FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0011593

Facility Name: Mendota Lutheran Home

Address: 500 Sixth Street (Number) Mendota (City) 61342 (Zip Code)

County: LaSalle

Telephone Number: (815) 539 - 7439 **Fax #** (815) 538 - 3400

HFS ID Number:

Date of Initial License for Current Owners: 1952

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune, CPA **Telephone Number:** (779) 875 - 3979
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Jeremy M. Brune, CPA, President
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	14	Sheltered Care (SC)	14	5,124	5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,358	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,946	10,574	3,026	24,546	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		363		363	12
13	DD 16 OR LESS					13
14	TOTALS	10,946	10,937	3,026	24,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.23%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,506

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	350,426	33,513	8,008	391,947		391,947		391,947			1
2	Food Purchase		234,715		234,715		234,715	(14,136)	220,579			2
3	Housekeeping	127,464	19,061		146,525		146,525		146,525			3
4	Laundry	63,712	10,097		73,809		73,809		73,809			4
5	Heat and Other Utilities			102,718	102,718		102,718		102,718			5
6	Maintenance	79,421	3,133	50,405	132,959		132,959	(3,614)	129,345			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	621,023	300,519	161,131	1,082,673		1,082,673	(17,750)	1,064,923			8
	B. Health Care and Programs											
9	Medical Director			21,360	21,360		21,360		21,360			9
10	Nursing and Medical Records	2,437,250	91,599	79,865	2,608,714		2,608,714		2,608,714			10
10a	Therapy											10a
11	Activities	84,565	11,331	1,320	97,216		97,216		97,216			11
12	Social Services	88,803	822	12,130	101,755		101,755		101,755			12
13	CNA Training											13
14	Program Transportation			1,386	1,386		1,386	(1,386)				14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,610,618	103,752	116,061	2,830,431		2,830,431	(1,386)	2,829,045			16
	C. General Administration											
17	Administrative	74,720		15,481	90,201		90,201		90,201			17
18	Directors Fees											18
19	Professional Services			168,235	168,235		168,235	(970)	167,265			19
20	Dues, Fees, Subscriptions & Promotions			18,156	18,156		18,156		18,156			20
21	Clerical & General Office Expenses	192,686	17,524	28,336	238,546		238,546	(17,743)	220,803			21
22	Employee Benefits & Payroll Taxes			706,503	706,503		706,503		706,503			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,904	4,904		4,904		4,904			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,525	69,525		69,525	(10,004)	59,521			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	267,406	17,524	1,011,140	1,296,070		1,296,070	(28,717)	1,267,353			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,499,047	421,795	1,288,332	5,209,174		5,209,174	(47,853)	5,161,321			29

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

SEE ACCOUNTANTS' PREPARATION 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: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			264,718	264,718		264,718	(264)	264,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,352	28,352		28,352	(17,774)	10,578			32
33	Real Estate Taxes			801	801		801	(801)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,649	6,649		6,649		6,649			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			300,520	300,520		300,520	(18,839)	281,681			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,069	530,653	715,722		715,722		715,722			39
40	Barber and Beauty Shops			14,895	14,895		14,895	(14,895)				40
41	Coffee and Gift Shops			117	117		117	(117)				41
42	Provider Participation Fee			191,089	191,089		191,089		191,089			42
43	Other (specify):* See Supplemental	36,835	1,679	18,955	57,469		57,469	(57,469)				43
44	TOTAL Special Cost Centers	36,835	186,748	755,709	979,292		979,292	(72,481)	906,811			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,535,882	608,543	2,344,561	6,488,986		6,488,986	(139,173)	6,349,813			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Mendota Lutheran Home
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Marketing	36,835	1,679	18,755	57,269
Investment Fees			200	200
				-
				-
				-
				-
				-
Sub-Total	36,835	1,679	18,955	57,469

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,136)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,246)	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	(17,774)	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	(970)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(932)	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 Supplemental Schedule	(96,115)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,173)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,173)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' PREPARATION REPORT

