

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	11,356	8,846	2,707	22,909	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		365		365	12
13	DD 16 OR LESS					13
14	TOTALS	11,356	9,211	2,707	23,274	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.43%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 2,357

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* 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: 01/01/18 Ending: 12/31/18

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	299,709	22,582	6,660	328,951		328,951		328,951		1
2	Food Purchase		196,073		196,073		196,073	(7,224)	188,849		2
3	Housekeeping	102,713	17,112		119,825		119,825		119,825		3
4	Laundry	75,316	7,931		83,247		83,247		83,247		4
5	Heat and Other Utilities			105,050	105,050		105,050	(9,572)	95,478		5
6	Maintenance	75,759	1,507	23,099	100,365		100,365		100,365		6
7	Other (specify):* See Supplemental										7
8	TOTAL General Services	553,497	245,205	134,809	933,511		933,511	(16,796)	916,715		8
	B. Health Care and Programs										
9	Medical Director			19,819	19,819		19,819		19,819		9
10	Nursing and Medical Records	2,010,426	61,236	33,075	2,104,737		2,104,737		2,104,737		10
10a	Therapy	74,626			74,626		74,626		74,626		10a
11	Activities	79,824	8,928	756	89,508		89,508		89,508		11
12	Social Services	79,641	367	13,567	93,575		93,575		93,575		12
13	CNA Training										13
14	Program Transportation			3,465	3,465		3,465	(3,465)			14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	2,244,517	70,531	70,682	2,385,730		2,385,730	(3,465)	2,382,265		16
	C. General Administration										
17	Administrative										17
18	Directors Fees										18
19	Professional Services			149,122	149,122		149,122	(8,500)	140,622		19
20	Dues, Fees, Subscriptions & Promotions			27,286	27,286		27,286		27,286		20
21	Clerical & General Office Expenses	271,945	16,364	40,909	329,218		329,218	(3,547)	325,671		21
22	Employee Benefits & Payroll Taxes			886,415	886,415		886,415		886,415		22
23	Inservice Training & Education			119	119		119		119		23
24	Travel and Seminar			1,967	1,967		1,967		1,967		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,425	70,425		70,425	(10,023)	60,402		26
27	Other (specify):* See Supplemental										27
28	TOTAL General Administration	271,945	16,364	1,176,243	1,464,552		1,464,552	(22,070)	1,442,482		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,069,959	332,100	1,381,734	4,783,793		4,783,793	(42,331)	4,741,462		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:

01/01/18

Ending:

12/31/18

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			293,027	293,027		293,027	(228)	292,799			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,641	45,641		45,641	(10,236)	35,405			32
33	Real Estate Taxes			326	326		326	(326)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,195	10,195		10,195		10,195			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			349,189	349,189		349,189	(10,790)	338,399			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,302	534,173	701,475		701,475		701,475			39
40	Barber and Beauty Shops			15,445	15,445		15,445	(14,485)	960			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,544	124,544		124,544		124,544			42
43	Other (specify):* See Supplemental	39,093	1,121	10,253	50,467		50,467	(50,467)				43
44	TOTAL Special Cost Centers	39,093	168,423	684,415	891,931		891,931	(64,952)	826,979			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,109,052	500,523	2,415,338	6,024,913		6,024,913	(118,073)	5,906,840			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
 01/01/18 - 12/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 43 - Other Special Cost Centers				
Marketing	39,093	1,121	10,253	50,467
				-
				-
				-
				-
				-
				-
Sub-Total	<u>39,093</u>	<u>1,121</u>	<u>10,253</u>	<u>50,467</u>

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(7,224)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,572)	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	(10,236)	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	(2,342)	21		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(88,699)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,073)		\$	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))	\$ (118,073)		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' PREPARATION REPORT

Mendota Lutheran Home

ID# 0011593

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Beauth Shop Revenue	\$ (14,485)	40	1
2	Transportation Revenue	(3,465)	14	2
3	Bank Charges	(1,205)	21	3
4	Directors and Officers Insurance	(10,023)	26	4
5	Real Estate Taxes (Non-Care Related)	(326)	33	5
6	Marketing	(50,467)	43	6
7	Professional Fees (Retainer)	(900)	19	7
8	Professional Fees (Non-Allowable)	(7,600)	19	8
9	Non-Care Depreciation	(228)	30	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	(88,699)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(7,224)	0	0	0	0	0	0	0	0	0	0	(7,224)	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	(9,572)	0	0	0	0	0	0	0	0	0	0	(9,572)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,796)	0	0	0	0	0	0	0	0	0	0	(16,796)	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	(3,465)	0	0	0	0	0	0	0	0	0	0	(3,465)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,465)	0	0	0	0	0	0	0	0	0	0	(3,465)	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	(8,500)	0	0	0	0	0	0	0	0	0	0	(8,500)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,547)	0	0	0	0	0	0	0	0	0	0	(3,547)	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	(10,023)	0	0	0	0	0	0	0	0	0	0	(10,023)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,070)	0	0	0	0	0	0	0	0	0	0	(22,070)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,331)	0	0	0	0	0	0	0	0	0	0	(42,331)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(228)	0	0	0	0	0	0	0	0	0	0	(228)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,236)	0	0	0	0	0	0	0	0	0	0	(10,236)	32
33	Real Estate Taxes	(326)	0	0	0	0	0	0	0	0	0	0	(326)	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	(10,790)	0	0	0	0	0	0	0	0	0	0	(10,790)	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	(14,485)	0	0	0	0	0	0	0	0	0	0	(14,485)	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):*	(50,467)	0	0	0	0	0	0	0	0	0	0	(50,467)	43
44	TOTAL Special Cost Centers	(64,952)	0	0	0	0	0	0	0	0	0	0	(64,952)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(118,073)	0	0	0	0	0	0	0	0	0	0	(118,073)	45

VII. RELATED PARTIES

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	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	*** - Health and Social Services Cmt.							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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

01/01/18

Ending: 12/31/18

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' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Midland States Bank		X	Mortgage	\$3,533.94	09/26/16	\$ 500,000	\$ 462,479	09/26/21	5.75%	\$ 27,313	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Midland States Bank		X	Line of Credit		03/25/18	490,000	285,768		6.55%	12,009	6								
7	First State Bank		X	Line of Credit				313,955			6,320	7								
8												8								
9	TOTAL Facility Related						\$ 990,000	\$ 1,062,202			\$ 45,641	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13	Interest Income		X								(10,236)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (10,236)	14								
15	TOTALS (line 9+line14)						\$ 990,000	\$ 1,062,202			\$ 35,405	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.)

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 2017 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 2018 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:	2013	_____	8
	2014	_____	9
	2015	_____	10
	2016	_____	11
	2017	_____	12
N/A - Mendota Lutheran Home is exempt from real estate taxes.			

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$ _____	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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION 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	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

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	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	Electric Upgrade - Life Safety Code Survey	2017	28,322						56
57	Boiler	2018	20,938						57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Depreciation			292,799		292,799		6,699,133	69
70	TOTAL (lines 4 thru 69)		\$ 6,439,296	\$ 292,799		\$ 292,799	\$	\$ 6,699,133	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,049,380	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,049,380	\$	\$	\$		\$	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	1999	\$ 16,583	\$	\$	\$		\$	76
77	Facility	Ford Elkhart	2010	50,002						77
78	Facility	Dodge Caravan	2012	40,669						78
79										79
80	TOTALS			\$ 107,254	\$	\$	\$		\$	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)	\$ 9,027,631	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,799	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 292,799	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)	\$ 6,699,133	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	\$ 5,500	\$	\$	86
87	Land (Including Demolition)	83,843			87
88	Tree of Life	10,707	228	6,168	88
89	Land	43,897			89
90					90
91	TOTALS	\$ 143,947	\$ 228	\$ 6,168	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' PREPARATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/18

Ending: 12/31/18

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								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: _____ *

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: \$ 10,195 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

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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

* 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

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' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 150,953	\$		\$ 150,953	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			69,618			69,618	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			229,112			229,112	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				89,297		89,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					78,005		78,005	12
13	Other (specify): See Supplemental	39 - 03				84,490			84,490	13
14	TOTAL			\$		\$ 534,173	\$ 167,302		\$ 701,475	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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(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	\$ 126,281	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>107,526</u>)	405,260		3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)	32,462		4
5	Short-Term Investments	52,390		5
6	Prepaid Insurance	71,805		6
7	Other Prepaid Expenses	3,331		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	20,437		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 711,966	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,781,959		12
13	Land	564,941		13
14	Buildings, at Historical Cost	6,117,294		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,188,279		16
17	Accumulated Depreciation (book methods)	(6,697,302)		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)	\$ 3,955,171	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,667,137	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 547,718	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	599,723		29
30	Accrued Salaries Payable	100,812		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,373		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	744		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)	\$ 1,272,370	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	462,479		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)	\$ 462,479	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,734,849	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,932,288	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,667,137	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Mendota Lutheran Home
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Interest Receivable	4,731		4,731
Medicare Cost Report Settlement	10,461		10,461
Estates Receivable	5,245		5,245
			-
			-
Sub-Total	<u>20,437</u>	<u>-</u>	<u>20,437</u>
Line 23 - Long Term Assets			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>
Line 36 - Other Current Liability			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,800,669	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,800,669	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(868,381)	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)	\$ (868,381)	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)	\$ 2,932,288	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,955,170	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,955,170	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,366	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 121,366	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	10	12
13	Barber and Beauty Care	14,485	13
14	Non-Patient Meals	7,224	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	692	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,411	23
D. Non-Operating Revenue			
24	Contributions	42,834	24
25	Interest and Other Investment Income***	10,236	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,070	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,515	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,515	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,156,532	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	933,511	31
32	Health Care	2,385,730	32
33	General Administration	1,464,552	33
B. Capital Expense			
34	Ownership	349,189	34
C. Ancillary Expense			
35	Special Cost Centers	767,387	35
36	Provider Participation Fee	124,544	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,024,913	40
41	Income before Income Taxes (line 30 minus line 40)**	(868,381)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (868,381)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,562,801	44
45	Private Pay - Net Inpatient Revenue	1,988,332	45
46	Medicare - Net Inpatient Revenue	1,404,037	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,955,170	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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	2,161	2,218	\$ 76,156	\$ 34.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,481	18,313	492,123	26.87	3
4	Licensed Practical Nurses	13,567	16,163	414,285	25.63	4
5	CNAs & Orderlies	62,691	69,549	989,089	14.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,942	4,046	74,626	18.44	8
9	Activity Director	2,065	2,123	37,357	17.60	9
10	Activity Assistants	3,218	3,304	42,467	12.85	10
11	Social Service Workers	5,000	5,266	79,641	15.12	11
12	Dietician					12
13	Food Service Supervisor	2,031	2,079	32,867	15.81	13
14	Head Cook	2,084	2,140	27,833	13.01	14
15	Cook Helpers/Assistants	21,922	23,695	239,009	10.09	15
16	Dishwashers					16
17	Maintenance Workers	3,927	4,039	75,759	18.76	17
18	Housekeepers	9,125	9,383	102,713	10.95	18
19	Laundry	6,646	6,919	75,316	10.89	19
20	Administrator	1,728	1,762	68,250	38.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,724	13,104	203,695	15.54	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	2,096	2,154	38,773	18.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,876	1,929	39,093	20.27	33
34	TOTAL (lines 1 - 33)	174,284	188,186	\$ 3,109,052 *	\$ 16.52	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	\$ 6,660	01 - 03	35
36	Medical Director	19,819	09 - 03	36
37	Medical Records Consultant	2,136	10 - 03	37
38	Nurse Consultant	110	10 - 03	38
39	Pharmacist Consultant	6,453	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	756	11 - 03	44
45	Social Service Consultant	1,282	12 - 03	45
46	Other(specify) <u>See Supplemental</u>	12,285		46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 49,501		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	6,486	10 - 03	51
52	Certified Nurse Assistants/Aides	10,763	10 - 03	52
53	TOTAL (lines 50 - 52)	\$ 17,249		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Mendota Lutheran Home
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Marketing	43	1,876	1,929	39,093	20.27		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		<u>1,876</u>	<u>1,929</u>	<u>39,093</u>	<u>20.27</u>		

Contracted Services							
Chaplain	12 - 03						10,585
Organist	12 - 03						1,700
Total						<u>-</u>	<u>12,285</u>

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/18Ending: 12/31/18**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
- (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. \$ 55,256 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. \$ 124,544
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,224
- (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? No
Firm Name: N/A
- (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? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT