FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 0047746

Facility Name: Lena Living Center

Address: 1010 South Logan St (Number) Lena (City) 61048 (Zip Code)

County: Stephenson

Telephone Number: (815) 369 - 4561 **Fax #** (815) 369 - 2900

HFS ID Number:

Date of Initial License for Current Owners: 02/27/06

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Edward N. Slack **Telephone Number:** (847) 628 - 8796
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,731	5,371	1,817	10,919	8
9	SNF/PED					9
10	ICF	4,851	6,982		11,833	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,582	12,353	1,817	22,752	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.75%

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)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/07/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/07/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,642

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,563	37,119	8,448	226,130		226,130		226,130			1
2	Food Purchase		159,890		159,890		159,890		159,890			2
3	Housekeeping	116,014	14,851		130,865		130,865		130,865			3
4	Laundry	36,156	10,047		46,203		46,203		46,203			4
5	Heat and Other Utilities			96,186	96,186		96,186	(11,432)	84,754			5
6	Maintenance	47,993	27,034	126,629	201,656		201,656	910	202,566			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	380,726	248,941	231,263	860,930		860,930	(10,522)	850,408			8
	B. Health Care and Programs											
9	Medical Director			9,100	9,100		9,100		9,100			9
10	Nursing and Medical Records	1,266,762	64,055	83,142	1,413,959		1,413,959	32,859	1,446,818			10
10a	Therapy											10a
11	Activities	52,043	2,909		54,952		54,952		54,952			11
12	Social Services	25,429		2,877	28,306		28,306		28,306			12
13	CNA Training											13
14	Program Transportation			18,854	18,854		18,854		18,854			14
15	Other (specify):* See Supplemental							5,394	5,394			15
16	TOTAL Health Care and Programs	1,344,234	66,964	113,973	1,525,171		1,525,171	38,253	1,563,424			16
	C. General Administration											
17	Administrative	76,003			76,003		76,003	22,070	98,073			17
18	Directors Fees											18
19	Professional Services			438,854	438,854		438,854	(304,484)	134,370			19
20	Dues, Fees, Subscriptions & Promotions			31,872	31,872		31,872	2,576	34,448			20
21	Clerical & General Office Expenses	46,786	13,673	142,521	202,980		202,980	(53,396)	149,584			21
22	Employee Benefits & Payroll Taxes			322,024	322,024		322,024		322,024			22
23	Inservice Training & Education											23
24	Travel and Seminar			100	100		100	726	826			24
25	Other Admin. Staff Transportation			38,602	38,602		38,602	(16,754)	21,848			25
26	Insurance-Prop.Liab.Malpractice			109,965	109,965		109,965	11,052	121,017			26
27	Other (specify):* See Supplemental							15,549	15,549			27
28	TOTAL General Administration	122,789	13,673	1,083,938	1,220,400		1,220,400	(322,661)	897,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,847,749	329,578	1,429,174	3,606,501		3,606,501	(294,930)	3,311,571			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.

Lena Living Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Total	-	-	-
Line 15 Detailed			
Alloc. - SAK Management Services, LLC			
Emp. Ben. - HC Programs			5,394
Total	-	-	5,394
Line 27 Detailed			
Alloc. - SAK Management Services, LLC			
Emp. Ben. - Gen. Admin.			15,549
Total	-	-	15,549

Lena Living Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Line 25 Supplemental Schedule

Description	Total	Non-Allowable
Healthcare Investigators, Inc.	4,472	4,472
Lisa Lobdell	7,902	7,902
Doris Rex	2,890	
Marjorie Boland	902	
Loretta Price	4,816	
Thomas Moen	494	
Laurie Krager	4,627	4,627
Keith Hufsey	4,297	
Bart Becker	124	
Patti Earnest	129	
Laurie Alumbaugh	1,497	
Michelle Binkley	201	
Josie York	25	
Celia Amill	75	
Nolayne Kraft	18	
Cindy Ware	34	
Bruce Harris	126	
Baymont Inn and Suites	5,972	
Alloc. - SAK Management Services, LLC	247	
Total	38,849	17,001
Allowable	21,848	

