FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 2/27/2006

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 1/1/18 to 12/31/18 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) Suzanne Koenig
(Title) Owner

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: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,413	5,310	2,566	10,289	8
9	SNF/PED					9
10	ICF	4,573	3,957	1,089	9,619	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,986	9,267	3,655	19,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.29%

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 [Y] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,550

Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC.

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	158,257	15,150	10,334	183,741		183,741		183,741			1
2	Food Purchase		152,963		152,963		152,963		152,963			2
3	Housekeeping	81,822	14,196		96,018		96,018		96,018			3
4	Laundry	32,940	9,111		42,051		42,051		42,051			4
5	Heat and Other Utilities			141,560	141,560		141,560	261	141,821			5
6	Maintenance	85,867	39,410	16,146	141,423		141,423	511	141,934			6
7	Other (specify):* See Supplemental			23,791	23,791		23,791		23,791			7
8	TOTAL General Services	358,886	230,830	191,831	781,547		781,547	772	782,319			8
	B. Health Care and Programs											
9	Medical Director			18,184	18,184		18,184		18,184			9
10	Nursing and Medical Records	1,434,848	123,895	35,477	1,594,220		1,594,220	15,614	1,609,834			10
10a	Therapy			262,341	262,341		262,341		262,341			10a
11	Activities	75,889	1,851	2,600	80,340		80,340		80,340			11
12	Social Services	20,958		4,860	25,818		25,818		25,818			12
13	CNA Training											13
14	Program Transportation			8,186	8,186		8,186		8,186			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,531,695	125,746	331,648	1,989,089		1,989,089	15,614	2,004,703			16
	C. General Administration											
17	Administrative	79,767		118,807	198,574		198,574	(98,624)	99,950			17
18	Directors Fees											18
19	Professional Services			172,858	172,858		172,858	14,103	186,961			19
20	Dues, Fees, Subscriptions & Promotions			38,811	38,811		38,811	4,257	43,068			20
21	Clerical & General Office Expenses	34,528	49,207	77,218	160,953		160,953	(29,212)	131,741			21
22	Employee Benefits & Payroll Taxes			256,620	256,620		256,620	17,187	273,807			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,463	23,463		23,463	9,103	32,566			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,135	110,135		110,135	3,291	113,426			26
27	Other (specify):* Marketing	60,722		11,352	72,074		72,074	(72,074)				27
28	TOTAL General Administration	175,017	49,207	809,264	1,033,488		1,033,488	(151,969)	881,519			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,065,598	405,783	1,332,743	3,804,124		3,804,124	(135,583)	3,668,541			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
1/1/18 - 12/31/18

Page 3 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 3 REFERENCE
7520.00	6460.00	Plant-Trash Removal	23,791.10	Trash and Refuse Removal	V07-3
			23,791.10		
			23,791.00	**PG 3, LINE 7, COLUMN 8**	
			0.10	*Rounding*	

Facility Name & ID Number Lena Living Center #0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			20,427	20,427		20,427	199,771	220,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,811	18,811		18,811	274,272	293,083			32
33	Real Estate Taxes							66,819	66,819			33
34	Rent-Facility & Grounds			618,000	618,000		618,000	(612,163)	5,837			34
35	Rent-Equipment & Vehicles			20,152	20,152		20,152	343	20,495			35
36	Other (specify):*											36
37	**TOTAL Ownership**			677,390	677,390		677,390	(70,958)	606,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,331	76,437	140,768		140,768		140,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,957	171,957		171,957		171,957			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,331	248,394	312,725		312,725		312,725			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,065,598	470,114	2,258,527	4,794,239		4,794,239	(206,541)	4,587,698			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: 1/1/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(25,494)	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	(39,520)	21		24
25	Fund Raising, Advertising and Promotional	(72,074)	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 *See Supplemental	7,004			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (130,084)		$	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)	(76,457)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (76,457)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (206,541)		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
Medicaid Cost Report
1/1/18 - 12/31/18

Page 3 Supplemental Schedule

Ref.	Desc.	Amount
5	Heat and other Utilities	261
6	Maintenance	511
10	Nursing	15,614
17	Administration	(98,624)
19	Professional Fees	12,028
20	Dues and Subscriptions	4,257
21	Office and Clerical	35,782
22	Employee Benefits	17,187
24	Seminar and Education	9,103
26	Insurance	3,291
30	Depreciation	1,414
32	Interest	
34	Rent - Building	5,837
35	Rent - Equipment	343
		7,004

Lena Living Center

ID# 0047746

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3		0		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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	261	0	0	0	0	0	0	0	0	261	5
6	Maintenance	0	0	511	0	0	0	0	0	0	0	0	511	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	772	0	0	0	0	0	0	0	0	772	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	15,614	0	0	0	0	0	0	0	0	15,614	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	15,614	0	0	0	0	0	0	0	0	15,614	16
	C. General Administration													
17	Administrative	0	0	(98,624)	0	0	0	0	0	0	0	0	(98,624)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,075	12,028	0	0	0	0	0	0	0	0	14,103	19
20	Fees, Subscriptions & Promotions	0	0	4,257	0	0	0	0	0	0	0	0	4,257	20
21	Clerical & General Office Expenses	(65,014)	20	35,782	0	0	0	0	0	0	0	0	(29,212)	21
22	Employee Benefits & Payroll Taxes	0	0	17,187	0	0	0	0	0	0	0	0	17,187	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	9,103	0	0	0	0	0	0	0	0	9,103	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	3,291	0	0	0	0	0	0	0	0	3,291	26
27	Other (specify):*	(72,074)	0	0	0	0	0	0	0	0	0	0	(72,074)	27
28	**TOTAL General Administration**	(137,088)	2,095	(16,976)	0	0	0	0	0	0	0	0	(151,969)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(137,088)	2,095	(590)	0	0	0	0	0	0	0	0	(135,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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	198,357	1,414	0	0	0	0	0	0	0	0	199,771	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	274,272	0	0	0	0	0	0	0	0	0	274,272	32
33	Real Estate Taxes	0	66,819	0	0	0	0	0	0	0	0	0	66,819	33
34	Rent-Facility & Grounds	0	(618,000)	5,837	0	0	0	0	0	0	0	0	(612,163)	34
35	Rent-Equipment & Vehicles	0	0	343	0	0	0	0	0	0	0	0	343	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(78,552)	7,594	0	0	0	0	0	0	0	0	(70,958)	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)**	(137,088)	(76,457)	7,004	0	0	0	0	0	0	0	0	(206,541)	45

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 618,000	Lena Property Partners, LLC	100.00%	$	$ (618,000)	1
2	V	19	Professional Fees		Lena Property Partners, LLC	100.00%	2,075	2,075	2
3	V	21	Office and Clerical		Lena Property Partners, LLC	100.00%	20	20	3
4	V	30	Depreciation		Lena Property Partners, LLC	100.00%	198,357	198,357	4
5	V	32	Interest		Lena Property Partners, LLC	100.00%	274,272	274,272	5
6	V	33	Real Estate Taxes		Lena Property Partners, LLC	100.00%	66,819	66,819	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 618,000			$ 541,543	$ * (76,457)	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: 1/1/18 Ending: 12/31/18

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	5	Heat and other Utilities	$			$ 261	$ 261	15
16	V	6	Maintenance				511	511	16
17	V	10	Nursing				15,614	15,614	17
18	V	17	Administration	118,807			20,183	(98,624)	18
19	V	19	Professional Fees				12,028	12,028	19
20	V	20	Dues and Subscriptions				4,257	4,257	20
21	V	21	Office and Clerical				35,782	35,782	21
22	V	22	Employee Benefits				17,187	17,187	22
23	V	24	Seminar and Education				9,103	9,103	23
24	V	26	Insurance				3,291	3,291	24
25	V	30	Depreciation				1,414	1,414	25
26	V	32	Interest						26
27	V	34	Rent - Building				5,837	5,837	27
28	V	35	Rent - Equipment				343	343	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			$ 118,807			$ 125,811	$ * 7,004	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: 1/1/2018 Ending: 12/31/2018

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								1
2	Suzanne Koenig	90%	Lena Living Center, LLC	Lena, Illinois	St. Anthony's			2
3	Gary Weintraub	10%			Property, LLC	Rock Island, Illinois	Bldg. Partnership	3
4					Lena Property			4
5					Partners, LLC	Lena, Illinois	Bldg. Partnership	5
6					SAK Management	Northfield, Illinois	Mgmt. Company	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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: ######

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: St. Anthony's Property Partners, LLC
Street Address: 767 30th Street
City / State / Zip Code: Rock Island, Illinois 61201
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: 1/1/2018 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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: 1/1/2018 Ending: 12/31/2018

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	$45,725.00	3/21/16	$ 5,660,559	$ 5,178,443		0.0500	$ 274,272	1
2	Providence Bank		X	Line of Credit	$2,216.50	11/28/17	429,000	429,000	2/28/19	0.0600	21,358	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Interest											6
7												7
8												8
9	TOTAL Facility Related				$47,941.50		$ 6,089,559	$ 5,607,443			$ 295,630	9
	B. Non-Facility Related*											
10	Interest Income Offset										(2,546)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,546)	14
15	TOTALS (line 9+line14)						$ 6,089,559	$ 5,607,443			$ 293,083	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 96,448	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.)		$ 92,053	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,395)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 71,214	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.		$ 66,819	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	66,735	8
	2014	59,787	9
	2015	62,582	10
	2016	65,711	11
	2017	64,806	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.

2017 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 2017 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 2017.

	(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	$ 70,723.22	$ 70,723.22
2.	10-12-04-101-006	Long Term Care Facility	$ 692.86	$ 692.86
3.	10-12-04-101-001	Long Term Care Facility	$ 20,637.40	$ 20,637.40
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,053.48	$ 92,053.48

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/18 Ending: 12/31/18

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, Entrywy, and Canopy			2016	3,084,288						22
23	Construction and Renovation - Addition, Entrywy, and Canopy			2016	42,506						23
24	Carpet Apt 8			2017	962						24
25	Carpet			2018	969						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: 1/1/18 Ending: 12/31/18

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		123,149	67
68	Depreciation - Lena Property Partners, LLC			184,700		184,700		1,276,099	68
69	Depreciation - SAK Management Services, Inc.			1,414		1,414			69
70	TOTAL (lines 4 thru 69)		$ 4,697,230	$ 190,361		$ 190,361	$	$ 1,399,248	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: 1/1/18 Ending: 12/31/18

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	$ 184,098	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See suplemental Schedule	396,000	1,748	1,748		various	396,000	74
75	TOTALS	$ 730,240	$ 29,837	$ 29,837	$		$ 580,098	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)	$ 5,717,470	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 220,198	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,198	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)	$ 1,979,346	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
1/1/18 - 12/31/18

Page 13 Supplemental Schedule

	Class	Cost	Depreciation	Accum
Lena Property Partners, LLC	Equip and Furnature	396,000	-	396,000
		396,000	-	396,000

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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				7,495			5
6								6
7	TOTAL				$ 7,495 **			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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Lexus	$	$ 12,657	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,657	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
1/1/18 - 12/31/18

Page 14 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 4 REFERENCE
N/A	6290.00	Rent-Building	5,837.00	Rent	V34-7
			5,837.00		
			5,837.00	**PG 14, LINE 34, COLUMN 8**	
			-		
8065.00	7040.00	Rent-Equipment	343.00		V35-3
8065.00	7020.00	Auto Expense	12,657.10	Lease and Rent - Equipment	V35-3
8065.00	7040.00	Rent-Equipment	7,494.96		V35-3
			20,495.06		
			20,495.00	**PG 14, LINE 35, COLUMN 8**	
			0.06	*Rounding*	

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

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: 1/1/2018 Ending: 12/31/2018

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	1,519	$ 119,132	$ 0	1,519	$ 119,132	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	154	18,381	0	154	18,381	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	1,565	124,828	0	1,565	124,828	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	63,933		63,933	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	12,503		12,503	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	64,332		64,332	13
14	TOTAL				$	3,238	$ 262,341	$ 140,768	3,238	$ 403,109	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.

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (64,572)	$ (299,352)	1
2	Cash-Patient Deposits	10,093	10,093	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 434,812)	615,717	883,717	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	77,314	77,314	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	5,365	51,095	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 643,917	$ 722,867	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	114,897	4,697,230	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,240	730,240	16
17	Accumulated Depreciation (book methods)	(283,956)	(1,979,346)	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): LOAN ISSUANCE COSTS	15,849	15,849	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 181,030	$ 3,753,973	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 824,947	$ 4,476,840	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,856,748	$ 1,857,748	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(6,113)	(6,113)	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,505	158,505	30
31	Accrued Taxes Payable (excluding real estate taxes)	(6,344)	(6,344)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,214	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)**	$ 2,002,796	$ 2,075,010	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		429,000	39
40	Mortgage Payable		5,178,443	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44		1,331,692	450,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,331,692	$ 6,057,443	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,334,488	$ 8,132,453	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,509,541)	$ (3,655,613)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 824,947	$ 4,476,840	48

***(See instructions.)**

Lena Living Center
Medicaid Cost Report
1/1/18 - 12/31/18

Page 17 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 17 REFERENCE
1070.10	1300.00	Refunds Due/Clearing Acct	5,364.50	Other Receivables	Line 9
LPP	1115.00	1115 · Property Tax Escrow	45,730.26	Escrow Account	Line 9
			51,094.76		
			(0.24)	*Rounding, tie out to Line 9*	

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: ###### Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,663,332)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,663,332)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(846,209)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (846,209)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,509,541)	24 *

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 3,192,200	1
2	Discounts and Allowances for all Levels	(169,925)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,022,275	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	788,281	6
7	Oxygen	6,750	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 795,031	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,600	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,366	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,222	19
20	Radiology and X-Ray	1,516	20
21	Other Medical Services	68,070	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 127,774	23
	D. Non-Operating Revenue		
24	Contributions	2,950	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,950	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**AL/IL**		28
28a	**Misc Revenue**		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,948,030	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	781,547	31
32	Health Care	1,989,089	32
33	General Administration	1,033,488	33
	B. Capital Expense		
34	Ownership	677,390	34
	C. Ancillary Expense		
35	Special Cost Centers	140,768	35
36	Provider Participation Fee	171,957	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,794,239	40
41	**Income before Income Taxes (line 30 minus line 40)****	(846,209)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (846,209)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,080,471	44
45	Private Pay - Net Inpatient Revenue	1,454,402	45
46	Medicare - Net Inpatient Revenue	(10,515)	46
47	Other-(specify) **ALL OTHER SNF/SCF IP REVENUE**	399,835	47
48	Other-(specify) **C/A ANCILLARY ACCOUNTS**	98,080	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,022,275	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: 1/1/2018 Ending: 12/31/2018

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	635	639	$ 29,318	$ 45.88	1
2	Assistant Director of Nursing	1,920	2,088	70,686	33.85	2
3	Registered Nurses	13,430	13,886	406,952	29.31	3
4	Licensed Practical Nurses	9,970	10,298	294,883	28.63	4
5	CNAs & Orderlies	42,866	44,556	602,398	13.52	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	0	0	0		9
10	Activity Assistants	7,555	8,023	75,889	9.46	10
11	Social Service Workers	1,500	1,700	20,958	12.33	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	14,816	15,989	158,257	9.90	14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,111	6,733	85,867	12.75	17
18	Housekeepers	7,553	7,970	81,822	10.27	18
19	Laundry	3,466	3,671	32,940	8.97	19
20	Administrator	1,945	2,086	79,767	38.24	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	2,224	2,396	34,528	14.41	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	1,969	2,245	30,611	13.64	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	2,426	2,555	60,722	23.77	33
34	TOTAL (lines 1 - 33)	118,386	124,835	$ 2,065,598 *	$ 16.55	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	0	$ 10,334		35
36	Medical Director	0	0		36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	35,477		38
39	Pharmacist Consultant	0	0		39
40	Physical Therapy Consultant	0	0		40
41	Occupational Therapy Consultant	0	0		41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0		43
44	Activity Consultant	0	2,600		44
45	Social Service Consultant	0	4,860		45
46	Other(specify)	0			46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 53,270		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: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dewayne Tremain	Administrator	0	$ 79,767
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,767

B. Administrative - Other

Description	Amount
SAK Management Svcs Mgmt Fees	$ 197,601
SAK Management Svcs Admin Consultant	(55,380)
SAK Management Svcs Data Processing	(23,414)
Admin Adjustment	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 118,807
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Healthcare Investigators, Inc.	Administrative Consultant	$ 17,229
Health Care Council of Illinois	Administrative Consultant	2,515
Personnel Planners, Inc.	Unemployment Consultant	1,950
	Legal Fees	39,999
Plante & Moran, PLLC	Accounting Services	26,287
Plante & Moran, PLLC	Accounting Services	8,100
Compu-Solutions, Inc.	Data Processing	31,455
Future Wave Tech, Inc.	Data Processing	19,965
PointClickCare	Data Processing	16,873
SAK Management Services LLC	Data Processing	8,486
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 172,858

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,833
Unemployment Compensation Insurance	20,156
FICA Taxes	151,346
Employee Health Insurance	29,179
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Drug Screening	581
Employee - Other	4,525
TOTAL (agree to Schedule V, line 22, col.8)	$ 256,620

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	
(Indicate # of checks performed)	1,698
Patient Background Checks	
Dues & Subscriptions	14,066
Licenses & Permits	3,171
Help Wanted	123
Recruiting Fee	19,752
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,811

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	23,463
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,463

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - 14,066**

(3) Did the nursing home make political contributions or payments to a politica
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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **171,957**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 othe
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
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