FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 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: Chris Joos, CPA **Telephone Number:** 614-222-9040
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Chris Joos, CPA — Partner
(Firm Name & Address) Plante & Moran, PLLC — 250 S. High Street, Ste 100 , Columbus, OH 43215
(Telephone) 614-222-9040 Fax # 248-233-8811

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	41	15,006	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	101	36,966	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	2,224	5,856	1,981	10,061	8
9	SNF/PED					9
10	ICF	4,392	4,559	144	9,095	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,616	10,415	2,125	19,156	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.82%

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 1,384

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	194,613	15,015	7,545	217,173		217,173		217,173			1
2	Food Purchase		197,156		197,156		197,156	(2,837)	194,319			2
3	Housekeeping	113,889	13,588		127,477		127,477		127,477			3
4	Laundry	22,539	11,935		34,474		34,474		34,474			4
5	Heat and Other Utilities			105,160	105,160		105,160		105,160			5
6	Maintenance	61,102	18,322	55,236	134,660		134,660	2,396	137,056			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	392,143	256,016	167,941	816,100		816,100	(441)	815,659			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	1,268,249	108,902	12,676	1,389,827		1,389,827	11,455	1,401,282			10
10a	Therapy			4,900	4,900		4,900		4,900			10a
11	Activities	54,723	1,487		56,210		56,210		56,210			11
12	Social Services	26,052		1,341	27,393		27,393		27,393			12
13	CNA Training											13
14	Program Transportation			15,083	15,083		15,083		15,083			14
15	Other (specify):* See Supplemental							1,980	1,980			15
16	TOTAL Health Care and Programs	1,349,024	110,389	40,300	1,499,713		1,499,713	13,435	1,513,148			16
	C. General Administration											
17	Administrative	82,629			82,629		82,629	18,548	101,177			17
18	Directors Fees											18
19	Professional Services			397,621	397,621		397,621	(267,947)	129,674			19
20	Dues, Fees, Subscriptions & Promotions			17,395	17,395		17,395	(474)	16,921			20
21	Clerical & General Office Expenses	45,101	11,051	103,534	159,686		159,686	1,946	161,632			21
22	Employee Benefits & Payroll Taxes			232,590	232,590		232,590	(9,565)	223,025			22
23	Inservice Training & Education											23
24	Travel and Seminar			721	721		721	3,615	4,336			24
25	Other Admin. Staff Transportation			14,216	14,216		14,216	8,297	22,513			25
26	Insurance-Prop.Liab.Malpractice			75,156	75,156		75,156	3,864	79,020			26
27	Other (specify):* See Supplemental							14,233	14,233			27
28	TOTAL General Administration	127,730	11,051	841,233	980,014		980,014	(227,483)	752,531			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,868,897	377,456	1,049,474	3,295,827		3,295,827	(214,489)	3,081,338			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Lena Living Center
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 15 - Other Health Care Services				
Alloc. - SAK Management Services, Inc.				-
Employee Benefits			1,980	1,980
				-
				-
				-
				-
				-
Sub-Total	-	-	1,980	1,980
Line 27 - Other General Administration				
Alloc. - SAK Management Services, Inc.				-
Employee Benefits			14,233	14,233
				-
				-
				-
				-
				-
Sub-Total	-	-	14,233	14,233

Lena Living Center
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Non-Allowable	
Baymont Inn & Suites - Freeport	Business Matters	Various	Various	-	1,798	-	1,798
Bruce Harris	Business Matters	Various	Various	122	-	-	122
Celia Amill	Business Matters	Various	Various	118	181	-	299
Cheri L Riddle	Business Matters	Various	Various	760	-	-	760
Cindy Ware	Business Matters	Various	Various	89	-	-	89
Diana Kuhlemeier	Business Matters	Various	Various	2,946	-	-	2,946
Healthcare Investigators, Inc.	Non - Allowable	Various	Various	-	-	1,769	1,769
Karen Luedtke	Business Matters	Various	Various	386	-	-	386
Keith Hufsey	Business Matters	Various	Various	1,942	-	-	1,942
Lisa Lobdell	Non - Allowable	Various	Various	-	-	869	869
Loretta Price	Business Matters	Various	Various	2,419	-	-	2,419
Marjorie Boland	Business Matters	Various	Various	460	-	-	460
Michelle Binkley	Business Matters	Various	Various	146	-	-	146
Petty Cash	Business Matters	Various	Various	212	-	-	212
							-
Alloc. - SAK Management Services, Inc.				10,935			10,935
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				20,534	1,979	2,638	25,151

Facility Name & ID Number Lena Living Center #0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,866	37,866		37,866	91,248	129,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72	72		72	276,129	276,201			32
33	Real Estate Taxes			68,262	68,262		68,262		68,262			33
34	Rent-Facility & Grounds			396,090	396,090		396,090	(383,455)	12,635			34
35	Rent-Equipment & Vehicles			29,881	29,881		29,881	1,092	30,973			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			532,171	532,171		532,171	(14,986)	517,185			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,253	363,134	434,387		434,387		434,387			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,840	160,840		160,840		160,840			42
43	Other (specify):* See Supplemental	67,180	10,247	17,541	94,968		94,968	(94,968)				43
44	**TOTAL Special Cost Centers**	67,180	81,500	541,515	690,195		690,195	(94,968)	595,227			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,936,077	458,956	2,123,160	4,518,193		4,518,193	(324,443)	4,193,750			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Lena Living Center
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Marketing	67,180	10,247	17,541	94,968
				-
				-
				-
				-
				-
				-
Sub-Total	67,180	10,247	17,541	94,968

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,837)	02		4
5	Telephone, TV & Radio in Resident Rooms	(15,467)	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				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	(2,025)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,797)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(222,014)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (315,140)		$	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)	(9,303)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,303)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (324,443)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Lena Living Center

ID# 0047746

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Income - Miscellaneous	$ (646)	21	1
2	Income - Medical Records	(20)	21	2
3	Bank Charges	(1,968)	21	3
4	Travel	(2,638)	25	4
5	Marketing	(94,796)	43	5
6	Professional - Other - Non Allowable	(19,905)	19	6
7	Professional - Legal - Non Allowable	(14,456)	19	7
8	Capitalized Assets < $2,500	2,223	06	8
9	Insurance Settlement	(89,408)	30	9
10				10
11	Lena Property Partners, LLC			11
12	Professional Fees	(150)	19	12
13	Licenses	(250)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(222,014)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES 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	(2,837)	0	0	0	0	0	0	0	0	0	0	(2,837)	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	2,223	0	173	0	0	0	0	0	0	0	0	2,396	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(614)	0	173	0	0	0	0	0	0	0	0	(441)	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	11,455	0	0	0	0	0	0	0	0	11,455	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	1,980	0	0	0	0	0	0	0	0	1,980	15
16	**TOTAL Health Care and Programs**	0	0	13,435	0	0	0	0	0	0	0	0	13,435	16
	C. General Administration													
17	Administrative	0	0	18,548	0	0	0	0	0	0	0	0	18,548	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(34,511)	150	(233,586)	0	0	0	0	0	0	0	0	(267,947)	19
20	Fees, Subscriptions & Promotions	(2,275)	250	1,551	0	0	0	0	0	0	0	0	(474)	20
21	Clerical & General Office Expenses	(90,898)	22,005	70,839	0	0	0	0	0	0	0	0	1,946	21
22	Employee Benefits & Payroll Taxes	0	0	(9,565)	0	0	0	0	0	0	0	0	(9,565)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,615	0	0	0	0	0	0	0	0	3,615	24
25	Other Admin. Staff Transportation	(2,638)	0	10,935	0	0	0	0	0	0	0	0	8,297	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,864	0	0	0	0	0	0	0	0	3,864	26
27	Other (specify):*	0	0	14,233	0	0	0	0	0	0	0	0	14,233	27
28	**TOTAL General Administration**	(130,322)	22,405	(119,566)	0	0	0	0	0	0	0	0	(227,483)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(130,936)	22,405	(105,958)	0	0	0	0	0	0	0	0	(214,489)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(89,408)	176,657	3,999	0	0	0	0	0	0	0	0	91,248	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	275,954	175	0	0	0	0	0	0	0	0	276,129	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(396,090)	12,635	0	0	0	0	0	0	0	0	(383,455)	34
35	Rent-Equipment & Vehicles	0	0	1,092	0	0	0	0	0	0	0	0	1,092	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(89,408)	56,521	17,901	0	0	0	0	0	0	0	0	(14,986)	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):*	(94,796)	0	(172)	0	0	0	0	0	0	0	0	(94,968)	43
44	TOTAL Special Cost Centers	(94,796)	0	(172)	0	0	0	0	0	0	0	0	(94,968)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(315,140)	78,926	(88,229)	0	0	0	0	0	0	0	0	(324,443)	45