Facility Name & ID Number Lena Living Center #0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			40,320	40,320		40,320	163,068	203,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							64,197	64,197			32
33	Real Estate Taxes			67,145	67,145		67,145	(14,114)	53,031			33
34	Rent-Facility & Grounds			204,718	204,718		204,718	(190,552)	14,166			34
35	Rent-Equipment & Vehicles			23,769	23,769		23,769	1,188	24,957			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			335,952	335,952		335,952	23,787	359,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,694	306,486	432,180		432,180		432,180			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,821	201,821		201,821		201,821			42
43	Other (specify):* See Supplemental	71,928	12,109	35,560	119,597		119,597	(119,597)				43
44	**TOTAL Special Cost Centers**	71,928	137,803	543,867	753,598		753,598	(119,597)	634,001			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,919,677	467,381	2,308,993	4,696,051		4,696,051	(390,740)	4,305,311			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

Lena Living Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Marketing	71,928	12,109	35,560
Total	71,928	12,109	35,560

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				4
5	Telephone, TV & Radio in Resident Rooms	(11,432)	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
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	(14,192)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(117,276)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(149,505)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,605)		$	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)	(97,135)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (97,135)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (390,740)		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

Lena Living Center

ID# 0047746

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medical Record Income	$ (116)	21	1
2	Other Income	(216)	21	2
3	Other Professional - Legal	(9,166)	19	3
4	Bank Charges	(203)	21	4
5	Travel - Marketing	(17,001)	25	5
6	Marketing	(119,597)	43	6
7	Capitalized Assets < $2,500	910	06	7
8				8
9				9
10				10
11				11
12				12
13	Lena Property Partners, LLC			13
14	Professional Fees	(2,276)	19	14
15	Dues and Subscriptions	(250)	20	15
16	Office and Clerical	(1,590)	21	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**	(149,505)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(11,432)	0	0	0	0	0	0	0	0	0	0	(11,432)	5
6	Maintenance	910	0	0	0	0	0	0	0	0	0	0	910	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,522)	0	0	0	0	0	0	0	0	0	0	(10,522)	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	32,859	0	0	0	0	0	0	0	0	32,859	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	5,394	0	0	0	0	0	0	0	0	5,394	15
16	**TOTAL Health Care and Programs**	0	0	38,253	0	0	0	0	0	0	0	0	38,253	16
	C. General Administration													
17	Administrative	0	0	22,070	0	0	0	0	0	0	0	0	22,070	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,442)	2,276	(295,318)	0	0	0	0	0	0	0	0	(304,484)	19
20	Fees, Subscriptions & Promotions	(250)	250	2,576	0	0	0	0	0	0	0	0	2,576	20
21	Clerical & General Office Expenses	(134,793)	1,590	79,807	0	0	0	0	0	0	0	0	(53,396)	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	726	0	0	0	0	0	0	0	0	726	24
25	Other Admin. Staff Transportation	(17,001)	0	247	0	0	0	0	0	0	0	0	(16,754)	25
26	Insurance-Prop.Liab.Malpractice	0	4,800	6,252	0	0	0	0	0	0	0	0	11,052	26
27	Other (specify):*	0	0	15,549	0	0	0	0	0	0	0	0	15,549	27
28	**TOTAL General Administration**	(163,486)	8,916	(168,091)	0	0	0	0	0	0	0	0	(322,661)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(174,008)	8,916	(129,838)	0	0	0	0	0	0	0	0	(294,930)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	163,068	0	0	0	0	0	0	0	0	0	163,068	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	64,197	0	0	0	0	0	0	0	0	0	64,197	32
33	Real Estate Taxes	0	(14,114)	0	0	0	0	0	0	0	0	0	(14,114)	33
34	Rent-Facility & Grounds	0	(204,718)	14,166	0	0	0	0	0	0	0	0	(190,552)	34
35	Rent-Equipment & Vehicles	0	0	1,188	0	0	0	0	0	0	0	0	1,188	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	8,433	15,354	0	0	0	0	0	0	0	0	23,787	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(119,597)	0	0	0	0	0	0	0	0	0	0	(119,597)	43
44	**TOTAL Special Cost Centers**	(119,597)	0	0	0	0	0	0	0	0	0	0	(119,597)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(293,605)	17,349	(114,484)	0	0	0	0	0	0	0	0	(390,740)	45

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
Suzanne Koenig	100%	St. Anthony's Nuring & Rehab Center, LLC	Rock Island, Illinois	Lena Property Partners, LLC	Lena, Illinois	Bldg. Partnership
				St. Anthony's Property, LLC	Rock Island, Illinois	Bldg. Partnership
				SAK Management	Northfield, Illinois	Mgmt. Company

