FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 **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 1/1/17 to 12/31/17 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Chris Joos, Partner
(Firm Name & Address) Plante Moran, PLLC, 250 S. High Street, ste 100
(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**

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	40.00	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3	52.00	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	608	5,976	3,834	10,418	8
9	SNF/PED					9
10	ICF	4,828	5,379	904	11,111	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,436	11,355	4,738	21,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.11%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 1,972

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	177,044	13,429	10,955	201,428		201,428		201,428			1
2	Food Purchase		192,654		192,654		192,654		192,654			2
3	Housekeeping	95,998	21,758		117,756		117,756		117,756			3
4	Laundry	11,277	8,379		19,656		19,656		19,656			4
5	Heat and Other Utilities			139,034	139,034		139,034		139,034			5
6	Maintenance	84,299	54,203	9,191	147,693		147,693	31	147,724			6
7	Other (specify):* See Supplemental			20,100	20,100		20,100		20,100			7
8	**TOTAL General Services**	368,618	290,423	179,280	838,321		838,321	31	838,352			8
	B. Health Care and Programs											
9	Medical Director			15,700	15,700		15,700		15,700			9
10	Nursing and Medical Records	1,379,396	168,441	28,509	1,576,346		1,576,346	1,715	1,578,061			10
10a	Therapy			455,668	455,668		455,668		455,668			10a
11	Activities	43,140	2,862	483	46,485		46,485		46,485			11
12	Social Services	26,152	108	393	26,653		26,653		26,653			12
13	CNA Training											13
14	Program Transportation			8,832	8,832		8,832		8,832			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,448,688	171,411	509,585	2,129,684		2,129,684	1,715	2,131,399			16
	C. General Administration											
17	Administrative	44,044		291,728	335,772		335,772	(260,052)	75,720			17
18	Directors Fees											18
19	Professional Services			158,995	158,995		158,995	(14,984)	144,011			19
20	Dues, Fees, Subscriptions & Promotions			27,074	27,074		27,074	7,398	34,472			20
21	Clerical & General Office Expenses	41,393	15,941	522,938	580,272		580,272	(453,171)	127,101			21
22	Employee Benefits & Payroll Taxes			290,947	290,947		290,947	5,990	296,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,296	2,296		2,296	18,300	20,596			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,199	61,199		61,199	3,278	64,477			26
27	Other (specify):* Marketing	51,124		6,726	57,850		57,850	(57,850)				27
28	**TOTAL General Administration**	136,561	15,941	1,361,903	1,514,405		1,514,405	(751,091)	763,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,953,867	477,775	2,050,768	4,482,410		4,482,410	(749,345)	3,733,065			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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
1/1/17 - 12/31/17

Page 3 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 3 REFERENCE
7520.00	6460.00	Plant-Trash Removal	20,100.43	Trash and Refuse Removal	V07-3
			20,100.43		
			20,100.00	**PG 3, LINE 7, COLUMN 8**	
			0.43	*Rounding*	

Facility Name & ID Number Lena Living Center #0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			32,336	32,336		32,336	187,306	219,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			287	287		287	290,479	290,766			32
33	Real Estate Taxes							64,805	64,805			33
34	Rent-Facility & Grounds			538,000	538,000		538,000	(529,994)	8,006			34
35	Rent-Equipment & Vehicles			29,480	29,480		29,480	597	30,077			35
36	Other (specify):*											36
37	**TOTAL Ownership**			600,103	600,103		600,103	13,193	613,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,668	66,445	111,113		111,113		111,113			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,388	172,388		172,388		172,388			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		44,668	238,833	283,501		283,501		283,501			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,953,867	522,443	2,889,704	5,366,014		5,366,014	(736,152)	4,629,862			45

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		4
5	Telephone, TV & Radio in Resident Rooms				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		32		10
11	Discounts, Allowances, Rebates & Refunds		21		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	(93,555)	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	(417,962)	21		24
25	Fund Raising, Advertising and Promotional	(57,850)	27		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	(43,326)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (612,693)		$	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)	(123,459)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (123,459)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (736,152)		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

