexuality	Judy Spenader	MLH	-
Mather Life Ways	Ways to Understand Resident Sexuality	Julie Wicks	MLH	-
Sue Kainrath	Safe Food Handlers Corp	Karen Wold	Peru IL	145
Sue Kainrath	Safe Food Handlers Corp	Linda Pellens	Peru IL	168
Sue Kainrath	Safe Food Handlers Corp	Toya Butler	Peru IL	153
Illinois Assoc of Nutrition & Food P	IANFP Fall Workshop	Karen Wold	Springfield, IL	333
Service Safe	Food Service Sanitation	Cathy Kiefer	Peru IL	180
Service Safe	Food Service Sanitation	Gina Johnson	Peru IL	156
Al Litwiller	Team Building	See attached Listing	MLH	75
Other				973
Total				<u>6,375</u>

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												
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17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