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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)	
1	V	34	Rent	$ 396,090	Lena Property Partners, LLC	100.00%	$	$ (396,090)	1
2	V	32	Interest	660	Lena Property Partners, LLC	100.00%		(660)	2
3	V	19	Professional Fees		Lena Property Partners, LLC	100.00%	150	150	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%	22,005	22,005	5
6	V	26	Property Insurance		Lena Property Partners, LLC	100.00%			6
7	V	30	Depreciation		Lena Property Partners, LLC	100.00%	176,657	176,657	7
8	V	32	Interest		Lena Property Partners, LLC	100.00%	276,614	276,614	8
9	V	33	Real Estate Taxes		Lena Property Partners, LLC	100.00%			9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 396,750			$ 475,676	$ * 78,926	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Suzanne Koenig	100%	St. Anthony's Nuring & Rehab Ctr, LLC	Rock Island, Illinois	Lena Property			1
2					Partners, LLC	Lena, Illinois	Bldg. Partnership	2
3					St. Anthony's			3
4					Property, LLC	Rock Island, Illinois	Bldg. Partnership	4
5					SAK Management	Northfield, Illinois	Mgmt. Company	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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6	Maintenance	$	SAK Management Services, LLC	100.00%	$ 173	$ 173	15
16	V	10	Nursing		SAK Management Services, LLC	100.00%	11,455	11,455	16
17	V	10A	Rehab		SAK Management Services, LLC	100.00%	0		17
18	V	15	Emp. Ben. - HC Programs		SAK Management Services, LLC	100.00%	1,980	1,980	18
19	V	17	Administration		SAK Management Services, LLC	100.00%	18,548	18,548	19
20	V	19	Professional Fees	240,785	SAK Management Services, LLC	100.00%	0	(240,785)	20
21	V	19	Professional Fees		SAK Management Services, LLC	100.00%	7,199	7,199	21
22	V	20	Dues and Subscriptions		SAK Management Services, LLC	100.00%	1,551	1,551	22
23	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	70,839	70,839	23
24	V	24	Seminar and Education	393	SAK Management Services, LLC	100.00%	4,008	3,615	24
25	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	0		25
26	V	25	Other Staff Admin. Trans.		SAK Management Services, LLC	100.00%	10,935	10,935	26
27	V	26	Insurance		SAK Management Services, LLC	100.00%	3,864	3,864	27
28	V	27	Emp. Ben. - Gen. Admin.		SAK Management Services, LLC	100.00%	14,233	14,233	28
29	V	30	Depreciation		SAK Management Services, LLC	100.00%	3,999	3,999	29
30	V	32	Interest		SAK Management Services, LLC	100.00%	175	175	30
31	V	34	Rent - Building		SAK Management Services, LLC	100.00%	12,635	12,635	31
32	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	1,092	1,092	32
33	V	22	Employee Benefits	9,565	SAK Management Services, LLC	100.00%		(9,565)	33
34	V	43	Marketing	172	SAK Management Services, LLC	100.00%		(172)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 250,915			$ 162,686	$ * (88,229)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	6	Maintenance	SAK Consulting Fees	1,665,753	12	$ 1,149	$	250,915	$ 173	1
2	10	Nursing	SAK Consulting Fees	1,665,753	12	76,044	76,044	250,915	11,455	2
3	10A	Rehab	Direct	12,333	12	12,333				3
4	15	Emp. Ben. - HC Programs	SAK Consulting Fees	1,665,753	12	13,143		250,915	1,980	4
5	17	Administration	SAK Consulting Fees	1,665,753	12	123,138	123,138	250,915	18,548	5
6	19	Professional Fees	Direct	1,321	12	1,321				6
7	19	Professional Fees	SAK Consulting Fees	1,665,753	12	47,794		250,915	7,199	7
8	20	Dues and Subscriptions	SAK Consulting Fees	1,665,753	12	10,297		250,915	1,551	8
9	21	Office and Clerical	SAK Consulting Fees	1,665,753	12	470,280	423,857	250,915	70,839	9
10	24	Seminar and Education	SAK Consulting Fees	1,665,753	12	26,608		250,915	4,008	10
11	25	Other Staff Admin. Trans.	Direct	3,557	12	3,557				11
12	25	Other Staff Admin. Trans.	SAK Consulting Fees	1,665,753	12	72,594		250,915	10,935	12
13	26	Insurance	SAK Consulting Fees	1,665,753	12	25,654		250,915	3,864	13
14	27	Emp. Ben. - Gen. Admin.	SAK Consulting Fees	1,665,753	12	94,490		250,915	14,233	14
15	30	Depreciation	SAK Consulting Fees	1,665,753	12	26,549		250,915	3,999	15
16	32	Interest	SAK Consulting Fees	1,665,753	12	1,165		250,915	175	16
17	34	Rent - Building	SAK Consulting Fees	1,665,753	12	83,880		250,915	12,635	17
18	35	Rent - Equipment	SAK Consulting Fees	1,665,753	12	7,250		250,915	1,092	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,097,246	$ 623,039		$ 162,686	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Providence Bank		X	Mortgage			$	$ 5,534,220			$ 263,995	1
2	Providence Bank		X	Line of Credit				429,000			12,691	2
3												3
4												4
5												5
	Working Capital											
6	Alloc. - SAK Management		X								175	6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,963,220			$ 276,861	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Int. Income - Bldg. Part.		X								(660)	13
14	TOTAL Non-Facility Related						$	$			$ (660)	14
15	TOTALS (line 9+line14)						$	$ 5,963,220			$ 276,201	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	60,011	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.)	$	62,582	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,571	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	65,711	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.	$	68,282	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	66,350	8
	2012	67,245	9
	2013	66,735	10
	2014	59,787	11
	2015	62,582	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