Lena Living Center

ID# 0047746

Report Period Beginning: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(7,613)	22	2
3	Non-Allowable Legal Costs	(35,713)	19	3
4		0		4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(43,326)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lena Living Center **#** 0047746 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	31	0	0	0	0	0	0	0	0	31	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	31	0	0	0	0	0	0	0	0	31	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	1,715	0	0	0	0	0	0	0	0	1,715	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	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	1,715	0	0	0	0	0	0	0	0	1,715	16
	C. General Administration													
17	Administrative	0	0	(260,052)	0	0	0	0	0	0	0	0	(260,052)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,713)	0	20,729	0	0	0	0	0	0	0	0	(14,984)	19
20	Fees, Subscriptions & Promotions	0	275	7,123	0	0	0	0	0	0	0	0	7,398	20
21	Clerical & General Office Expenses	(511,517)	2,486	55,860	0	0	0	0	0	0	0	0	(453,171)	21
22	Employee Benefits & Payroll Taxes	(7,613)	0	13,603	0	0	0	0	0	0	0	0	5,990	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,300	0	0	0	0	0	0	0	0	18,300	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,278	0	0	0	0	0	0	0	0	3,278	26
27	Other (specify):*	(57,850)	0	0	0	0	0	0	0	0	0	0	(57,850)	27
28	**TOTAL General Administration**	(612,693)	2,761	(141,159)	0	0	0	0	0	0	0	0	(751,091)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(612,693)	2,761	(139,413)	0	0	0	0	0	0	0	0	(749,345)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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	184,700	2,606	0	0	0	0	0	0	0	0	187,306	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	290,243	236	0	0	0	0	0	0	0	0	290,479	32
33	Real Estate Taxes	0	64,805	0	0	0	0	0	0	0	0	0	64,805	33
34	Rent-Facility & Grounds	0	(538,000)	8,006	0	0	0	0	0	0	0	0	(529,994)	34
35	Rent-Equipment & Vehicles	0	0	597	0	0	0	0	0	0	0	0	597	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	1,748	11,445	0	0	0	0	0	0	0	0	13,193	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(612,693)	4,509	(127,968)	0	0	0	0	0	0	0	0	(736,152)	45

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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. ☐ 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	$ 538,000	Lena Property Partners, LLC	100.00%	$	$ (538,000)	1
2	V	20	Dues, Fees and Subscriptions		Lena Property Partners, LLC	100.00%	275	275	2
3	V	21	Office and Clerical		Lena Property Partners, LLC	100.00%	2,486	2,486	3
4	V	30	Depreciation		Lena Property Partners, LLC	100.00%	184,700	184,700	4
5	V	32	Interest		Lena Property Partners, LLC	100.00%	290,243	290,243	5
6	V	33	Real Estate Taxes		Lena Property Partners, LLC	100.00%	64,805	64,805	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 538,000			$ 542,509	$ * 4,509	14

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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%	$ 31	$ 31	15
16	V	10	Nursing		SAK Management Services, LLC	100.00%	1,715	1,715	16
17	V	17	Administration	291,728	SAK Management Services, LLC	100.00%	31,676	(260,052)	17
18	V	19	Professional Fees		SAK Management Services, LLC	100.00%	20,729	20,729	18
19	V	20	Dues and Subscriptions		SAK Management Services, LLC	100.00%	7,123	7,123	19
20	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	55,860	55,860	20
21	V	22	Employee Benefits		SAK Management Services, LLC	100.00%	13,603	13,603	21
22	V	24	Seminar and Education		SAK Management Services, LLC	100.00%	18,300	18,300	22
23	V	26	Insurance		SAK Management Services, LLC	100.00%	3,278	3,278	23
24	V	30	Depreciation		SAK Management Services, LLC	100.00%	2,606	2,606	24
25	V	32	Interest		SAK Management Services, LLC	100.00%	236	236	25
26	V	34	Rent - Building		SAK Management Services, LLC	100.00%	8,006	8,006	26
27	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	597	597	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 291,728			$ 163,760	$ * (127,968)	39

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		SEE EXHIBIT 2 - SAK MANAGEMENT SERVICES ALLOCATIONS				$	$		$	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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Providence Bank		X	Mortgage	$42,956.00	3/21/16	$ 5,660,559	$ 5,360,578	3/21/21	4.9500	$ 274,065	1
2	Providence Bank		X	Line of Credit				429,000			16,178	2
3												3
4												4
5												5
	Working Capital											
6	Alloc. - SAK Management										236	6
7	Misc Interest Expense										287	7
8												8
9	TOTAL Facility Related				$42,956.00		$ 5,660,559	$ 5,789,578			$ 290,766	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,660,559	$ 5,789,578			$ 290,766	15

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

**** 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: 1/1/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 68,282	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.)		$ 64,806	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,476)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 68,281	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.		$ 64,805	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	67,245	8
	2013	66,735	9
	2014	59,787	10
	2015	62,582	11
	2016	65,711	12

Estimated based on PY

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lena Living Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0047746

CONTACT PERSON REGARDING THIS REPORT Chris Joos

TELEPHONE 614.222.9040 FAX #: 248.233.8811

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 70,571.38	$ 70,571.38
2.	10-12-04-101-006	Long Term Care Facility	$ 691.38	$ 691.38
3.	10-12-04-101-001	Long Term Care Facility	$ 20,593.08	$ 20,593.08
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,855.84	$ 91,855.84

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/17 Ending: 12/31/17

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).

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	43,455						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	Carpet Apt 8			2017	962						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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			4,247		4,247		107,521	67
68	Depreciation - Lena Property Partners, LLC			184,700		184,700		1,091,399	68
69	Depreciation - SAK Management Services, Inc.							18,149	69
70	TOTAL (lines 4 thru 69)		$ 4,696,261	$ 188,947		$ 188,947	$	$ 1,217,069	70

**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: 1/1/17 Ending: 12/31/17

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	$ 334,240	$ 28,089	$ 28,089	$	various	$ 156,009	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental Schedule	411,439	2,606	2,606		various	409,655	74
75	TOTALS	$ 745,679	$ 30,695	$ 30,695	$		$ 565,664	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,731,940	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,642	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 219,642	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)	$ 1,782,733	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.

Lena Living Center
Medicaid Cost Report
1/1/17 - 12/31/17

Page 13 Supplemental Schedule

	Class	Cost	Depreciation	Accum
Lena Property Partners, LLC	Equip and Furnature	396,000.00	-	396,000.00
Alloc. - SAK Management Services, Inc.	Equip and Furnature	15,439.00	2,606.00	13,655.00
		411,439	2,606	409,655

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Supplemental Schedule				8,006			5
6								6
7	TOTAL				$ 8,006 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 13,489 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	$	$ 16,588	17
18					18
19					19
20					20
21	TOTAL		$	$ 16,588	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.

Lena Living Center
Medicaid Cost Report
1/1/17 - 12/31/17

Page 14 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 4 REFERENCE
N/A	6290 - Rent	SAK Management Services, Inc.	8,006.00	Rent	V34-7
			8,006.00	**PG 14, LINE 34, COLUMN 8**	
			-		
8065.00	7020.00	Auto Expense	16,588.00	Lease and Rent - Equipment	V35-3
8065.00	7040.00	Rent-Equipment	12,892.14	Lease and Rent - Equipment	V35-3
N/A	6170 · Equipment Rental	SAK Management Services, Inc.	597.00	Equipment Rental	V35-7
			30,077.14		
			30,077.00	**PG 14, LINE 35, COLUMN 8**	
			0.14	*Rounding*	

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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.

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	V10A	0.00	hrs	$ 0	2,675	$ 205,706	$ 0	2,675	$ 205,706	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	444	51,893	0	444	51,893	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	2,533	198,069	0	2,533	198,069	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	0.00	hrs	0	0	0	0			8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	58,659		58,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	7,786		7,786	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	44,668		44,668	13
14	TOTAL				$	5,652	$ 455,668	$ 111,113	5,652	$ 566,781	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.

STATE OF ILLINOIS

Facility Name & ID Number Lena Living Center **#** 0047746 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 120,020	$ 128,331	1
2	Cash-Patient Deposits	10,079	10,079	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 505,696)	628,870	628,870	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,826	26,826	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	11,342	13,987	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 797,137	$ 808,093	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	113,928	4,696,261	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,240	730,240	16
17	Accumulated Depreciation (book methods)	(263,530)	(1,750,929)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 184,638	$ 3,965,572	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 981,775	$ 4,773,665	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,612,235	$ 1,612,235	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,079	10,079	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,408	137,408	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,693	3,693	31
32	Accrued Real Estate Taxes(Sch.IX-B)		96,449	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,763,415	$ 1,859,864	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		529,000	39
40	Mortgage Payable		5,360,578	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Intercompany Rec/Pay	881,692		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 881,692	$ 5,889,578	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,645,107	$ 7,749,442	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,663,332)	$ (2,875,777)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 981,775	$ 4,873,665	48

***(See instructions.)**

Lena Living Center
Medicaid Cost Report
1/1/17 - 12/31/17

Page 17 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 17 REFERENCE
1070.10	1300.00	Refunds Due/Clearing Acct	11,342.40	Other Receivables	Line 9
LPP	1115.00	1115 · Property Tax Escrow	2,645.14	Escrow Account	Line 9
			13,987.54		
			0.54	*Rounding, tie out to Line 9*	

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (920,439)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (920,439)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(742,894)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **ROUNDING**	1	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (742,893)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	(0)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (0)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,663,332)	24 *

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 3,462,453	1
2	Discounts and Allowances for all Levels	(813,726)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,648,727	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,789,877	6
7	Oxygen	6,750	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,796,627	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	2,600	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,659	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,546	19
20	Radiology and X-Ray	2,240	20
21	Other Medical Services	64,228	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 133,273	23
	D. Non-Operating Revenue		
24	Contributions	470	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 470	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL		28
28a	Misc Revenue	44,023	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,023	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,623,120	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	838,321	31
32	Health Care	2,129,684	32
33	General Administration	1,514,405	33
	B. Capital Expense		
34	Ownership	600,103	34
	C. Ancillary Expense		
35	Special Cost Centers	111,113	35
36	Provider Participation Fee	172,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,366,014	40
41	**Income before Income Taxes (line 30 minus line 40)****	(742,894)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (742,894)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,076,962	44
45	Private Pay - Net Inpatient Revenue	1,781,638	45
46	Medicare - Net Inpatient Revenue	983,464	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	441,609	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,634,946)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,648,727	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	1,969	2,057	$ 92,130	$ 44.79	1
2	Assistant Director of Nursing	1,898	2,073	67,919	32.76	2
3	Registered Nurses	9,843	14,134	329,745	23.33	3
4	Licensed Practical Nurses	10,530	13,320	314,397	23.60	4
5	CNAs & Orderlies	41,152	45,472	549,250	12.08	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,962	2,088	25,474	12.20	9
10	Activity Assistants	1,887	2,022	17,666	8.74	10
11	Social Service Workers	1,874	2,074	26,152	12.61	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	1,587	1,743	27,117	15.56	14
15	Cook Helpers/Assistants	12,587	13,367	149,927	11.22	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	5,724	6,482	84,299	13.01	17
18	Housekeepers	10,074	10,918	95,998	8.79	18
19	Laundry	1,107	1,223	11,277	9.22	19
20	Administrator	1,414	1,730	44,044	25.46	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	2,837	2,930	41,393	14.13	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,961	2,174	25,955	11.94	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) Marketing	2,487	2,655	51,124	19.26	33
34	TOTAL (lines 1 - 33)	110,893	126,462	$ 1,953,867 *	$ 15.45	34