Mendota Lutheran Home

ID# 0011593

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue	$ (3,614)	06	1
2	Transportation Revenue	(1,386)	14	2
3	Miscellaneous Revenue	(1,639)	21	3
4	Bank Charges	(5,926)	21	4
5	Directors and Officers Insurance	(10,004)	26	5
6	Non-Care Depreciation	(264)	30	6
7	Real Estate Taxes (Non - Care)	(801)	33	7
8	Barber and Beauty Revenue	(14,895)	40	8
9	Gift Shop Revenue	(117)	41	9
10	Marketing	(57,269)	43	10
11	Investment Fees	(200)	43	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**	(96,115)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home # 0011593 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,136)	0	0	0	0	0	0	0	0	0	0	(14,136)	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	(3,614)	0	0	0	0	0	0	0	0	0	0	(3,614)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,750)	0	0	0	0	0	0	0	0	0	0	(17,750)	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	(1,386)	0	0	0	0	0	0	0	0	0	0	(1,386)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,386)	0	0	0	0	0	0	0	0	0	0	(1,386)	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	(970)	0	0	0	0	0	0	0	0	0	0	(970)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(17,743)	0	0	0	0	0	0	0	0	0	0	(17,743)	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	(10,004)	0	0	0	0	0	0	0	0	0	0	(10,004)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,717)	0	0	0	0	0	0	0	0	0	0	(28,717)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,853)	0	0	0	0	0	0	0	0	0	0	(47,853)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mendota Lutheran Home # 0011593 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(264)	0	0	0	0	0	0	0	0	0	0	(264)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,774)	0	0	0	0	0	0	0	0	0	0	(17,774)	32
33	Real Estate Taxes	(801)	0	0	0	0	0	0	0	0	0	0	(801)	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**	(18,839)	0	0	0	0	0	0	0	0	0	0	(18,839)	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	(14,895)	0	0	0	0	0	0	0	0	0	0	(14,895)	40
41	Coffee and Gift Shops	(117)	0	0	0	0	0	0	0	0	0	0	(117)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(57,469)	0	0	0	0	0	0	0	0	0	0	(57,469)	43
44	**TOTAL Special Cost Centers**	(72,481)	0	0	0	0	0	0	0	0	0	0	(72,481)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(139,173)	0	0	0	0	0	0	0	0	0	0	(139,173)	45

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Minutes							1
2								2
3	Greta Bates							3
4	Pr. Tammy Anderson							4
5	Dave Jones							5
6	John Nielsen							6
7	Ed Block							7
8	Pr. Anne Hoflen							8
9	Lambert Leonard							9
10	Lorraine Loomis							10
11	Tim Munson							11
12								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 2016.							24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Midland States Bank		X	Mortgage	$3,533.94	09/26/16	$ 500,000	$ 495,407	09/26/21	5.750%	$ 7,016	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midland States Bank		X	Line of Credit		09/26/16	490,000	355,104	09/26/17	5.536%	21,336	6
7												7
8												8
9	TOTAL Facility Related				$3,533.94		$ 990,000	$ 850,511			$ 28,352	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(17,774)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17,774)	14
15	TOTALS (line 9+line14)						$ 990,000	$ 850,511			$ 10,578	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' PREPARATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home **#** 0011593 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A - Mendota Lutheran Home is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mendota Lutheran Home COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0011593

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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).