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 204,718	Lena Property Partners, LLC	100.00%	$	$ (204,718)	1
2	V	32	Interest	3,960	Lena Property Partners, LLC	100.00%		(3,960)	2
3	V	19	Professional Fees		Lena Property Partners, LLC	100.00%	2,276	2,276	3
4	V	20	Dues, Fees and Subscriptions		Lena Property Partners, LLC	100.00%	250	250	4
5	V	21	Office and Clerical		Lena Property Partners, LLC	100.00%	1,590	1,590	5
6	V	26	Property Insurance		Lena Property Partners, LLC	100.00%	4,800	4,800	6
7	V	30	Depreciation		Lena Property Partners, LLC	100.00%	163,068	163,068	7
8	V	32	Interest		Lena Property Partners, LLC	100.00%	68,157	68,157	8
9	V	33	Real Estate Taxes	67,145	Lena Property Partners, LLC	100.00%	53,031	(14,114)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 275,823			$ 293,172	$ * 17,349	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$	SAK Management Services, LLC	100.00%	$ 32,859	$ 32,859	15
16	V	15	Emp. Ben. - HC Programs		SAK Management Services, LLC	100.00%	5,394	5,394	16
17	V	17	Administration		SAK Management Services, LLC	100.00%	22,070	22,070	17
18	V	19	Professional Fees	308,195	SAK Management Services, LLC	100.00%	0	(308,195)	18
19	V	19	Professional Fees		SAK Management Services, LLC	100.00%	12,877	12,877	19
20	V	20	Dues and Subscriptions		SAK Management Services, LLC	100.00%	2,576	2,576	20
21	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	72,655	72,655	21
22	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	7,152	7,152	22
23	V	24	Seminar and Education		SAK Management Services, LLC	100.00%	726	726	23
24	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	247	247	24
25	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	0		25
26	V	26	Insurance		SAK Management Services, LLC	100.00%	6,252	6,252	26
27	V	27	Emp. Ben. - Gen. Admin.		SAK Management Services, LLC	100.00%	15,549	15,549	27
28	V	30	Depreciation		SAK Management Services, LLC	100.00%	0		28
29	V	32	Interest		SAK Management Services, LLC	100.00%	0		29
30	V	34	Rent - Building		SAK Management Services, LLC	100.00%	14,166	14,166	30
31	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	1,188	1,188	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 308,195			$ 193,711	$ * (114,484)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lena Property Partners, LLC
Street Address: 1010 South Logan Street
City / State / Zip Code: Lena, Illinois 61048
Phone Number: (
Fax Number: (

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SAK Management Services, LLC
Street Address: 1 Northfield Plaza, Suite 480
City / State / Zip Code: Northfield, Illinois 60093
Phone Number: (847) 446 - 8400
Fax Number: (847) 446 - 8432

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing	SAK Consulting Fees	1,667,019		$ 181,661	$ 181,661	301,530	$ 32,859	1
2	15	Emp. Ben. - HC Programs	SAK Consulting Fees	1,667,019		29,819		301,530	5,394	2
3	17	Administration	SAK Consulting Fees	1,667,019		122,013	122,013	301,530	22,070	3
4	19	Professional Fees	Direct	160,528		160,528				4
5	19	Professional Fees	SAK Consulting Fees	1,667,019		71,191		301,530	12,877	5
6	20	Dues and Subscriptions	SAK Consulting Fees	1,667,019		14,244		301,530	2,576	6
7	21	Office and Clerical	SAK Consulting Fees	1,667,019		401,678	401,678	301,530	72,655	7
8	21	Office and Clerical	SAK Consulting Fees	1,667,019		39,540		301,530	7,152	8
9	24	Seminar and Education	SAK Consulting Fees	1,667,019		4,011		301,530	726	9
10	25	Other Staff Admin. Trans.	Direct	115,072		115,072		247	247	10
11	25	Other Staff Admin. Trans.	SAK Consulting Fees	1,667,019				301,530		11
12	26	Insurance	SAK Consulting Fees	1,667,019		34,566		301,530	6,252	12
13	27	Emp. Ben. - Gen. Admin.	SAK Consulting Fees	1,667,019		85,963		301,530	15,549	13
14	30	Depreciation	SAK Consulting Fees	1,667,019				301,530		14
15	32	Interest	SAK Consulting Fees	1,667,019				301,530		15
16	34	Rent - Building	SAK Consulting Fees	1,667,019		78,319		301,530	14,166	16
17	35	Rent - Equipment	SAK Consulting Fees	1,667,019		6,569		301,530	1,188	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,345,174	$ 705,352		$ 193,711	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Providence Bank		X	Mortgage			$	$ 2,486,465			$ 30,153	1
2	Providence Bank		X	Construction Loan				2,896,296			35,123	2
3	Providence Bank		X	Line of Credit				237,570			2,881	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,620,331			$ 68,157	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X									12
13	Interest Income - Bldg Part.		X								(3,960)	13
14	TOTAL Non-Facility Related						$	$			$ (3,960)	14
15	TOTALS (line 9+line14)						$	$ 5,620,331			$ 64,197	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.)**

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	69,532	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.)	$	59,787	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,745)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	62,776	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.	$	53,031	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	65,221	8
	2011	66,350	9
	2012	67,245	10
	2013	66,735	11
	2014	59,787	12

2015 Real Estate Tax Accrual = $59,787 * 1.05 = $62,776

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lena Living Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0047746

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-04-102-001	Long Term Care Facility	$ 39,302.32	$ 39,302.32
2.	10-12-04-101-006	Long Term Care Facility	$ 665.34	$ 665.34
3.	10-12-04-101-001	Long Term Care Facility	$ 19,819.26	$ 19,819.26
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,786.92	$ 59,786.92

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,546 B. General Construction Type: Exterior Brick / Stucco Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2006	$ 290,000	1
2					2
3	TOTALS			$ 290,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	92		2006		$ 1,310,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	7,823						9
10	Various			2007	25,300						10
11	Various			2008	29,285						11
12	Various			2009	30,648						12
13	Various			2010	30,464						13
14	Various			2011	24,049						14
15	Hot Water Heater			2012	3,000						15
16	Hot Water Boiler			2012	5,520						16
17	Water Heater			2013	9,857						17
18	Heat Pump			2013	4,654						18
19	Carpeting - Room 9 and 11			2014	3,295						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

*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 Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Lena Property Partners, LLC (Building Parntership)		$	$		$	$	$	37
38									38
39	Sprinkler System	2013	70,365						39
40	Sprinkler System - Water Main	2013	18,511						40
41	Tile - Hallways	2013	23,190						41
42	Lighting Modifications - Hallways / Resident Rooms	2013	33,472						42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Depreciation - Lena Living Center, LLC			9,120		9,120		96,803	68
69	Depreciation - Lena Property Partners, LLC			163,068		163,068		726,021	69
70	TOTAL (lines 4 thru 69)		$ 1,629,433	$ 172,188		$ 172,188	$	$ 822,824	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 129,930	$ 25,865	$ 25,865	$		$ 133,766	71
72	Current Year Purchases	29,086	4,286	4,286			4,286	72
73	Fully Depreciated Assets							73
74	R.P. Allocations	424,249					412,991	74
75	TOTALS	$ 583,265	$ 30,151	$ 30,151	$		$ 551,043	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	1987 Ford F150	2013	$ 6,000	$ 1,049	$ 1,049	$		$ 3,376	76
77										77
78										78
79										79
80	TOTALS			$ 6,000	$ 1,049	$ 1,049	$		$ 3,376	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)	$ 2,508,698	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 203,388	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 203,388	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)	$ 1,377,243	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	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

Lena Living Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 13 Supplemental Schedule

Description	Cost	Book Depr.	S/L Depr.	Accumulated Depreciation
Related Party 1 - Lena Property Partners, LLC				
Prior	396,000			396,000
Current				
Total	396,000	-	-	396,000
Related Party 2 - SAK Management Services, LLC				
Prior	28,249			16,991
Current				
Total	28,249	-	-	16,991
Related Party 3 -				
Prior				
Current				
Total	-	-	-	-
Related Party 4				
Prior				
Current				
Total	-	-	-	-
Total	**424,249**	**-**	**-**	**412,991**

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	See							5
6	Attachment				14,166			6
7	TOTAL				$ 14,166 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,334 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Lexus	$	$ 15,623	17
18					18
19					19
20					20
21	TOTAL		$	$ 15,623	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Alloc. - SAK Management Services, LLC	14,166
Total	14,166

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Item Rented	Amount
Marlin Leasing / Business Bank		4,898
Great American Financial Services		1,895
Integra Business System		1,354
Alloc. - SAK Management Services, LLC		1,188
Total		9,334

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 116,875	$		$ 116,875	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,059			27,059	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			155,375			155,375	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				80,548		80,548	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					45,146		45,146	12
13	Other (specify): See Supplemental	39 - 03				7,177			7,177	13
14	TOTAL			$		$ 306,486	$ 125,694		$ 432,180	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

Lena Living Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	30,665	
Oxygen	14,482	
Laboratory		5,339
Radiology		1,838
Total	45,146	7,177

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 91,334	$ 98,521	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,030)	896,303	896,303	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	14,716	1,126,783	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,002,353	$ 2,121,607	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		290,000	13
14	Buildings, at Historical Cost		1,455,538	14
15	Leasehold Improvements, at Historical Cost	112,966	112,966	15
16	Equipment, at Historical Cost	235,366	631,366	16
17	Accumulated Depreciation (book methods)	(238,230)	(1,360,251)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		2,630,720	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 110,102	$ 3,760,339	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,112,455	$ 5,881,946	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 531,400	$ 605,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		237,570	29
30	Accrued Salaries Payable	127,054	127,054	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,776	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	649,058	2,658,729	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,307,512	$ 3,691,430	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,486,465	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,486,465	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,307,512	$ 6,177,895	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (195,057)	$ (295,949)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,112,455	$ 5,881,946	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lena Living Center, LLC
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Settlements	14,716	14,716
Construction Reserve		1,022,386
Property Tax Escrow		89,681
Total	14,716	1,126,783
Line 23 - Other Long Term Assets		
Construction In Progress		2,590,088
Acquisition / Debt Issuance Costs		40,632
Total	-	2,630,720
Line 36 - Other Current Liabilities		
Due to Affiliated Entities	649,058	-
Construction Loan		2,658,729
Total	649,058	2,658,729
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 469,342	1
2	Restatements (describe):		2
3	**PY Cost Report to FS Difference - Depreciation ADJ**	8,656	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 477,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(603,797)	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	(69,258)	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)**	$ (673,055)	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)**	$ (195,057)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,966,811	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,966,811	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,091	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 119,091	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		12
13	Barber and Beauty Care	1,800	13
14	Non-Patient Meals	4,220	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,020	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	332	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 332	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,092,254	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	860,930	31
32	Health Care	1,525,171	32
33	General Administration	1,220,400	33
	B. Capital Expense		
34	Ownership	335,952	34
	C. Ancillary Expense		
35	Special Cost Centers	551,777	35
36	Provider Participation Fee	201,821	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,696,051	40
41	**Income before Income Taxes (line 30 minus line 40)****	(603,797)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (603,797)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,068,602	44
45	Private Pay - Net Inpatient Revenue	2,058,504	45
46	Medicare - Net Inpatient Revenue	748,084	46
47	Other-(specify) Insurance - Net Inpatient Revenue	91,621	47
48	Other-(specify) Veterans and Hospice - Net Inpatient Revenue		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,966,811	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

Lena Living Center, LLC
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Medical Records	116	116
Other Income	216	216
Total	332	332

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,009	2,113	$ 75,219	$ 35.60	1
2	Assistant Director of Nursing	1,740	2,108	55,828	26.48	2
3	Registered Nurses	11,560	12,240	309,141	25.26	3
4	Licensed Practical Nurses	8,674	9,442	189,412	20.06	4
5	CNAs & Orderlies	47,160	49,902	545,899	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,790	5,163	52,043	10.08	10
11	Social Service Workers	1,948	2,080	25,429	12.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,653	17,687	180,563	10.21	15
16	Dishwashers					16
17	Maintenance Workers	3,959	4,260	47,993	11.27	17
18	Housekeepers	11,438	12,175	116,014	9.53	18
19	Laundry	3,734	4,107	36,156	8.80	19
20	Administrator	1,648	1,808	76,003	42.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,000	4,431	46,786	10.56	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	1,868	2,107	22,709	10.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,621	5,057	140,482	27.78	33
34	TOTAL (lines 1 - 33)	125,802	134,680	$ 1,919,677 *	$ 14.25	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,448	01 - 03	35
36	Medical Director		9,100	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,436	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				44
45	Social Service Consultant		2,877	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,861		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 77,706	10 - 03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 77,706		53

Lena Living Center, LLC
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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
MDS Coordinator (Line 10)	1,901	2,125	68,554
Marketing (Line 43)	2,720	2,932	71,928
Total	4,621	5,057	140,482

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Barker	Administrator	0	$ 3,768
Bart Becker	Administrator	0	49,343
Laurie Alumbaugh	Administrator	0	6,191
Bernadean McCoy	Administrator	0	16,701
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,003

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
SAK Management Services, LLC	Management Fees	$ 205,319
SAK Management Services, LLC	Administrative Consultant	102,876
SAK Management Services, LLC	Data Processing	
SAK Management Services, LLC	Legal	
Personnel Planners, Inc.	Unemployment Consultant	1,338
Plante & Moran, PLLC	Accounting	12,745
Polsinelli Shughart, PC	Legal	23,671
Jackson Lewis, PC	Legal	4,080
Stephen N Sher	Legal	2,455
Stone, Pogrund & Korey, LLC	Legal	2,171
Aronberg, Golgen, Davis & Ga	Legal	225
See Supplemental Schedule	See Supplemental Schedule	83,974
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 438,854

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,686
Unemployment Compensation Insurance	27,719
FICA Taxes	148,199
Employee Health Insurance	38,900
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	7,520
TOTAL (agree to Schedule V, line 22, col.8)	$ 322,024

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,220
Health Care Worker Background Check	1,780
(Indicate # of checks performed)	
Patient Background Checks	1,000
Dues and Subscriptions	20,382
Licenses	500
Advertising and Promotion	
Alloc. - SAK Management Services, LLC	2,576
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,448

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	100
Alloc. - SAK Management Services, LLC	726
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 826

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Description of Services	Total
Future Wave Tech, Inc.	IT Consulting	21,998
Wescom Solutions, Inc.	Data Processing	24,734
Proliant	Payroll Processing	7,645
Compu-Solutions	IT Consulting	24,300
LTC Solutions	Data Processing	1,913
Other	Data Processing	3,384
Sub-Total		83,974

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Non-Allowable Amount
Polsinelli Shughart, PC	01/21/15	Non-Allowable (Prior Period)	96	96
Polsinelli Shughart, PC	01/21/15	Non-Allowable (Prior Period)	6,899	6,899
Jackson Lewis, PC	04/21/15	Employee Benefits / Union Petition	4,080	
Polsinelli Shughart, PC	04/28/15	Medicaid MCO Contracting	231	
Polsinelli Shughart, PC	04/28/15	Medicaid MCO Contracting	96	
Polsinelli Shughart, PC	04/28/15	Employee Benefits / Union Petition	8,316	
Stephen N Sher	04/30/15	Loan Documentation Review	2,455	
Polsinelli Shughart, PC	05/29/15	Medicaid MCO Contracting	1,234	
Stone, Pogrund, & Korey, LLC	06/01/15	Collections	288	288
Polsinelli Shughart, PC	06/22/15	Medicaid MCO Contracting / Survey	2,271	
Stone, Pogrund, & Korey, LLC	06/30/15	Collections	961	961
Polsinelli Shughart, PC	07/01/15	Hospice Contract Review	450	
Stone, Pogrund, & Korey, LLC	08/01/15	Collections	427	427
Aronberg, Goldgehn, Davis & Garmisa	08/17/15	Annual Filings	225	
Stone, Pogrund, & Korey, LLC	09/01/15	Collections	275	275
Polsinelli Shughart, PC	09/01/15	Medicaid MCO Contracting / Survey	1,825	
Polsinelli Shughart, PC	09/01/15	Survey / HIPAA Modifications	1,380	
Polsinelli Shughart, PC	10/12/15	Survey	636	
Polsinelli Shughart, PC	11/24/15	Annual Filings (Registered Agent)	237	
Stone, Pogrund, & Korey, LLC	12/01/15	Collections	220	220
Sub-Total			32,602	9,166

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. **ICLTC - $19,908**

(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. $ **1,387** Line **10 - 02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **201,821**
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.

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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,220**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees