	FOR BHF USE						

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 2/27/06

Type of Ownership:

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

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 ______

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,640	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,738	2,738	8
9	SNF/PED					9
10	ICF	10,272	8,472		18,744	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,272	8,472	2,738	21,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.80%

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)
None

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 2/27/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/27/06 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 2,601

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	222,875	25,027	5,541	253,443		253,443	5,342	258,785			1
2	Food Purchase		185,698		185,698		185,698		185,698			2
3	Housekeeping	83,149	16,252		99,401		99,401		99,401			3
4	Laundry	23,543	7,653		31,196		31,196		31,196			4
5	Heat and Other Utilities			104,114	104,114		104,114	808	104,922			5
6	Maintenance	87,478	26,931	27,516	141,925		141,925	2,187	144,112			6
7	Other (specify):* Waste Rem./Mgmt Co. Benefi			29,321	29,321		29,321	790	30,111			7
8	**TOTAL General Services**	417,045	261,561	166,492	845,098		845,098	9,127	854,225			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	1,491,133	205,747	255,603	1,952,483		1,952,483	49,341	2,001,824			10
10a	Therapy											10a
11	Activities	48,873	1,693	1,085	51,651		51,651		51,651			11
12	Social Services	27,482		298	27,780		27,780		27,780			12
13	CNA Training											13
14	Program Transportation			3,636	3,636		3,636		3,636			14
15	Other (specify):* Mgmt Co Benefits Alloc							7,294	7,294			15
16	**TOTAL Health Care and Programs**	1,567,488	207,440	274,422	2,049,350		2,049,350	56,635	2,105,985			16
	C. General Administration											
17	Administrative	95,654		238,390	334,044		334,044	(176,273)	157,771			17
18	Directors Fees											18
19	Professional Services			92,010	92,010		92,010	24,788	116,798			19
20	Dues, Fees, Subscriptions & Promotions			32,951	32,951		32,951	5,882	38,833			20
21	Clerical & General Office Expenses	48,283	26,355	22,864	97,502		97,502	151,789	249,291			21
22	Employee Benefits & Payroll Taxes			221,375	221,375		221,375		221,375			22
23	Inservice Training & Education			1,049	1,049		1,049		1,049			23
24	Travel and Seminar			45	45		45	8,460	8,505			24
25	Other Admin. Staff Transportation			18,087	18,087		18,087	566	18,653			25
26	Insurance-Prop.Liab.Malpractice			119,441	119,441		119,441	7,937	127,378			26
27	Other (specify):* Mgmt Co Benefits Alloc							29,442	29,442			27
28	**TOTAL General Administration**	143,937	26,355	746,212	916,504		916,504	52,591	969,095			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,128,470	495,356	1,187,126	3,810,952		3,810,952	118,353	3,929,305			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lena Living Center #0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,801	27,801		27,801	197,042	224,843			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,000	60,000		60,000	306,312	366,312			32
33	Real Estate Taxes							92,470	92,470			33
34	Rent-Facility & Grounds			672,000	672,000		672,000	(656,900)	15,100			34
35	Rent-Equipment & Vehicles			1,973	1,973		1,973	1,452	3,425			35
36	Other (specify):*											36
37	TOTAL Ownership			761,774	761,774		761,774	(59,624)	702,150			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,398	418,055	496,453		496,453		496,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,233	178,233		178,233		178,233			42
43	Other (specify):* See Att Sch 4A	53,241	1,058	117,518	171,817		171,817	(160,039)	11,778			43
44	TOTAL Special Cost Centers	53,241	79,456	713,806	846,503		846,503	(160,039)	686,464			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,181,711	574,812	2,662,706	5,419,229		5,419,229	(101,310)	5,317,919			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Lena Living Center

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			7,551	7,551		7,551		7,551			
	Radiology Expenses			4,227	4,227		4,227		4,227			
	Non-Allowable Expenses	53,241	1,058	105,740	160,039		160,039	(160,039)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	53,241	1,058	117,518	171,817	0	171,817	(160,039)	11,778			

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	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	(27,151)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,315)	30		9
10	Interest and Other Investment Income	(80)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(60,000)	32		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	(16,384)	43		18
19	Entertainment	(12,051)	43		19
20	Contributions		43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,593)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,651)	43		24
25	Fund Raising, Advertising and Promotional	(2,561)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax		43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(49,364)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (224,150)		$	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)	122,840		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 122,840		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (101,310)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Lena Living Center

ID# 0047746

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	$ (520)	21	1
2	Expense Minor Capitalized Items	2,121	6	2
3	Expense Minor Capitalized Items	2,276	21	3
4	Marketing Wages	(53,241)	43	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(49,364)		49

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	20	Licenses and Fees	$	Lena Property Partners, LLC	100.00%	$ 75	$ 75	1
2	V	21	Office and Clerical		Lena Property Partners, LLC	100.00%	705	705	2
3	V	30	Depreciation		Lena Property Partners, LLC	100.00%	198,357	198,357	3
4	V	32	Interest		Lena Property Partners, LLC	100.00%	366,305	366,305	4
5	V	33	Real Estate Taxes		Lena Property Partners, LLC	100.00%	92,470	92,470	5
6	V	34	Rent	672,000	Lena Property Partners, LLC	100.00%		(672,000)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 672,000			$ 657,912	$ * (14,088)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	SAK Management Services LLC	100.00%	$ 5,342	$ 5,342	15
16	V	5	Heat and Other Utilities		SAK Management Services LLC	100.00%	808	808	16
17	V	6	Maintenance		SAK Management Services LLC	100.00%	66	66	17
18	V	7	Emp Benefit Alloc-Dietary		SAK Management Services LLC	100.00%	790	790	18
19	V	10	Nursing and Medical Records		SAK Management Services LLC	100.00%	49,341	49,341	19
20	V	15	Emp Benefit Alloc-Healthcare		SAK Management Services LLC	100.00%	7,294	7,294	20
21	V	17	Administrative	238,390	SAK Management Services LLC	100.00%	62,117	(176,273)	21
22	V	19	Professional Services		SAK Management Services LLC	100.00%	31,381	31,381	22
23	V	20	Dues, Fees, Subs & Promo		SAK Management Services LLC	100.00%	5,807	5,807	23
24	V	21	Clerical & Gen Office Expenses		SAK Management Services LLC	100.00%	149,328	149,328	24
25	V	24	Travel and Seminar		SAK Management Services LLC	100.00%	8,460	8,460	25
26	V	25	Other Admin. Staff Trans		SAK Management Services LLC	100.00%	566	566	26
27	V	26	Insurance-Prop.Liab.Malpractice		SAK Management Services LLC	100.00%	7,937	7,937	27
28	V	27	Emp Benefit Alloc-Admin		SAK Management Services LLC	100.00%	29,442	29,442	28
29	V	32	Interest		SAK Management Services LLC	100.00%	87	87	29
30	V	34	Rent-Facility & Grounds		SAK Management Services LLC	100.00%	15,100	15,100	30
31	V	35	Equipment Rental		SAK Management Services LLC	100.00%	1,452	1,452	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 238,390			$ 375,318	$ * 136,928	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Nursing & Rehab Center	Rock Island	St. Anthony's			1
2			Bria of Belleville	Belleville	Property, LLC	Rock Island, Illinois	Bldg. Partnership	2
3					Lena Property			3
4					Partners, LLC	Lena, Illinois	Bldg. Partnership	4
5					SAK Management LL(	Riverwoods, Illinois	Mgmt. Company	5
6					SAK Texas, LLC	Riverwoods, Illinois	Mgmt. Company	6
7					SAK SCC, LLC	Riverwoods, Illinois	Mgmt. Company	7
8					SAK Ohio, LLC	Riverwoods, Illinois	Mgmt. Company	8
9					SAK NM, LLC	Riverwoods, Illinois	Mgmt. Company	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Leonard Koenig	Administrator	Administrative	0.00	None	40	100.00	Salary	4,847	L17,C1	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	$ 4,847		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: 300 Saunders Rd, Suite 300
City / State / Zip Code: Riverwoods, IL 60015
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	1	Dietary	Percentage of Revenues	100	6	$ 52,430	$ 52,430	10.19	$ 5,342	1
2	5	Heat and Other Utilities	Percentage of Revenues	100	6	7,927		10.19	808	2
3	6	Maintenance	Percentage of Revenues	100	6	640		10.19	66	3
4	7	Emp Benefit Alloc-Dietary	Percentage of Revenues	100	6	7,751		10.19	790	4
5	10	Nursing and Medical Records	Percentage of Revenues	100	6	484,294	484,294	10.19	49,341	5
6	15	Emp Benefit Alloc-Healthcare	Percentage of Revenues	100	6	71,593		10.19	7,294	6
7	17	Administrative	Percentage of Revenues	100	6	609,695	609,695	10.19	62,117	7
8	19	Professional Services	Percentage of Revenues	100	6	308,009		10.19	31,381	8
9	20	Dues, Fees, Subs & Promo	Percentage of Revenues	100	6	56,993		10.19	5,807	9
10	21	Clerical & Gen Office Expenses	Percentage of Revenues	100	6	1,465,728	1,345,112	10.19	149,328	10
11	24	Travel and Seminar	Percentage of Revenues	100	6	83,035		10.19	8,460	11
12	25	Other Admin. Staff Trans	Percentage of Revenues	100	6	5,557		10.19	566	12
13	26	Insurance-Prop.Liab.Malpractice	Percentage of Revenues	100	6	77,902		10.19	7,937	13
14	27	Emp Benefit Alloc-Admin	Percentage of Revenues	100	6	288,979		10.19	29,442	14
15	32	Interest	Percentage of Revenues	100	6	855		10.19	87	15
16	34	Rent-Facility & Grounds	Percentage of Revenues	100	6	148,210		10.19	15,100	16
17	35	Equipment Rental	Percentage of Revenues	100	6	14,256		10.19	1,452	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,683,854	$ 2,491,531		$ 375,318	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number: Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,899,041		0.0500	$ 339,096	1
2	Providence Bank		X	Line of Credit	$2,216.50	11/28/17	429,000	339,001		0.0600	27,209	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$47,941.50		$ 6,089,559	$ 5,238,042			$ 366,305	9
	B. Non-Facility Related*											
10								Related Paty Interest			60,000	10
11								Offset Interest Income			(80)	11
12								Allocated from SAK Management LLC			87	12
13								Disallow Related Party Interest			(60,000)	13
14	TOTAL Non-Facility Related						$	$			$ 7	14
15	TOTALS (line 9+line14)						$ 6,089,559	$ 5,238,042			$ 366,312	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.		$ 66,288	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.)	2019	$ 93,120	2
3. Under or (over) accrual (line 2 minus line 1).		$ 26,832	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 65,638	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.		$ 92,470	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	62,582	8
2016	65,711	9
2017	64,806	10
2018	91,574	11
2019	93,120	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lena Living Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0047746

CONTACT PERSON REGARDING THIS REPORT Jerry Januszewski

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	10-12-04-102-001	Long Term Care Facility	$ 71,542.60	$ 71,542.60
2.	10-12-04-101-006	Long Term Care Facility	$ 700.84	$ 700.84
3.	10-12-04-101-001	Long Term Care Facility	$ 20,876.44	$ 20,876.44
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,119.88	$ 93,119.88

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$	40	$ 32,750	$ 32,750	$ 337,603	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	10,244		20	512	512	8,182	9
10	Various			2007	11,416		7			11,416	10
11	Various			2008	5,979		20	299	299	5,538	11
12	Various			2009	4,494		5			4,494	12
13	Various			2011	24,049		20	1,202	1,202	9,616	13
14	Various			2012	4,422		10	442	442	3,757	14
15	Water Heater			2013	9,857		10	986	986	7,888	15
16	Heat Pump			2013	4,654		10	465	465	3,720	16
17	Sprinkler System			2013	43,455		20	2,173	2,173	17,384	17
18	Sprinkler System			2013	52,736		20	2,637	2,637	21,096	18
19	Lighting System Retrofit			2013	36,722		20	1,836	1,836	14,688	19
20	Tile - Hallways			2013	23,190		20	1,160	1,160	9,280	20
21	Water Heater			2016	23,425		10	2,343	2,343	11,715	21
22	Security System - Access Control System			2016	3,862		10	386	386	1,930	22
23	Construction and Renovation - Addition, Entrywy, and Canopy			2016	3,084,288		25	123,372	123,372	616,860	23
24	Construction and Renovation - Addition, Entrywy, and Canopy			2016	42,506		25	1,700	1,700	8,500	24
25	Carpet Apt 8			2017	962		10	96	96	384	25
26	Carpet			2018	969		10	97	97	291	26
27	Install New Booster Heater			2019	4,487		10	449	449	898	27
28	Water Heater			2019	16,796		10	1,680	1,680	3,360	28
29	Boiler			2019	9,540		10	954	954	1,908	29
30	Air Conditioner-Laundry Room			2019	4,860		10	486	486	972	30
31	Carpet Apt 7			2019	2,934		10	293	293	293	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Metal Roof	2020	$ 8,770	$	20	$ 219	$ 219	$ 219	37
38	Repair Front Entrance Doors	2020	5,234		10	262	262	262	38
39	Fire Damper	2020	10,560		10	528	528	528	39
40	New Diodes	2020	3,082		10	154	154	154	40
41	Replace Control Panel	2020	3,450		10	173	173	173	41
42	Install New Compressor	2020	5,157		10	258	258	258	42
43	Repair Emergency Power Supply	2020	5,695		10	285	285	285	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	Depreciation - Lena Living Center, LLC			4,067			(4,067)		60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,777,795	$ 4,067		$ 178,197	$ 174,130	$ 1,103,652	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 730,793	$ 22,046	$ 46,264	$ 24,218	5-7 Yrs	$ 730,793	71
72	Current Year Purchases	7,631	1,688	382	(1,306)	10 Yrs	382	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 738,424	$ 23,734	$ 46,646	$ 22,912		$ 731,175	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	N/A									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)	$ 5,806,219	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,801	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,843	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 197,042	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,834,827	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Allocated from Management Co.				15,100			5
6								6
7	TOTAL				$ 15,100 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 1,973 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	Allocated from Management Co			1,452	19
20					20
21	TOTAL		$	$ 1,452	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1	2	3	4	5	6	7	8	
		Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	4,486	$ 185,098	$	4,486	$ 185,098	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		562	23,006		562	23,006	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,015	209,951		5,015	209,951	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				78,398		78,398	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	10,063	$ 418,055	$ 78,398	10,063	$ 496,453	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 536,313	$ 589,406	1
2	Cash-Patient Deposits	10,093	10,093	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 625,462)	658,548	1,016,681	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	32,353	32,353	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,237,307	$ 1,648,533	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	148,926	4,777,795	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	399,023	738,424	16
17	Accumulated Depreciation (book methods)	(334,851)	(1,834,827)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		39,024	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 213,098	$ 4,010,416	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,450,405	$ 5,658,949	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,897,833	$ 1,900,428	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,079	10,079	28
29	Short-Term Notes Payable		339,001	29
30	Accrued Salaries Payable	91,129	91,129	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		65,638	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	23,618	23,618	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,022,659	$ 2,429,893	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,899,041	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	1,382,692	501,000	43
44	PPP Loan	455,400	455,400	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,838,092	$ 5,855,441	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,860,751	$ 8,285,334	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,410,346)	$ (2,626,385)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,450,405	$ 5,658,949	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Lena Living Center # 0047746 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,696,056)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,696,056)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	285,710	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)**	$ 285,710	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)**	$ (2,410,346)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,074,236	1
2	Discounts and Allowances for all Levels	386,943	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,461,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,557	6
7	Oxygen	3,000	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 191,557	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	998,246	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	171	19
20	Radiology and X-Ray		20
21	Other Medical Services	46,541	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,048,644	23
	D. Non-Operating Revenue		
24	Contributions	475	24
25	Interest and Other Investment Income***	80	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 555	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	520	28
28a	Prior Year Accrual Reversals	2,484	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,004	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,704,939	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	845,098	31
32	Health Care	2,049,350	32
33	General Administration	916,504	33
	B. Capital Expense		
34	Ownership	761,774	34
	C. Ancillary Expense		
35	Special Cost Centers	668,270	35
36	Provider Participation Fee	178,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,419,229	40
41	**Income before Income Taxes (line 30 minus line 40)****	285,710	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 285,710	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,483,558	44
45	Private Pay - Net Inpatient Revenue	1,564,556	45
46	Medicare - Net Inpatient Revenue	1,292,276	46
47	Other-(specify) Insurance	120,789	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,461,179	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,385	1,499	$ 51,229	$ 34.18	1
2	Assistant Director of Nursing	1,681	2,056	76,479	37.20	2
3	Registered Nurses	17,219	18,109	468,627	25.88	3
4	Licensed Practical Nurses	10,384	10,658	304,491	28.57	4
5	CNAs & Orderlies	48,139	49,752	554,338	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,340	3,708	48,873	13.18	10
11	Social Service Workers	1,791	1,859	27,482	14.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,121	20,017	222,875	11.13	15
16	Dishwashers					16
17	Maintenance Workers	5,747	6,357	87,478	13.76	17
18	Housekeepers	7,322	8,251	83,149	10.08	18
19	Laundry	2,168	2,464	23,543	9.55	19
20	Administrator	2,184	2,297	95,654	41.64	20
21	Assistant Administrator					21
22	Other Administrative	1,998	2,158	53,241	24.67	22
23	Office Manager					23
24	Clerical	1,713	1,910	48,283	25.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,761	2,188	35,969	16.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,953	133,283	$ 2,181,711 *	$ 16.37	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,541	L1, C3	35
36	Medical Director	Monthly	13,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,770	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	1,085	L11, C3	44
45	Social Service Consultant	4	298	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	18	$ 27,494		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	83	$ 5,139	L10, C3	50
51	Licensed Practical Nurses	119	5,856	L10, C3	51
52	Certified Nurse Assistants/Aides	6,482	237,838	L10, C3	52
53	TOTAL (lines 50 - 52)	6,684	$ 248,833		53

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Chad Dawson	Administrator	0	$	13,381
Richard Rimkus	Administrator	0		1,004
Arthur Wilkins	Administrator	0		76,422
Leonard Koenig	Administrator	0		4,847
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	95,654

B. Administrative - Other

Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$	238,390
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	238,390

C. Professional Services

Vendor/Payee	Type		Amount
Cohn Reznick	Accounting Services		3,600
Templin Healthcare Accounting	Accounting Services		4,843
IPR Tech Group	Data Processing		17,725
PointClickCare	Data Processing		26,326
MTS Consulting	Tax Consultant	$	320
Proliant	Data Processing		9,660
Personnel Planners, Inc.	Unemployment Consultant		1,425
Ability Netwrork	Data Processing		5,733
InPath Security	Data Processing		1,595
See Attached Legal Schedule	Legal Fees		20,783
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	92,010

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	33,432
Unemployment Compensation Insurance		25,464
FICA Taxes		164,521
Employee Health Insurance		(5,089)
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits		3,047
TOTAL (agree to Schedule V, line 22, col.8)	$	221,375

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

Description	Line #		Amount
		$	
N/A			
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	3,980
Advertising: Employee Recruitment		13,080
Health Care Worker Background Check (Indicate # of checks performed 220)		2,204
Patient Background Checks 13		130
Miscellaneous Licenses		233
Miscellaneous Dues and Subscriptions		1,873
Health Care Council of Illinois		11,451
Allocated from Management Co.		5,882
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	38,833

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		45
Seminar Expense		
Allocated from Management Co.		8,460
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	8,505

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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. **11,451** **Health Care Council of Illinois**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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?

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,626** Line **10**

(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. $ **178,233**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

(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? **100% Line 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? **N/A**
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:

(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