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1951-75	$ 82,752	1
2	Facility		1993	348,949	2
3	TOTALS			$ 431,701	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	114		1953	1953	$ 262,939	$		$	$	$	4
5			1971	1971	472,968						5
6			1975	1975	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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2005	$ 1,830	$		$	$	$	37
38	Various	2006	109,102						38
39	Various	2007	59,049						39
40	Various	2009	121,016						40
41	Various	2010	119,113						41
42	Various	2011	108,586						42
43	Various	2012	170,902						43
44	Walk in Cooler	2013	44,657						44
45	Hot Water Heaters and Installation (2)	2014	23,115						45
46	Fire System - Backflow Valves	2015	3,246						46
47	10 Ton Rooftop AC Unit	2015	12,630						47
48	Painting - Resident Rooms	2015	3,865						48
49	Painting - Resident Rooms	2016	4,145						49
50	Heat Exchanger Motor Repair - Rooftop Unit	2016	2,537						50
51	Elevator Equipment Room Construction - Walls, Drywall - Basement	2016	6,189						51
52	Front Door Closet Door Construction - Walls, Drywall - Front Entrance	2016	2,650						52
53	PTAC Resistance Heat	2016	7,890						53
54	Roof Repair	2016	17,017						54
55	Water Softner - West Wing	2016	17,880						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			137,730		137,730		4,450,458	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,390,036	$ 137,730		$ 137,730	$	$ 4,450,458	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,939,277	$ 118,073	$ 118,073	$		$ 1,603,520	71
72	Current Year Purchases	6,684	517	517			517	72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	$ 1,945,961	$ 118,590	$ 118,590	$		$ 1,604,037	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	$	$	$		$ 16,583	76
77	Facility	Ford Elkhard - 2010	2010	50,002					50,002	77
78	Facility	Dodge Caravan - 2012	2012	40,669	8,134	8,134			36,602	78
79										79
80	TOTALS			$ 107,254	$ 8,134	$ 8,134	$		$ 103,187	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)	$ 8,874,952	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 264,454	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 264,454	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)	$ 6,157,682	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	5,675	88
89	Land	43,897			89
90					90
91	TOTALS	$ 143,302	$ 264	$ 5,675	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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	See Suppl				0			5
6								6
7	TOTAL				$ **			7

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 6,649 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Mendota Lutheran Home
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
N/A		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
GE Capital, Inc. - Copier	671	671
Marco, Inc. - Copier	5,978	5,978
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	6,649	6,649

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 177,521	$		$ 177,521	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			50,688			50,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			292,468			292,468	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 prescrpts				98,825		98,825	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					86,244		86,244	12
13	Other (specify): See Supplemental	39 - 03				9,976			9,976	13
14	TOTAL			$		$ 530,653	$ 185,069		$ 715,722	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' PREPARATION REPORT

Mendota Lutheran Home
Medicaid Cost Report
01/01/16 - 12/31/16

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		86,244		86,244
Radiology			4,244	4,244
Laboratory			5,732	5,732
				-
				-
				-
				-
				-
				-
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Total	-	86,244	9,976	96,220

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 91,256	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,514)	673,466		3
4	Supply Inventory (priced at Cost - FIFO)	43,183		4
5	Short-Term Investments	57,655		5
6	Prepaid Insurance	58,228		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	16,540		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 940,328	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,644,134		12
13	Land	564,941		13
14	Buildings, at Historical Cost	6,079,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,152,456		16
17	Accumulated Depreciation (book methods)	(6,163,357)		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): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,277,705	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,218,033	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 391,074	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	355,104		29
30	Accrued Salaries Payable	119,852		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,214		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,860		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 873,104	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	495,407		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 495,407	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,368,511	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,849,522	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,218,033	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Interest and Dividends Receivable	3,349		3,349
Third Party Payer Settlements	6,119		6,119
Estates Receivable	4,671		4,671
Employee 401K Forfeitures	2,401		2,401
			-
Sub-Total	16,540	-	16,540
Line 23 - Long Term Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 36 - Other Current Liability			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,421,401	1
2	Restatements (describe):		2
3	**Rounding**	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,421,405	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(571,883)	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)**	$ (571,883)	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)**	$ 3,849,522	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,348,622	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,348,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	208,011	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 208,011	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	884	12
13	Barber and Beauty Care	15,283	13
14	Non-Patient Meals	14,136	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	57,471	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 87,774	23
	D. Non-Operating Revenue		
24	Contributions	247,513	24
25	Interest and Other Investment Income***	17,774	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 265,287	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,409	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,409	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,917,103	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,082,673	31
32	Health Care	2,830,431	32
33	General Administration	1,296,070	33
	B. Capital Expense		
34	Ownership	300,520	34
	C. Ancillary Expense		
35	Special Cost Centers	788,203	35
36	Provider Participation Fee	191,089	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,488,986	40
41	**Income before Income Taxes (line 30 minus line 40)****	(571,883)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (571,883)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,535,818	44
45	Private Pay - Net Inpatient Revenue	2,484,179	45
46	Medicare - Net Inpatient Revenue	1,328,625	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,348,622	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' PREPARATION REPORT

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Page 19 Supplemental Schedule

Description	Amount	Total
Transportation Revenue	5,000	5,000
Vending Commissions	770	770
Miscellaneous Revenue	1,639	1,639
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
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		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	7,409	7,409

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,271	$ 74,151	$ 32.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,908	23,920	657,093	27.47	3
4	Licensed Practical Nurses	13,941	15,156	388,141	25.61	4
5	CNAs & Orderlies	86,413	95,083	1,260,959	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,428	6,966	84,565	12.14	10
11	Social Service Workers	5,622	6,097	88,803	14.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,869	32,658	350,426	10.73	15
16	Dishwashers					16
17	Maintenance Workers	4,087	4,554	79,421	17.44	17
18	Housekeepers	10,060	11,186	127,464	11.39	18
19	Laundry	5,825	6,407	63,712	9.94	19
20	Administrator	1,744	1,920	74,720	38.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,837	11,811	192,686	16.31	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) See Supplemental	1,557	1,717	36,835	21.45	33
34	TOTAL (lines 1 - 33)	205,049	223,898	$ 3,535,882 *	$ 15.79	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,008	01 - 03	35
36	Medical Director		21,360	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		969	10 - 03	38
39	Pharmacist Consultant		6,159	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		1,320	11 - 03	44
45	Social Service Consultant		1,320	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule		11,114		47
48					48
49	TOTAL (lines 35 - 48)		$ 50,250		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 5,779	10 - 03	50
51	Licensed Practical Nurses		14,105	10 - 03	51
52	Certified Nurse Assistants/Aides		52,549	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 72,433		53

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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Marketing	43	1,557	1,717	36,835	21.45		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		1,557	1,717	36,835	21.45		
Contracted Services							
Podiatrist	10						304
Pastoral Care	12						10,810
Total						-	11,114

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jon Ragsdale	Administrator	0	$ 13,790
Michelle Urnikis	Administrator	0	60,930
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,720

B. Administrative - Other

Description	Amount
Pathway Health Services, Inc. (Interim Administrator)	$ 15,481
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,481
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jeremy Brune & Associates, LLC	Audit / Cost Reports	$ 22,514
Echols & Associates, PC	401K Audit	7,880
Wessels Sherman	Legal (Retainer)	970
DC Computers	IT Consultants	41,300
Wescom Solutions	Data Processing	39,333
Paylocity	Data Processing	20,006
Cerner Corporation	Data Processing	8,457
Telemedicine Solutions	Data Processing	7,722
Frontier	Data Processing	13,512
Ability Network	Data Processing	4,550
E Health Data Solutions	Data Processing	1,991
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 168,235

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,567
Unemployment Compensation Insurance	831
FICA Taxes	255,373
Employee Health Insurance	325,862
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals and Drug Testing	4,845
Employee Recognition	11,705
4015 Matching Contributions	33,320
TOTAL (agree to Schedule V, line 22, col.8)	$ 706,503

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,953
Health Care Worker Background Check	
(Indicate # of checks performed)	805
Patient Background Checks	920
Dues - Leading Age	5,191
Dues and Subscriptions	2,297
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,156

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,904
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,904

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **Leading Age - $5,191**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,984** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **191,089**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **14,136**

(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 (Not Final)**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? **N/A**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees