

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0011593</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>Mendota Lutheran Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																																	
Address: <u>500 Sixth Street</u> <u>Mendota</u> <u>61342</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>LaSalle</u>																																																																																			
Telephone Number: <u>(815) 539 - 7439</u> Fax # <u>(815) 538 - 3400</u>																																																																																			
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jon Ragsdale</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Administrator</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u></td></tr><tr><td>(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>1952</u></td><td colspan="2">(Date) _____</td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">(Date) _____</td></tr><tr><td colspan="2"><table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Jeremy M. Brune, CPA</u></td><td colspan="2">Telephone Number: <u>(779) 875-3979</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jon Ragsdale</u>	Paid Preparer	(Title) <u>Administrator</u>	(Signed) _____	(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u>	(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u>	Date of Initial License for Current Owners: <u>1952</u>		(Date) _____		Type of Ownership:		(Date) _____		<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other _____					In the event there are further questions about this report, please contact:				Name: <u>Jeremy M. Brune, CPA</u>		Telephone Number: <u>(779) 875-3979</u>		Email Address: _____			
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SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Mendota Lutheran Home

#

0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

08/17/12

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	113	Skilled (SNF)	99	39,327	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	127	TOTALS	113	44,451	7

B. Census-For the entire report period.

1	2	3	4	5		
Level of Care	Patient Days by Level of Care and Primary Source of Payment					
	Medicaid Recipient	Private Pay	Other	Total		
8	SNF	13,559	11,817	4,365	29,741	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,702		1,702	12
13	DD 16 OR LESS					13
14	TOTALS	13,559	13,519	4,365	31,443	14

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

70.74%

SEE ACCOUNTANTS' COMPILATION REPORT

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

X

NO

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

YES

X

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

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

4,365

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/12

Fiscal Year:

12/31/12

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

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

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	370,111	52,736	6,535	429,382		429,382		429,382			1
2	Food Purchase		292,979		292,979	(37,604)	255,375	(12,416)	242,959			2
3	Housekeeping	139,252	21,335		160,587		160,587		160,587			3
4	Laundry	78,955	11,379		90,334		90,334		90,334			4
5	Heat and Other Utilities			134,298	134,298		134,298		134,298			5
6	Maintenance	74,931	6,172	40,472	121,575		121,575		121,575			6
7	Other (specify):*											7
8	TOTAL General Services	663,249	384,601	181,305	1,229,155	(37,604)	1,191,551	(12,416)	1,179,135			8
	B. Health Care and Programs											
9	Medical Director			22,141	22,141		22,141		22,141			9
10	Nursing and Medical Records	2,813,662	76,570	113,655	3,003,887		3,003,887		3,003,887			10
10a	Therapy											10a
11	Activities	83,545	13,058	1,211	97,814		97,814		97,814			11
12	Social Services	94,429	3,893	1,260	99,582		99,582		99,582			12
13	CNA Training											13
14	Program Transportation			2,079	2,079		2,079	(800)	1,279			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,991,636	93,521	140,346	3,225,503		3,225,503	(800)	3,224,703			16
	C. General Administration											
17	Administrative	77,896			77,896		77,896		77,896			17
18	Directors Fees											18
19	Professional Services			124,574	124,574		124,574	(3,751)	120,823			19
20	Dues, Fees, Subscriptions & Promotions			43,921	43,921		43,921	(28,038)	15,883			20
21	Clerical & General Office Expenses	207,488	13,898	131,651	353,037		353,037	(106,174)	246,863			21
22	Employee Benefits & Payroll Taxes			891,881	891,881	37,604	929,485	(31,160)	898,325			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,851	7,851		7,851	(570)	7,281			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,612	67,612		67,612		67,612			26
27	Other (specify):*											27
28	TOTAL General Administration	285,384	13,898	1,267,490	1,566,772	37,604	1,604,376	(169,693)	1,434,683			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,940,269	492,020	1,589,141	6,021,430		6,021,430	(182,909)	5,838,521			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Page 3 Reclass

Description	Meals Served	Resident Meals	Employee Meals
Employees Meals			
Employees	40		
Meals Per Day	1		
Days in Year	365		
Meals Served Per Year	<u>14,600</u>		13.40%
Mendota Lutheran Residents			
Census	31,443		
Meals Per Day	3		
Meals Served Per year	<u>94,329</u>	86.60%	
Total Meals Served	<u>108,929</u>	86.60%	13.40%
Food Cost			
Page 3 Line 2 Column 2	292,979		
Pre-Allocation Adjustments			
Meal Income - Page 5	(12,416)		
Food Cost For Allocation	280,563	280,563	280,563
Allocated Food Cost		<u>242,959</u>	<u>37,604</u>

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			259,731	259,731		259,731	(264)	259,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,075	16,075		16,075	(16,075)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			275,806	275,806		275,806	(16,339)	259,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		261,058	854,738	1,115,796		1,115,796		1,115,796			39
40	Barber and Beauty Shops			17,050	17,050		17,050	(16,957)	93			40
41	Coffee and Gift Shops			799	799		799	(799)				41
42	Provider Participation Fee			340,913	340,913		340,913		340,913			42
43	Other (specify):* Marketing	29,419	2,635		32,054		32,054	(32,054)				43
44	TOTAL Special Cost Centers	29,419	263,693	1,213,500	1,506,612		1,506,612	(49,810)	1,456,802			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,969,688	755,713	3,078,447	7,803,848		7,803,848	(249,058)	7,554,790			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(12,416)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,346)	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	(16,075)	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	(101,299)	21		24
25	Fund Raising, Advertising and Promotional	(28,038)	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	(87,884)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (249,058)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (249,058)		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' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gift Shop Revenue - To Extent of Expense	\$ (799)	41	1
2	Barber and Beauty Shop Revenue	(16,957)	40	2
3	Marketing Salaries	(29,419)	43	3
4	Marketing Supplies	(2,635)	43	4
5	Transportation Revenue	(800)	14	5
6	Miscellaneous Revenue	(203)	21	6
7	Bank Charges	(30)	21	7
8	Other Office Expenses	(1,296)	21	8
9	Metlife Surrendar Charges	(31,160)	22	9
10	Non-Care Depreciation	(264)	30	10
11	Collections	(3,751)	19	11
12	Out of State Travel	(570)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(87,884)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	(12,416)	0	0	0	0	0	0	0	0	0	0	(12,416)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,416)	0	0	0	0	0	0	0	0	0	0	(12,416)	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	(800)	0	0	0	0	0	0	0	0	0	0	(800)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(800)	0	0	0	0	0	0	0	0	0	0	(800)	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	(3,751)	0	0	0	0	0	0	0	0	0	0	(3,751)	19
20	Fees, Subscriptions & Promotions	(28,038)	0	0	0	0	0	0	0	0	0	0	(28,038)	20
21	Clerical & General Office Expenses	(106,174)	0	0	0	0	0	0	0	0	0	0	(106,174)	21
22	Employee Benefits & Payroll Taxes	(31,160)	0	0	0	0	0	0	0	0	0	0	(31,160)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(570)	0	0	0	0	0	0	0	0	0	0	(570)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(169,693)	0	0	0	0	0	0	0	0	0	0	(169,693)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(182,909)	0	0	0	0	0	0	0	0	0	0	(182,909)	29

STATE OF ILLINOIS

Summary B

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

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
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(264)	0	0	0	0	0	0	0	0	0	0	(264) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(16,075)	0	0	0	0	0	0	0	0	0	0	(16,075) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(16,339)	0	0	0	0	0	0	0	0	0	0	(16,339) 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	(16,957)	0	0	0	0	0	0	0	0	0	0	(16,957) 40
41	Coffee and Gift Shops	(799)	0	0	0	0	0	0	0	0	0	0	(799) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(32,054)	0	0	0	0	0	0	0	0	0	0	(32,054) 43
44	TOTAL Special Cost Centers	(49,810)	0	0	0	0	0	0	0	0	0	0	(49,810) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(249,058)	0	0	0	0	0	0	0	0	0	0	(249,058) 45

VII. RELATED PARTIES

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Director Listing							1
2								2
3	Ginny Becker	0						3
4	Rev. Kevin Weeks	0						4
5	Rev. Dale Peterson	0						5
6	Ken Kurth	0						6
7	Jeff Simonton	0						7
8	JoAnne Miller	0						8
9	Gloria Cogdal	0						9
10	Greta Bates	0						10
11	John Nielsen	0						11
12								12
13								13
14								14
15								15
16								16
17	None of these Board Members							17
18	received compensation nor provided							18
19	direct services to Mendota Lutheran							19
20	Home during 2012.							20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Eureka Savings		X	Line of Credit								12,646	6
7	Life Services Network		X	Workers Comp. Insurance								2,114	7
8	Other		X									1,315	8
9	TOTAL Facility Related						\$				\$	16,075	9
	B. Non-Facility Related*												
10	Interest Income											(16,075)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(16,075)	14
15	TOTALS (line 9+line14)						\$				\$		15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

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.

HFS 3745 (N-4-99)

2011 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 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2005	\$ 1,830	\$		\$	\$	\$	37
38 Various	2006	109,102						38
39 Various	2007	59,049						39
40 Various	2008	28,686						40
41 Hydraulic System in Elevator	2009	8,784						41
42 Building Improvements	2009	1,400						42
43 New Carpet in Chapel	2009	1,900						43
44 Ceiling Radiation Detector	2009	1,977						44
45 Outpatient Physical Therapy Renovation	2009	13,566						45
46 Gas Furnace	2009	5,065						46
47 Gas Furnace	2009	3,800						47
48 West Wing Construction	2009	2,216						48
49 Stairway Light Fixtures	2009	742						49
50 Steamer	2009	3,749						50
51 Convection Steamer	2009	2,574						51
52 Mohawk Carpet Installation	2009	7,233						52
53 Walk-In Freezer	2009	4,965						53
54 Outdoor Logo	2009	550						54
55 Install New Walk-Curb-Railing	2009	4,500						55
56 Chapel Painting	2009	1,100						56
57 Preparation of Construction Documents	2009	4,397						57
58 Construction Preparation	2009	780						58
59 Wire Pulling & Device Terminations	2009	4,140						59
60 Preparation of Construction Documents	2009	695						60
61 Installation of Kitchen Steamer	2009	1,133						61
62 Emergency Generator Modifications	2009	16,454						62
63 Johnson Contract	2009	610						63
64 Dishwashing Room - Drywall and Flooring	2010	7,371						64
65 Sprinkler System	2010	94,500						65
66 Paint Rooms	2010	6,100						66
67 Automatic Doors	2010	4,061						67
68 Door Locks and Installation	2010	7,081						68
69 Fire Protection System	2011	24,424						69
70 TOTAL (lines 4 thru 69)		\$ 6,205,721	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,205,721	\$		\$	\$	\$	1
2	Boiler	2011	20,757						2
3	Painting - Hallways and Wing Lounges	2011	7,040						3
4	Garage Construction	2011	50,300						4
5	Overhead Doors	2011	3,170						5
6	Electrical Wiring	2011	2,895						6
7	Painting - Hallways and Wing Lounges	2012	38,163						7
8	Flooring - Therapy Department / Lounge	2012	11,067						8
9	Concrete Sidewalk	2012	21,032						9
10	Roof	2012	100,640						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	Depreciation			136,718		136,718		4,099,437	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,460,785	\$ 136,718		\$ 136,718	\$	\$ 4,099,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,944,648	\$84,231	\$84,231	\$	3 - 15	\$1,611,941	71
72	Current Year Purchases	289,434	24,451	24,451		3 - 10	24,451	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,234,082	\$108,682	\$108,682	\$		\$1,636,392	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 - 98	1999	\$16,583	\$	\$	\$	5	\$16,583	76
77	Facility	Ford Elkhart - 10	2010	50,002	10,000	10,000		5	25,000	77
78	Facility	Dodge Caravan - 12	2012	40,669	4,067	4,067		5	4,067	78
79										79
80	TOTALS			\$107,254	\$14,067	\$14,067	\$		\$45,650	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,233,822	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$259,467	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$259,467	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,781,479	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Tree of Life	\$10,562	\$264	\$4,597	86
87	Land	5,500			87
88	Land (Including House Demolition)	83,843			88
89					89
90					90
91	TOTALS	\$99,905	\$264	\$4,597	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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: \$

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. /2013 \$

13. /2014 \$

14. /2015 \$

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

☒ 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' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	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	\$		\$ 328,140	\$		\$ 328,140	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			67,723			67,723	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			437,108			437,108	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				105,726		105,726	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					155,332		155,332	12
13	Other (specify): See Supplemental	39 - 03				21,767			21,767	13
14	TOTAL			\$		\$ 854,738	\$ 261,058		\$ 1,115,796	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 16 Supplemental Schedule

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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	\$ 179,885	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,000)	882,557		3
4	Supply Inventory (priced at Cost)	47,285		4
5	Short-Term Investments	530,087		5
6	Prepaid Insurance	122,404		6
7	Other Prepaid Expenses	19,629		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	292,726		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,074,573	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	403,898		12
13	Land	521,044		13
14	Buildings, at Historical Cost	4,220,576		14
15	Leasehold Improvements, at Historical Cost	1,984,955		15
16	Equipment, at Historical Cost	2,348,649		16
17	Accumulated Depreciation (book methods)	(5,786,075)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,693,047	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,767,620	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 732,103	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	83,915		29
30	Accrued Salaries Payable	249,797		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,805		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,014		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,079,634	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	260,549		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 260,549	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,340,183	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,427,437	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,767,620	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Contributions Receivable	287,485	
Interest and Dividends Receivable	4,650	
Other Assets	591	
Total	292,726	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,113,600	1
2	Restatements (describe):		2
3	Audit Adjustments - Prior Year	79,724	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,193,324	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	234,113	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)	\$ 234,113	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,427,437	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,391,070	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,391,070	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	509,889	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 509,889	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,498	12
13	Barber and Beauty Care	16,957	13
14	Non-Patient Meals	12,416	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	70,313	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 103,184	23
	D. Non-Operating Revenue		
24	Contributions	799,506	24
25	Interest and Other Investment Income***	226,795	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,026,301	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,517	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,517	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,037,961	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,229,155	31
32	Health Care	3,225,503	32
33	General Administration	1,566,772	33
	B. Capital Expense		
34	Ownership	275,806	34
	C. Ancillary Expense		
35	Special Cost Centers	1,165,699	35
36	Provider Participation Fee	340,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,803,848	40
41	Income before Income Taxes (line 30 minus line 40)**	234,113	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 234,113	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,922,605	44
45	Private Pay - Net Inpatient Revenue	2,492,382	45
46	Medicare - Net Inpatient Revenue	1,976,083	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,391,070	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 19 Supplemental Schedule

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Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,760	2,094	\$ 67,865	\$ 32.41	1
2	Assistant Director of Nursing	1,752	2,080	58,934	28.33	2
3	Registered Nurses	19,434	22,624	608,786	26.91	3
4	Licensed Practical Nurses	25,468	27,556	590,800	21.44	4
5	CNAs & Orderlies	100,585	108,731	1,421,490	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,250	33,711	14.98	9
10	Activity Assistants	4,539	5,370	49,834	9.28	10
11	Social Service Workers	6,372	8,796	94,429	10.74	11
12	Dietician					12
13	Food Service Supervisor	1,852	2,120	32,548	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,911	35,391	337,563	9.54	15
16	Dishwashers					16
17	Maintenance Workers	3,849	4,719	74,931	15.88	17
18	Housekeepers	8,922	13,576	139,252	10.26	18
19	Laundry	7,338	9,162	78,955	8.62	19
20	Administrator	1,840	2,108	77,896	36.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,540	14,803	207,488	14.02	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	5,285	5,927	65,787	11.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,306	1,765	29,419	16.67	33
34	TOTAL (lines 1 - 33)	233,705	269,072	\$ 3,969,688 *	\$ 14.75	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	159	\$ 6,535	01 - 03	35
36	Medical Director	312	22,141	09 - 03	36
37	Medical Records Consultant	28	1,200	10 - 03	37
38	Nurse Consultant	233	25,260	10 - 03	38
39	Pharmacist Consultant		5,260	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	16	1,211	11 - 03	44
45	Social Service Consultant	16	1,260	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	764	\$ 62,867		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	48	\$ 2,352	10 - 03	50
51	Licensed Practical Nurses	599	21,694	10 - 03	51
52	Certified Nurse Assistants/Aides	2,505	57,889	10 - 03	52
53	TOTAL (lines 50 - 52)	3,152	\$ 81,935		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jon Ragsdale	Adminsitator	0	\$ 77,896
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,896
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
WIPFLI	Accounting	\$	21,225
Jeremy Brune & Associates	Accounting		3,799
Echols & Associates, P.C.	Accounting		3,143
FR&R Healthcare Consulting	Consulting		165
Nebo Systems	Data Processing		220
Paylocity and ADP	Data Processing		17,938
Kronos	Data Processing		2,757
Ability Ease	Data Processing		4,370
DC Computers	Computer Support		18,319
Cerner / Wescom Solutions	Data Processing		34,353
Workforce Now	Data Processing		3,579
See Supplemental Schedule			14,706
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 124,574
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	123,643
Unemployment Compensation Insurance			48,607
FICA Taxes			290,872
Employee Health Insurance			337,831
Employee Meals			37,604
Illinois Municipal Retirement Fund (IMRF)*			
401K Employer Match			31,369
Employee Recognition			18,790
Physicals and Drug Testing			9,609
401K Surrendar Fees			31,160
Pg. 5 Adjustments			(31,160)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 898,325
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		\$	1,008
Advertising: Employee Recruitment			4,056
Health Care Worker Background Check (Indicate # of checks performed)			1,210
Patient Background Checks			460
Manuals and Subscriptions			2,603
Association Dues			6,546
Advertising and Public Relations			28,038
Less: Public Relations Expense			(13,276)
Non-allowable advertising			(14,762)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,883
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	570
In-State Travel			2,349
Seminar Expense			4,932
Page 5 Adjustment			(570)
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	7,281

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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

Page 21 Supplemental Schedule

Description	Type	Amount
Box C - Professional Fees		
Slavin & Slavin	Legal	2,088
Aplington, Kaufman, McClintock & Steele	Collections	3,751
Duane Morris	Legal	7,534
Wessels Sherman	HR Consultants	1,038
Other	Other	295
Total		14,706

Mendota Lutheran Home
Medicaid Cost Report
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Page 21 Supplemental Schedule - Legal Invoice Schedule

Description	Amount	Allowable
Slavin & Slavin	439	439
Slavin & Slavin	104	104
Slavin & Slavin	35	35
Slavin & Slavin	105	105
Slavin & Slavin	279	279
Slavin & Slavin	123	123
Slavin & Slavin	120	120
Slavin & Slavin	760	760
Slavin & Slavin	35	35
Slavin & Slavin	88	88
Duane Morris, LLP	6,582	6,582
Duane Morris, LLP	952	952
Total	9,622	9,622

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

Page 21 Seminar and Travel Schedule

Course Name	Date	Location	Attendee	Job Description	Seminar	Travel
Developing Emotional Intelligence	02/27/12	LaSalle, IL	Sheri Bowne	Nursing	199	25
Developing Emotional Intelligence	02/27/12	LaSalle, IL	Celina Reyez	Nursing	199	25
Discovering Your Memory Power	04/04/12	Mendota, IL	Mary Wren	Nursing	5	10
Discovering Your Memory Power	04/04/12	Mendota, IL	Sheri Bowne	Nursing	5	-
April 2012 MDS & Industry Updates	04/30/12	Mendota, IL	Erica Valencia	Nursing	35	-
April 2012 MDS & Industry Updates	04/30/12	Mendota, IL	Jana Trainor	Nursing	35	-
Skin Care Conditioning	05/15/12	Oak Brook, IL	Mary Wren	Nursing	95	7
Skin Care Conditioning	05/15/12	Oak Brook, IL	Sheri Bowne	Nursing	95	7
Annual Healthcare Symposium	06/22/12	Streator, IL	Mary Wren	Nursing	-	28
ADIC	06/05/12	East Peoria, IL	Mary Wren	Nursing	98	130
ADIC	06/05/12	East Peoria, IL	Sheri Bowne	Nursing	98	151
Geriatric Sensory Proc. & Fall Prevention	07/10/12	Bloomington, IL	Kari Lazzaratto	Nursing	179	72
AANAB 3.0 MDS Certification & Wkshop	07/17/12-07/19/12	Oak Park, IL	Erica Valencia	Nursing	550	272
Rehospitalization Series-Part 5	08/14/12	Mendota, IL	Mary Wren	Nursing	79	-
Rehospitalization Series-Part 6	08/21/12	Mendota, IL	Mary Wren	Nursing	79	-
ARD Planner & Therapy Minutes	11/14/12	Mendota, IL	Erica Valencia	Nursing	65	-
ARD Planner & Therapy Minutes	11/14/12	Mendota, IL	Jana Trainor	Nursing	65	-
Assessments & Structured Prog Notes	11/20/12	Mendota, IL	Erica Valencia	Nursing	65	-
Assessments & Structured Prog Notes	11/20/12	Mendota, IL	Jana Trainor	Nursing	65	-
Refreshments	N/A	N/A	Various	Nursing		75
Video and Publications	N/A	N/A	Various	Nursing	475	34
New Challenges & Consequences	1/19/12 & 1/26/12	Mendota, IL	Jon Ragsdale	Administration	93	-
Discovering Your Memory Power	04/04/12	Mendota, IL	Jon Ragsdale	Administration	5	-
ADIC	06/05/12	East Peoria, IL	Jon Ragsdale	Administration	95	221
2012 Annual Convention	10/30/12	Springfield, IL	Jon Ragsdale	Administration	125	281
Therapy Updates for 2012 & Beyond	10/31/12	Mendota, IL	Anita Matuszewski	Administration	99	-
Keeping Up W/SNF Regulatory Expectations	10/31/12	Mendota, IL	Sue Wujek	Administration	99	-
Payroll Law 2013	12/05/12	LaSalle, IL	Sue Wujek	Administration	199	-
Part A SNF Billing Seminar	12/19/12	Oak Brook, IL	Anita Matuszewski	Administration	59	106
MSP Billing Seminar	12/19/12	Oak Brook, IL	Anita Matuszewski	Administration	52	-
Video and Publications	N/A	N/A	Various	Administration		101
Power Seminar	04/27/12	St. Paul, Minn	Marylee Simpson	Administration	200	570
Criminal History Record Information	09/24/12	Springfield, IL	Marylee Simpson	Administration	25	276
Payroll Law 2013	12/05/12	LaSalle, IL	Marylee Simpson	Administration	199	-
Human Resources	12/06/12	LaSalle, IL	Marylee Simpson	Administration		15
ObamaCare is Here to Stay	12/13/12	Mendota, IL	Marylee Simpson	Administration	75	-
Human Resources	12/18/12	LaSalle, IL	Marylee Simpson	Administration		15
Activity Assist. Training Program	03/01/13	Wheeling, IL	Cindy Phillips	Activities	75	8
Activity Assist. Training Program	03/01/13	Wheeling, IL	Marci Nestler	Activities	75	120
Discovering Your Memory Power	04/04/12	Mendota, IL	Connie Buchanan	Activities	5	-
Dementia Care	04/25/12	East Peoria, IL	Connie Buchanan	Activities	90	212
Video and Publications	N/A	N/A	Various	Activities	199	-
New Challenges & Consequences	1/19/12 & 1/26/12	Mendota	John Due	Maintenance	93	-
Various	N/A	N/A		Maintenance	310	26
Discovering Your Memory Power	04/04/12	Mendota, IL	Julie Wicks	Social Services	5	-
Food Service Sanitation Class	4/9/12-4/26/12	Oglesby, IL	Alex Cuevas	Dietary	64	48
Food Service Sanitation Class	4/9/12-4/26/12	Oglesby, IL	Joan Wenzel	Dietary	64	84
Video and Publications	N/A	N/A	Various	Dietary	145	-
					4,932	2,919

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

(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. \$ 37,604 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,416

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Jeremy Brune & Associates, LLC

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

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