* 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		$ 10,955	01 - 03	35
36	Medical Director		15,700	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		28,509	10 - 03	38
39	Pharmacist Consultant				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		393	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 55,557		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cynthia Ware	Administrator	0	$ 44,044
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 44,044

B. Administrative - Other

Description	Amount
SAK Management Services - Management Fees	$ 228,970
SAK Management Services - Administrative Consultant	54,014
SAK Management Services - Data Processing	8,744
TOTAL (agree to Schedule V, line 17, col. 3)	$ 291,728
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Healthcare Investigators, Inc.	Administrative consultant	$ 19,906
Personnel Planners, Inc	Unemployment Consultant	1,200
Polsinelli Shughart PC	Legal Fees	33,691
Dempsey Law Firm, LLP	Legal Fees	825
NursesPRN	Legal Fees	1,198
Plante & Moran, PLLC	Accounting Services	15,200
Compu-Solutions Inc	Data Processing	32,318
Future Wave Tech, Inc	Data Processing	19,727
Proliant	Data Processing	8,085
PointClickCare	Data Processing	26,845
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 158,995

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,970
Unemployment Compensation Insurance	18,782
FICA Taxes	156,967
Employee Health Insurance	52,767
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Misc Benefits	3,461
SAK Management Services, LLC Allocation	13,603
Less Marketing Benefits	(7,613)
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,937

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,295
(Indicate # of checks performed)	
Patient Background Checks	833
Dues/Subscriptions	9,196
Licenses & Permits	4,505
Help Wanted	404
Recruiting Fee	10,841
SAK MGMT & LPP Allocations	7,398
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,472

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,296
SAK Management Services, LLC Allocation	18,300
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,596

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 - 11,960**

(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. $ **0** Line **N/A**

(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. $ **172,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

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

(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

PM STAFF - > COPY IN FROM TB FILE, IL MCD CR ENTRY TAB

PG 1 & 2

IDPH License ID Number:	0047746
Facility Name:	Lena Living Center
Street	1010 South Logan St
City	Lena
Zip Code	61048.00
County	Stephenson
Telephone Number:	############
Fax #	############
HFS ID Number:	0.00
Date of Initial License for Current Owners:	38775.00
VOLUNTARY,NON-PROFIT	
Charitable Corp.	
Trust	
IRS Exemption Code	
PROPRIETARY	X
Individual	
Partnership	
Corporation	
"Sub-S" Corp.	
Limited Liability Co.	X
Trust	
Other	
Other	
GOVERNMENTAL	
State	
County	
Other	
Other	
Name:	Edward N. Slack
Telephone Number:	############
Email Address:	0.00
Beds at Beginning	
Skilled (SNF)	40.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	52.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Beds at End	
Skilled (SNF)	40.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	52.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Licensed Bed Days	
Skilled (SNF)	14600.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	18980.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
MCD Census	
Skilled (SNF)	608.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	4828.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Private Pay Census	
Skilled (SNF)	5976.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	5379.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
All Other Census	
Skilled (SNF)	3834.00
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	904.00
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Medicare Days	1972.00

PG 3 & 4

A. General Services	Salary/Wage	Supplies	Other	Reclass	Adjustment
Dietary	177,044	13,429	10,955	-	-
Food Purchase	-	192,654	-	-	-
Housekeeping	95,998	21,758	-	-	-
Laundry	11,277	8,379	-	-	-
Heat and Other Utilities	-	-	139,034	-	-
Maintenance	84,299	54,203	9,191	-	31
Other (specify):*	-	-	20,100	-	-
TOTAL General Services					
B. Health Care and Programs					
Medical Director	0.00	0.00	15700.00	0.00	0.00
Nursing and Medical Records	1379396.00	########	28509.00	0.00	1715.00
Therapy	0.00	0.00	########	0.00	0.00
Activities	43140.00	2862.00	483.00	0.00	0.00
Social Services	26152.00	108.00	393.00	0.00	0.00
CNA Training	0.00	0.00	0.00	0.00	0.00
Program Transportation	0.00	0.00	8832.00	0.00	0.00
Other (specify):*	0.00	0.00	0.00	0.00	0.00
TOTAL Health Care and Programs					
C. General Administration					
Administrative	44044.00	0.00	########	0.00	########
Directors Fees	0.00	0.00	0.00	0.00	0.00
Professional Services	0.00	0.00	########	0.00	-14984.00
Dues, Fees, Subscriptions & Promotions	0.00	0.00	27074.00	0.00	7398.00
Clerical & General Office Expenses	41393.00	15941.00	########	0.00	########
Employee Benefits & Payroll Taxes	0.00	0.00	########	0.00	5990.00
Inservice Training & Education	0.00	0.00	0.00	0.00	0.00
Travel and Seminar	0.00	0.00	2296.00	0.00	18300.00
Other Admin. Staff Transportation	0.00	0.00	0.00	0.00	0.00
Insurance-Prop.Liab.Malpractice	0.00	0.00	61199.00	0.00	3278.00
Other (specify):*	51124.00	0	6726	0	-57850
D. Ownership					
Depreciation	0.00	0.00	32336.00	0.00	########
Amortization of Pre-Op. & Org.	0.00	0	0	0	0
Interest	0.00	0	287	0	290479
Real Estate Taxes	0.00	0	0	0	64805
Rent-Facility & Grounds	0.00	0	538000	0	-529994
Rent-Equipment & Vehicles	0.00	0	29480	0	597
Other (specify):*	0.00	0	0	0	0
TOTAL Ownership					
Ancillary Expense					
E. Special Cost Centers					
Medically Necessary Transportation	0.00	0	0	0	0
Ancillary Service Centers	0.00	44668	66445	0	0
Barber and Beauty Shops	0.00	0	0	0	0
Coffee and Gift Shops	0.00	0	0	0	0
Provider Participation Fee	0.00	0	172388	0	0
Other (specify):*	0.00	0	0	0	0

PG 5 & 5A

Day Care	0.00		
Other Care for Outpatients	0.00		
Governmental Sponsored Special Programs	0.00		
Non-Patient Meals	0.00		
Telephone, TV & Radio in Resident Rooms	0.00		
Rented Facility Space	0.00		
Sale of Supplies to Non-Patients	0.00		
Laundry for Non-Patients	0.00		
Non-Straightline Depreciation	0.00		
Interest and Other Investment Income	0.00		
Discounts, Allowances, Rebates & Refunds	0.00		
Non-Working Officer's or Owner's Salary	0.00		
Sales Tax	0.00		
Non-Care Related Interest	0.00		
Non-Care Related Owner's Transactions	0.00		
Personal Expenses (Including Transportatio	0.00		
Non-Care Related Fees	0.00		
Fines and Penalties	-93555.00		
Entertainment	0.00		
Contributions	0.00		
Owner or Key-Man Insurance	0.00		
Special Legal Fees & Legal Retainers	0.00		
Malpractice Insurance for Individuals	0.00		
Bad Debt	-417962.00		
Fund Raising, Advertising and Promotional	-57850.00		
Property Replacement Tax	0.00		
CNA Training for Non-Employees	0.00		
Yellow Page Advertising	0.00		
Other-Attach Schedule	-43326.00		
Non-Paid Workers-Attach Schedule*	0.00		
Donated Goods-Attach Schedule*	0.00		
Pre-Operating Expense	0.00		
Costs (Schedule VII)	-123459.00	VII-B	
Other- Attach Schedule	0.00		
PG5A Line 1	Independent Livi	0	43
PG5A Line 2	Non-Allowable B	-7613	22
PG5A Line 3	Non-Allowable L	-35713	19
PG5A Line 4		0	
PG5A Line 5		0	
PG5A Line 6		0	
PG5A Line 7		0	
PG5A Line 8		0	
PG5A Line 9		0	
PG5A Line 10		0	
PG5A Line 11		0	
PG5A Line 12		0	
PG5A Line 13		0	
PG5A Line 14		0	
PG5A Line 15		0	
PG5A Line 16		0	
PG5A Line 17		0	
PG5A Line 18		0	
PG5A Line 19		0	
PG5A Line 20		0	
PG5A Line 21		0	
PG5A Line 22		0	
PG5A Line 23		0	
PG5A Line 24		0	
PG5A Line 25		0	
PG5A Line 26		0	
PG5A Line 27		0	
PG5A Line 28		0	
PG5A Line 29		0	
PG5A Line 30		0	
PG5A Line 31		0	
PG5A Line 32		0	
PG5A Line 33		0	
PG5A Line 34		0	
PG5A Line 35		0	
PG5A Line 36		0	
PG5A Line 37		0	
PG5A Line 38		0	
PG5A Line 39		0	
PG5A Line 40		0	
PG5A Line 41		0	
PG5A Line 42		0	
PG5A Line 43		0	
PG5A Line 44		0	
PG5A Line 45		0	
PG5A Line 46		0	
PG5A Line 47		0	
PG5A Line 48		0	

PG 16

Licensed Occupational Therapist	V10A
Licensed Occupational Therapist	0.00
Licensed Occupational Therapist	0.00
Licensed Occupational Therapist	2675.00
Licensed Occupational Therapist	205706.00
Licensed Occupational Therapist	0.00
Licensed Speech and Language	V10A
Licensed Speech and Language	0.00
Licensed Speech and Language	0.00
Licensed Speech and Language	444.00
Licensed Speech and Language	51893.00
Licensed Speech and Language	0.00
Licensed Recreational Therapist	V10A
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Recreational Therapist	0.00
Licensed Physical Therapist	V10A
Licensed Physical Therapist	0.00
Licensed Physical Therapist	0.00
Licensed Physical Therapist	2533.00
Licensed Physical Therapist	198069.00
Licensed Physical Therapist	0.00
Habilitation	V39
Habilitation	0.00
Habilitation	0.00
Habilitation	0.00
Habilitation	0.00
Habilitation	0.00
Pharmacy	V39
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	0.00
Pharmacy	58659.00
LAB/RADIOLOGY	V39
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	0.00
LAB/RADIOLOGY	7786.00
BILLABLE SUPPLIES/IV THERAPY/ETC	V39
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00
BILLABLE SUPPLIES/IV THERAPY/ETC	44668.00

PG 17

Cash on Hand and in Banks	120020.00
Cash-Patient Deposits	10079.00
Accounts & Short-Term Notes Receivable-	628870.00
Patients (less allowance	505696.24
Supply Inventory (priced at	0.00
Short-Term Investments	0.00
Prepaid Insurance	0.00
Other Prepaid Expenses	26826.00
Accounts Receivable (owners or related par	0.00
Other(specify):	11342.00
Long-Term Notes Receivable	0.00
Long-Term Investments	0.00
Land	0.00
Buildings, at Historical Cost	113928.00
Leasehold Improvements, at Historical Cost	0.00
Equipment, at Historical Cost	334240.00
Accumulated Depreciation (book methods)	-263530.00
Deferred Charges	0.00
Organization & Pre-Operating Costs	0.00
Accumulated Amortization - Organization &	0.00
Restricted Funds	0.00
Other Long-Term Assets (specify):	0.00
Other(specify):	0.00
Accounts Payable	1612235.00
Officer's Accounts Payable	0.00
Accounts Payable-Patient Deposits	10079.00
Short-Term Notes Payable	0.00
Accrued Salaries Payable	137408.00
Accrued Taxes Payable	3693.00
Accrued Real Estate Taxes(Sch.IX-B)	0.00
Accrued Interest Payable	0.00
Deferred Compensation	0.00
Federal and State Income Taxes	0.00
Other 1	0.00
Other 2	0.00
Long-Term Notes Payable	0.00
Mortgage Payable	0.00
Bonds Payable	0.00
Deferred Compensation	0.00
Other 1	0.00
Other 2	881692.00

PG 18

Balance at Beginning of Year, as Previously	-920439.00	
Restatement 1	0.00	0
Restatement 2	0.00	0
Restatement 3	0.00	0
A. Additions (deductions):		
Aquisitions of Pooled Companies	0.00	
Proceeds from Sale of Stock	0.00	
Stock Options Exercised	0.00	
Contributions and Grants	0.00	
Expenditures for Specific Purposes	0.00	
Dividends Paid or Other Distributions to Ow	0.00	
Donated Property, Plant, and Equipment	0.00	
Other (describe)	0.00	0
Other (describe)	1.00	ROUNDING
B. Transfers (Itemize):		
Transfer1	-0.01	ILU net asset activity for the year
Transfer2	0.00	0
Transfer3	0.00	0
Transfer4	0.00	0
Transfer5	0.00	0

Dental Receptor — All variants of Caps	9811403.00
Community and Assistance for all variant	8855.00
Map Case	0.00
Mechanical Components	0.00
Therapy	47997.00
Program	97994.00
Requirements for Education	0.00
Other Government Grants	0.00
Chair Training Rehabilitationists	0.00
Medical Practice	0.00
Rocker and Beauty Chair	8899.00
Other Equipment	0.00
Telephone, Telecomm and Radio	0.00
Department of Natural	0.00
Sale of Goods	59855.00
Sale of Supplies to Non-Patients	0.00
Other Sales	0.00
Marketing and X-Ray	8199.00
Laundry Services	0.00
Interest	0.00
Interest and Other Investment Income**	0.00
Switchback Income (Insurance, Legal, Etc.)	0.00
Total	1.2e+06
C-Clerks	43855.00 Miss Rosamund
Dyke-at Services	2258.00
Cost Center	4/1/1905
Corporal Administration	45.6e+06
Corporal	0.00
Special Coin Carriers	1.01e+07
Temporary Performance Pay	1.01e+07
C-Clerks	0.00 0
C-Clerks	0.00 0
C-Clerks	0.00 0
Workday Type	0
Workday Code Academic Reserve	47.6e+06
Private Pay - Not Inpatient Revenue	2754.00
Private Pay - Inpatient Revenue	0.00
Other (specify)	4/1/1905
Other (specify)	2015/6/15 DUE BEYOND PAYMENT ACCOUNTS
Total	1.2e+06

Director of Nursing	0.00	0.00	0.00
Director of Physical Therapy	0.00	0.00	0.00
Registered Nurses	9540.00	4818.00	9997.00
Licensed Practical Nurses	9540.00	4818.00	9997.00
Clinic or Practice	41453.00	45670	53453.00
Clinic Trainees	0.00	0.00	0.00
Dental Hygienist	0.00	0.00	0.00
Student Primary Care	0.00	0.00	0.00
Ambry Director	9999.00	4388	47823.0
Ambry Technicians	9999.00	4388	47823.0
Dental Service Workers	4979.00	4570	49847
Dentists	0.00	0.00	0.00
Food Service Supervisor	0.00	0	0
Cook, Restaurant	4987.00	4388	49847
Cook Helpers/Assistants	4987.00	4388	49847
Dishwashers	0.00	0.00	0.00
Food Service Workers	0.00	0.00	0.00
Housekeepers	4975.00	4388	49823
Janitors	4975.00	4388	49823
Administrator	9454.00	5788	49814
Assistant Administrator	0.00	0	0.00
Other administrative	9977.00	8534.00	49.8e+04
Office Manager	0.00	0.00	0.00
Clerks	0.00	0	0.00
Vocational instructors	0.00	0.00	0.00
Academic instructors	0.00	0.00	0.00
Graduate Interns	0.00	0.00	0.00
Qualified MR Prof. (QMRP)	0.00	0.00	0.00
Habilitation Supervisor/Coordinator	0.00	0.00	0.00
Habilitation Aides (DD Waiver)	47.00	0.00	0.00
Other (specify)	0.00	0.00	0.00
Other Health Care/Ancillary	0.00	0.00	0.00
Other(specify)	9997.00	4988	53453