PY Real Estate Accrual Adjusted After Cost Report from $62,276 to $60,011

2016 Real Estate Tax Accrual = $62,582 * 1.05 = $65,711

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-04-102-001	Long Term Care Facility	$ 41,139.46	$ 41,139.46
2.	10-12-04-101-006	Long Term Care Facility	$ 696.44	$ 696.44
3.	10-12-04-101-001	Long Term Care Facility	$ 20,745.70	$ 20,745.70
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,581.60	$ 62,581.60

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,142 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).

Doll Apartments

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' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		2006		$ 1,310,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	21,660						9
10	Various			2008	5,979						10
11	Various			2009	4,494						11
12	Various			2011	24,049						12
13	Various			2012	4,422						13
14	Water Heater			2013	9,857						14
15	Heat Pump			2013	4,654						15
16	Sprinkler System			2013	88,876						16
17	Sprinkler System			2013	52,736						17
18	Lightin System Retrofit			2013	36,722						18
19	Tile - Hallways			2013	23,190						19
20	Water Heater - **			2016	23,425						20
21	Security System - Access Control System - **			2016	3,862						21
22	Construction and Renovation - Addition, Entryway, and Canopy			2016	3,084,288						22
23	Construction and Renovation - Addition, Entryway, and Canopy - **			2016	42,506						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' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									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	Depreciation - Lena Living Center, LLC			37,866		37,866		276,097	67
68	Depreciation - Lena Property Partners, LLC			176,657		176,657		1,298,677	68
69	Depreciation - SAK Management Services, Inc.			3,999		3,999		18,149	69
70	TOTAL (lines 4 thru 69)		$ 4,740,720	$ 218,522		$ 218,522	$	$ 1,592,923	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 159,016	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Page 13 SUPP	419,951						74
75	TOTALS	$ 578,967	$	$	$		$	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	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 6,000	$	$	$		$	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)	$ 5,615,687	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 218,522	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,522	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)	$ 1,592,923	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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Medicaid Cost Report
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Page 13 - Related Party Allocations

Related Party	Grouping	Class					Cost
Lena Property Partners, LLC	Fully	Furn. & Equipment					396,000
Alloc. - SAK Management Services, Inc.	Prior	Furn. & Equipment					23,951
			-	-	-	-	419,951

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	See Suppl				12,635			5
6								6
7	TOTAL				$ 12,635 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 18,385 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	$	$ 12,588	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,588	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Lena Living Center
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Alloc. - SAK Management Services, Inc.	12,635	12,635
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	12,635	12,635
Equipment Rental		
AdvaCare	5,707	5,707
Centrad Healthcare	2,002	2,002
Great America Financial Services	2,025	2,025
Integra Business System	1,913	1,913
Marlin Business Bank	5,646	5,646
		-
Alloc. - SAK Management Services, Inc.	1,092	1,092
		-
		-
		-
		-
		-
		-
Total	18,385	18,385

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 146,421	$		$ 146,421	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			39,001			39,001	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			168,928			168,928	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				34,365		34,365	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					36,888		36,888	12
13	Other (specify): See Supplemental	39 - 03				8,784			8,784	13
14	TOTAL			$		$ 363,134	$ 71,253		$ 434,387	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Lena Living Center
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Nursing Supplies		36,888		36,888
Laboratory			7,091	7,091
Radiology			1,693	1,693
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
Total	-	36,888	8,784	45,672

STATE OF ILLINOIS

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 92,828	$ 96,775	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,528)	946,283	946,283	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,000	35,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule		13,729	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,074,111	$ 1,091,787	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		4,582,333	14
15	Leasehold Improvements, at Historical Cost	112,966	112,966	15
16	Equipment, at Historical Cost	264,876	660,876	16
17	Accumulated Depreciation (book methods)	(276,097)	(1,574,774)	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		5,247	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 101,745	$ 4,076,648	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,175,856	$ 5,168,435	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,031,604	$ 1,074,560	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		429,000	29
30	Accrued Salaries Payable	188,246	188,246	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		65,711	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	876,445		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,096,295	$ 1,757,517	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,534,220	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)**	$	$ 5,534,220	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,096,295	$ 7,291,737	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (920,439)	$ (2,123,302)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,175,856	$ 5,168,435	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Lena Living Center
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01/01/16 - 12/31/16

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Real Estate Tax Escrow		13,729	13,729
			-
			-
			-
			-
Sub-Total	-	13,729	13,729
Line 23 - Long Term Assets			
Due to Affiliated Entities		5,247	5,247
			-
			-
			-
			-
Sub-Total	-	5,247	5,247
Line 36 - Other Current Liability			
Due to Lena Property Partners, LLC	876,445	(876,445)	-
			-
			-
			-
			-
Sub-Total	876,445	(876,445)	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (195,057)	1
2	Restatements (describe):		2
3	**PY Cost Report to FS Difference - Depreciation ADJ**	(1,218)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (196,275)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(723,614)	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	(550)	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)**	$ (724,164)	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)**	$ (920,439)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,462,646	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,462,646	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	172,686	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 172,686	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	650	13
14	Non-Patient Meals	2,837	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	64,726	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 68,213	23
	D. Non-Operating Revenue		
24	Contributions	960	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 960	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	90,074	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 90,074	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,794,579	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	816,100	31
32	Health Care	1,499,713	32
33	General Administration	980,014	33
	B. Capital Expense		
34	Ownership	532,171	34
	C. Ancillary Expense		
35	Special Cost Centers	529,355	35
36	Provider Participation Fee	160,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,518,193	40
41	**Income before Income Taxes (line 30 minus line 40)****	(723,614)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (723,614)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 869,009	44
45	Private Pay - Net Inpatient Revenue	1,753,516	45
46	Medicare - Net Inpatient Revenue	668,671	46
47	Other-(specify) Insurance - Net Patient Revenue	171,333	47
48	Other-(specify) Hospice - Net Patient Revenue	117	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,462,646	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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Page 19 Supplemental Schedule

Description	Amount	Total
Other Income	646	646
Medical Records	20	20
Insurance Reimbursement	89,408	89,408
		-
		-
		-
		-
		-
		-
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Total	90,074	90,074

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,843	1,955	$ 80,646	$ 41.25	1
2	Assistant Director of Nursing	1,832	2,080	61,309	29.48	2
3	Registered Nurses	11,603	12,649	356,354	28.17	3
4	Licensed Practical Nurses	9,058	9,848	231,391	23.50	4
5	CNAs & Orderlies	42,424	44,753	514,540	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,038	5,316	54,723	10.29	10
11	Social Service Workers	1,912	2,080	26,052	12.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,304	19,504	194,613	9.98	15
16	Dishwashers					16
17	Maintenance Workers	4,286	4,684	61,102	13.04	17
18	Housekeepers	11,599	12,410	113,889	9.18	18
19	Laundry	2,266	2,434	22,539	9.26	19
20	Administrator	1,960	2,080	82,629	39.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,434	3,673	45,101	12.28	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	1,898	2,115	24,009	11.35	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,324	3,566	67,180	18.84	33
34	TOTAL (lines 1 - 33)	120,781	129,147	$ 1,936,077 *	$ 14.99	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,545	01 - 03	35
36	Medical Director		6,300	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,520	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		1,341	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule		4,900		47
48					48
49	TOTAL (lines 35 - 48)		$ 22,606		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		10,156	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 10,156		53

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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Marketing	43	3,324	3,566	67,180	18.84		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		3,324	3,566	67,180	18.84		
Contracted Services							
Rehab Consulting	10a - 03						4,900
Total						-	4,900

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cynthia Ware	Administrator	0	$ 82,629
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,629

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	Management Fee	$ 185,880
SAK Management Services	Administrative Consultant	50,405
SAK Management Services	Data Processing	4,500
Plante & Moran, PLLC	Accounting	6,545
Compu Solutions, Inc.	Data Processing	40,316
Future Wave Tech, Inc.	Data Processing	23,229
Health Data Solutions	Data Processing	500
LTC Solutions	Data Processing	1,063
Management and Network	Data Processing	750
Proliant	Data Processing	8,372
Wescom Solutions	Data Processing	11,776
See Supplemental Schedule		64,285
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 397,621

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,175
Unemployment Compensation Insurance	13,476
FICA Taxes	139,623
Employee Health Insurance	33,186
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,130
Alloc. - SAK Management Services	(9,565)
TOTAL (agree to Schedule V, line 22, col.8)	$ 223,025

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	1,960
Health Care Worker Background Check	
(Indicate # of checks performed)	1,020
Patient Background Checks	110
Dues - ICLTC	7,952
Dues and Subscriptions	1,838
Licenses and Permits	500
Alloc. - SAK Management Services	1,551
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,921

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	721
Alloc. - SAK Management Services	3,615
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,336

* Attach copy of IMRF notifications

**See instructions.

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
Personnel Planners, Inc.	Unemployment Consultant	1,500	1,500
Polsinelli Shughart, PC	Legal	20,089	20,089
Stephen N Sher	Legal	8,335	8,335
Stone, Pogrund & Korey, LLC	Non - Allowable	14,456	14,456
Healthcare Investigators, Inc.	Non - Allowable	19,905	19,905
			-
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			-
			-
			-
			-
			-
Total		64,285	64,285

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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Stone Pogrund & Korey LLC	Non - Allowable	01/01/16	55	55	-
Stone Pogrund & Korey LLC	Non - Allowable	01/01/16	1,389	1,389	-
Stone Pogrund & Korey LLC	Non - Allowable	01/29/16	2,623	2,623	-
Stone Pogrund & Korey LLC	Non - Allowable	02/29/16	1,881	1,881	-
Polsinelli Shughart, PC	Business Matters	03/07/16	1,589	-	1,589
Stone Pogrund & Korey LLC	Non - Allowable	03/31/16	1,967	1,967	-
Polsinelli Shughart, PC	Business Matters	04/01/16	3,276	-	3,276
Stephen N. Sher	Business Matters	04/11/16	7,754	-	7,754
Stephen N. Sher	Business Matters	04/11/16	225	-	225
Stone Pogrund & Korey LLC	Non - Allowable	04/29/16	1,424	1,424	-
Polsinelli Shughart, PC	Business Matters	05/01/16	2,484	-	2,484
Stone Pogrund & Korey LLC	Non - Allowable	06/01/16	868	868	-
Polsinelli Shughart, PC	Business Matters	06/07/16	5,965	-	5,965
Polsinelli Shughart, PC	Business Matters	06/24/16	106	-	106
Stone Pogrund & Korey LLC	Non - Allowable	06/30/16	193	193	-
Polsinelli Shughart, PC	Business Matters	07/26/16	4,905	-	4,905
Stone Pogrund & Korey LLC	Non - Allowable	07/29/16	894	894	-
Stone Pogrund & Korey LLC	Non - Allowable	08/31/16	1,030	1,030	-
Stephen N. Sher	Business Matters	09/06/16	356	-	356
Polsinelli Shughart, PC	Business Matters	09/16/16	1,765	-	1,765
Stone Pogrund & Korey LLC	Non - Allowable	09/30/16	217	217	-
Stone Pogrund & Korey LLC	Non - Allowable	10/31/16	1,416	1,416	-
Stone Pogrund & Korey LLC	Non - Allowable	11/30/16	501	501	-
					-
					-
					-
					-
					-
					-
					-
Total			42,880	14,456	28,423

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $7,952**

(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. $ **1,506** Line **10 - 02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **160,840**
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' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,837**

(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