

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0047126</u></p> <p>Facility Name: <u>St Antonys Nsg & Rehab Ctr</u></p> <p>Address: <u>767 30th Street</u> <u>Rock Island</u> <u>61201</u> <small>Number City Zip Code</small></p> <p>County: <u>Rock Island</u></p> <p>Telephone Number: <u>309.788.7631</u> Fax # <u>309.788.9823</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/19/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Chris Joos</u> Telephone Number: <u>614.222.9040</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/17</u> to <u>12/31/17</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Flora Reznik</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran, PLLC 250 S. High Street, ste 100</u> (Telephone) <u>614.222.9040</u> Fax # <u>248.233.8811</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Flora Reznik</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran, PLLC 250 S. High Street, ste 100</u> (Telephone) <u>614.222.9040</u> Fax # <u>248.233.8811</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Flora Reznik</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran, PLLC 250 S. High Street, ste 100</u> (Telephone) <u>614.222.9040</u> Fax # <u>248.233.8811</u>							

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	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	52.00	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	78.00	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,101	4,923	4,011	16,035	8
9	SNF/PED					9
10	ICF	20,090	2,236	49	22,375	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,191	7,159	4,060	38,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.95%

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

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

I. On what date did you start providing long term care at this location?
Date started 05/19/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/19/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 52 and days of care provided 2,769

Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number St Antonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	262,618	12,693	12,046	287,357		287,357		287,357		1
2	Food Purchase		319,428		319,428		319,428		319,428		2
3	Housekeeping	188,619	33,052		221,671		221,671		221,671		3
4	Laundry	67,024	33,474		100,498		100,498		100,498		4
5	Heat and Other Utilities			264,757	264,757		264,757	(13,775)	250,982		5
6	Maintenance	129,557	37,732	4,746	172,035		172,035	44	172,079		6
7	Other (specify):* See Supplemental	41,929		33,000	74,929		74,929		74,929		7
8	TOTAL General Services	689,747	436,379	314,549	1,440,675		1,440,675	(13,731)	1,426,944		8
	B. Health Care and Programs										
9	Medical Director			25,000	25,000		25,000		25,000		9
10	Nursing and Medical Records	2,433,476	225,903	8,224	2,667,603		2,667,603	2,391	2,669,994		10
10a	Therapy			768,497	768,497		768,497		768,497		10a
11	Activities	52,194			52,194		52,194		52,194		11
12	Social Services	29,409		3,706	33,115		33,115		33,115		12
13	CNA Training										13
14	Program Transportation			6,098	6,098		6,098		6,098		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,515,079	225,903	811,525	3,552,507		3,552,507	2,391	3,554,898		16
	C. General Administration										
17	Administrative	93,709		449,229	542,938		542,938	(405,085)	137,853		17
18	Directors Fees										18
19	Professional Services			158,000	158,000		158,000	(2,910)	155,090		19
20	Dues, Fees, Subscriptions & Promotions			46,350	46,350		46,350	9,926	56,276		20
21	Clerical & General Office Expenses	165,604	36,474	1,111,065	1,313,143		1,313,143	(1,005,981)	307,162		21
22	Employee Benefits & Payroll Taxes			380,341	380,341		380,341	14,013	394,354		22
23	Inservice Training & Education										23
24	Travel and Seminar			491	491		491	19,423	19,914		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(245)	(245)		(245)	149,845	149,600		26
27	Other (specify):* Marketing & Contrib	45,635		2,278	47,913		47,913	(47,913)			27
28	TOTAL General Administration	304,948	36,474	2,147,509	2,488,931		2,488,931	(1,268,682)	1,220,249		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,509,774	698,756	3,273,583	7,482,113		7,482,113	(1,280,022)	6,202,091		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.

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
1/1/17 - 12/31/17

Page 3 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 3 REFERENCE
7625.10	6431.00	Plant Security-Payroll	41,929.40	Security Services Salary	V07-1
7520.00	6460.00	Plant-Trash Removal	<u>32,999.86</u>	Trash and Refuse Removal	V07-3
			74,929.26		
			<u>74,929.00</u>	PG 3, LINE 7, COLUMN 8	
			0.26	<i>Rounding</i>	

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			31,802	31,802		31,802	356,230	388,032		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			86,198	86,198		86,198	531,404	617,602		32
33	Real Estate Taxes							78,048	78,048		33
34	Rent-Facility & Grounds			1,073,890	1,073,890		1,073,890	(1,062,732)	11,158		34
35	Rent-Equipment & Vehicles			6,083	6,083		6,083	832	6,915		35
36	Other (specify):*							68,146	68,146		36
37	TOTAL Ownership			1,197,973	1,197,973		1,197,973	(28,072)	1,169,901		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			97,611	97,611		97,611		97,611		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			286,562	286,562		286,562		286,562		42
43	Other (specify):* Non-Allowable Cos			603	603		603	(603)			43
44	TOTAL Special Cost Centers			384,776	384,776		384,776	(603)	384,173		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,509,774	698,756	4,856,332	9,064,862		9,064,862	(1,308,697)	7,756,165		45

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

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
1/1/17 - 12/31/17

Page 4 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 4 REFERENCE
N/A	SAPP Related Party Account	Mortgage Insurance	68,146.00	Mortgage Insurance	V36-7
			<u>68,146.00</u>	PG 4, LINE 36, COLUMN 8	

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms	(13,775)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(239,264)	21		18
19	Entertainment				19
20	Contributions	(506)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(844,771)	21		24
25	Fund Raising, Advertising and Promotional	(47,407)	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	(52,340)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,198,063)		\$	30

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	2	
		Amount	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)	(110,634)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,634)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,308,697)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

St Antonys Nsg & Rehab Ctr

ID# 0047126

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Independent Living	\$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(4,945)	22	2
3	Non-Allowable Costs	(603)	43	3
4	Non-Allowable Legal Fees	(46,698)	19	4
5	Theft Loss	(94)	21	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
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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	(52,340)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Antonys Nsg & Rehab Ctr# 0047126

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(13,775)	0	0	0	0	0	0	0	0	0	0	(13,775)	5
6	Maintenance	0	0	44	0	0	0	0	0	0	0	0	44	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,775)	0	44	0	(13,731)	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	2,391	0	0	0	0	0	0	0	0	2,391	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	2,391	0	2,391	16							
	C. General Administration													
17	Administrative	0	0	(405,085)	0	0	0	0	0	0	0	0	(405,085)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(46,698)	14,900	28,888	0	0	0	0	0	0	0	0	(2,910)	19
20	Fees, Subscriptions & Promotions	0	0	9,926	0	0	0	0	0	0	0	0	9,926	20
21	Clerical & General Office Expenses	(1,084,129)	300	77,848	0	0	0	0	0	0	0	0	(1,005,981)	21
22	Employee Benefits & Payroll Taxes	(4,945)	0	18,958	0	0	0	0	0	0	0	0	14,013	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	19,423	0	0	0	0	0	0	0	0	19,423	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	145,276	4,569	0	0	0	0	0	0	0	0	149,845	26
27	Other (specify):*	(47,913)	0	0	0	0	0	0	0	0	0	0	(47,913)	27
28	TOTAL General Administration	(1,183,685)	160,476	(245,473)	0	(1,268,682)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,197,460)	160,476	(243,038)	0	(1,280,022)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Antonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	352,598	3,632	0	0	0	0	0	0	0	0	356,230	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	531,076	328	0	0	0	0	0	0	0	0	531,404	32
33	Real Estate Taxes	0	78,048	0	0	0	0	0	0	0	0	0	78,048	33
34	Rent-Facility & Grounds	0	(1,073,890)	11,158	0	0	0	0	0	0	0	0	(1,062,732)	34
35	Rent-Equipment & Vehicles	0	0	832	0	0	0	0	0	0	0	0	832	35
36	Other (specify):*	0	68,146	0	0	0	0	0	0	0	0	0	68,146	36
37	TOTAL Ownership	0	(44,022)	15,950	0	0	0	0	0	0	0	0	(28,072)	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):*	(603)	0	0	0	0	0	0	0	0	0	0	(603)	43
44	TOTAL Special Cost Centers	(603)	0	0	0	0	0	0	0	0	0	0	(603)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,198,063)	116,454	(227,088)	0	0	0	0	0	0	0	0	(1,308,697)	45

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	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)		
1	V	34 Rent	\$ 1,073,890	St. Anthony's Property Partners, LLC	100.00%	\$	(1,073,890)	1	
2	V	19 Professional Fees		St. Anthony's Property Partners, LLC	100.00%	14,900	14,900	2	
3	V	21 Office and Clerical		St. Anthony's Property Partners, LLC	100.00%	300	300	3	
4	V	26 Property Insurance		St. Anthony's Property Partners, LLC	100.00%	145,276	145,276	4	
5	V	30 Depreciation		St. Anthony's Property Partners, LLC	100.00%	352,598	352,598	5	
6	V	32 Amortization		St. Anthony's Property Partners, LLC	100.00%	24,574	24,574	6	
7	V	32 Interest		St. Anthony's Property Partners, LLC	100.00%	506,502	506,502	7	
8	V	33 Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	78,048	78,048	8	
9	V	36 Mortgage Insurance		St. Anthony's Property Partners, LLC	100.00%	68,146	68,146	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 1,073,890			\$ 1,190,344	\$ *	116,454	14

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

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. 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	<u>6</u> Maintenance	\$	SAK Management Services, LLC	100.00%	\$ 44	\$	44	15
16	V	<u>10</u> Nursing		SAK Management Services, LLC	100.00%	2,391		2,391	16
17	V	<u>17</u> Administration	449,229	SAK Management Services, LLC	100.00%	44,144		(405,085)	17
18	V	<u>19</u> Professional Fees		SAK Management Services, LLC	100.00%	28,888		28,888	18
19	V	<u>20</u> Dues and Subscriptions		SAK Management Services, LLC	100.00%	9,926		9,926	19
20	V	<u>21</u> Office and Clerical		SAK Management Services, LLC	100.00%	77,848		77,848	20
21	V	<u>22</u> Employee Benefits		SAK Management Services, LLC	100.00%	18,958		18,958	21
22	V	<u>24</u> Seminar and Education		SAK Management Services, LLC	100.00%	19,423		19,423	22
23	V	<u>26</u> Insurance		SAK Management Services, LLC	100.00%	4,569		4,569	23
24	V	<u>30</u> Depreciation		SAK Management Services, LLC	100.00%	3,632		3,632	24
25	V	<u>32</u> Interest		SAK Management Services, LLC	100.00%	328		328	25
26	V	<u>34</u> Rent - Building		SAK Management Services, LLC	100.00%	11,158		11,158	26
27	V	<u>35</u> Rent - Equipment		SAK Management Services, LLC	100.00%	832		832	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 449,229			\$ 222,141	\$ *	(227,088)	39

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

Facility Name & ID Number

St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

1/1/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Suzanne Koenig	90%	Lena Living Center, LLC	Lena, Illinois	St. Anthony's			1
2	Gary Weintraub	10%			Property, LLC	Rock Island, Illinois	Bldg. Partnership	2
3					Lena Property			3
4					Partners, LLC	Lena, Illinois	Bldg. Partnership	4
5					SAK Management	Northfield, Illinois	Mgmt. Company	5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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 St Anthony's Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<u>SEE EXHIBIT 2 - SAK MANAGEMENT SERVICES ALLOCATIONS</u>				\$	\$		\$	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

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	HUD		X	Mortgage	\$86,884.57	9/17/12	\$ 11,995,400	\$ 11,279,239	1/1/2048	4.5000	\$ 531,076	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Bank Leumi		X	Line of Credit				889,177			58,294	6								
7	Monroe Capital		X	Line of Credit				186,449			27,967	7								
8	Alloc. - SAK Management										328	8								
9	TOTAL Facility Related				\$86,884.57		\$ 11,995,400	\$ 12,354,865			\$ 617,665	9								
B. Non-Facility Related*																				
10	Interest Income Offset										(63)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (63)	14								
15	TOTALS (line 9+line14)						\$ 11,995,400	\$ 12,354,865			\$ 617,602	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 68,146 Line # 36

* 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.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthonys Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Chris Joos

TELEPHONE 614.222.9040 FAX #: 248.233.8811

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-364-21-002</u>	<u>Long Term Care Facility</u>	\$ <u>7,400.92</u>	\$ <u>7,400.92</u>
2. <u>07-364-21-001</u>	<u>Long Term Care Facility</u>	\$ <u>71,197.28</u>	\$ <u>71,197.28</u>
3. <u>07-363-55-002</u>	<u>Long Term Care Facility</u>	\$ <u>1,461.60</u>	\$ <u>1,461.60</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>80,059.80</u></u>	\$ <u><u>80,059.80</u></u>

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 NO

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

C. Tax Bills

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

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

1/1/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 5

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 319,300, 2005, \$ 155,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 319,300, (blank), \$ 155,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130	2005		\$ 2,050,000	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Sliding/Kitchen/Fire Door		2017	6,748					9
10	Basement electrical panel		2017	4,936					10
11	Water Heaters/Boilers		2017	78,601					11
12	Parking Lot Sink Hole		2017	6,727					12
13	Fire Sprinkler		2017	1,804					13
14	Servewell Buffet		2017	3,225					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	St. Anthony's Property Partners, LLC								27
28									28
29	Complete Facility Rehabilitation and Renovation		2012	6,510,694					29
30	Complete Facility Rehabilitation and Renovation		2013	1,200,533					30
31	Chiller		2016	127,850					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 St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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					5,108	5,108	5,108	67
68					303,810	303,810	2,546,548	68
69							38,486	69
70		\$ 9,991,118	\$ 308,918		\$ 308,918	\$	\$ 2,590,142	70

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

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	\$ 394,725	\$ 23,612	\$ 23,612	\$	Various	\$ 367,005	71
72	Current Year Purchases	7,360	82	82		15	82	72
73	Fully Depreciated Assets							73
74	See Supplemental File	731,808	52,420	52,420		Various	311,755	74
75	TOTALS	\$ 1,133,893	\$ 76,114	\$ 76,114	\$		\$ 678,842	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Windstar	2005	\$ 1,506	\$	\$	\$	7	\$ 1,506	76
77	Facility	Snow Plow Truck	2010	5,500				7	5,500	77
78	Facility	Ford E 350 Bus	2014	15,623	3,000	3,000		5	14,123	78
79										79
80	TOTALS			\$ 22,629	\$ 3,000	\$ 3,000	\$		\$ 21,129	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)	\$ 11,302,640	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 388,032	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 388,032	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)	\$ 3,290,113	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.

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
1/1/17 - 12/31/17

Page 13 Supplemental Schedule

	Class	Cost	Depreciation	Accum
St. Anthony's Property Partners, LLC	Furniture & Equipment	710,291	48,788	292,725
Alloc. - SAK Management Services, Inc.	Furniture & Equipment	21,517	3,632	19,030
		<hr/>	<hr/>	<hr/>
		731,808	52,420	311,755

Facility Name & ID Number St Antonys Nsg & Rehab Ctr

0047126

Report Period Beginning: 1/1/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Supplemental Schedule				11,158			5
6								6
7	TOTAL				\$ 11,158			7

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	\$ _____

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: _____*

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: \$ 6,915 Description: See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
1/1/17 - 12/31/17

Page 14 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 14 REFERENCE
N/A	6290 - Rent	SAK Management Services, Inc.	11,158.00	Rent	V34-7
			<u>11,158.00</u>	PG 14, LINE 34, COLUMN 8	
			-		
8065.00	7040.00	Rent-Equipment	5,143.18	Lease and Rent - Equipment	V35-3
8065.00	7020.00	Auto Expense	939.67	Lease and Rent - Equipment	V35-3
N/A	6170 - Equipment Rental	SAK Management Services, Inc.	<u>832.00</u>	Equipment Rental	V35-7
			6,914.85		
			<u>6,915.00</u>	PG 14, LINE 35, COLUMN 8	
			(0.15)	<i>Rounding</i>	

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	Service	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	V10A	0.00 hrs	\$ 0	3,876	\$ 312,063	\$ 0	3,876	\$ 312,063	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	842	92,460	0	842	92,460	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	4,615	363,974	0	4,615	363,974	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	92,952		92,952	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>LAB/RADIOLOGY</u>	V39	0.00	0	0	0	4,659		4,659	12
13	Other (specify): <u>BILLABLE SUPPLIES</u>	V39	0.00	0	0	0	0			13
14	TOTAL			\$	9,333	\$ 768,497	\$ 97,611	9,333	\$ 866,108	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 100,185	\$ 104,096	1
2	Cash-Patient Deposits	58,307	58,307	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>825,242</u>)	1,390,783	1,929,783	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		68,915	6
7	Other Prepaid Expenses	20,000	20,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	26,094	489,929	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,595,369	\$ 2,671,030	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost	102,041	10,028,483	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	424,714	1,135,005	16
17	Accumulated Depreciation (book methods)	(393,325)	(3,241,854)	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): <u>See Supplemental Schedule</u>		156,442	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 133,430	\$ 8,233,076	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,728,799	\$ 10,904,106	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,287,526	\$ 2,364,113	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,307	58,307	28
29	Short-Term Notes Payable	1,075,626	1,075,626	29
30	Accrued Salaries Payable	205,522	205,522	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,584	20,584	31
32	Accrued Real Estate Taxes(Sch.IX-B)		84,063	32
33	Accrued Interest Payable		263,672	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)	\$ 3,647,565	\$ 4,071,887	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,279,239	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>See Supplemental Schedule</u>	3,547,765	4,238,531	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,547,765	\$ 15,517,770	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,195,330	\$ 19,589,657	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,466,531)	\$ (8,685,551)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,728,799	\$ 10,904,106	48

*(See instructions.)

St Anthony's Nsg & Rehab Ctr
Medicaid Cost Report
1/1/17 - 12/31/17

Page 17 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 17 REFERENCE
1070.10	1300.00	Refunds Due/Clearing Acct	26,094.00	Other Receivables	Line 9
SAPP	112.0	Replacement Reserve Escrow	340,074.00	Escrow Account	Line 9
SAPP	112.6	REAL ESTATE ESCROW DEPOSIT	(26,102.00)	Escrow Account	Line 9
SAPP	112.7	MIP Insurance Escrow	34,073.00	Escrow Account	Line 9
SAPP	112.8	Insurance Escrow	115,790.00	Escrow Account	Line 9
			<u>489,929.00</u>		
			-	<i>tie out to PG17, s/b 0</i>	
SAPP	119.0	Loan Issuance Costs	156,442.00	Loan Costs	Line 23
			-	<i>tie out to PG17, s/b 0</i>	
2430.00	5250.00	Due to SAPP	(734,131.00)	Related Party Loans - Int. Non-Allowable	Line 44
2430.00	5443.00	Note Payable - Suzy Koenig	(169,386.00)	Related Party Loans - Int. Non-Allowable	Line 44
2430.00	5500.00	Due to SAK MGMT	(2,796,014.00)	Related Party Loans - Int. Non-Allowable	Line 44
2430.00	PM 11710	Due to SAPP	151,766.00	Related Party Loans - Int. Non-Allowable	Line 44
	1130	Tenant/Member accounts receivab	(205,215.00)	Related Party Receivable/Payable	Line 44
	114.8	Due from St. Anthony's Nrg&Reha	400,346.00	Related Party Receivable/Payable	Line 44
	114.9	Allowance for D/A	(734,131.00)	Related Party Receivable/Payable	Line 44
	PM 2110	Due to St. Anthony's Nursing	(151,766.00)	Related Party Receivable/Payable	Line 44
			<u>(4,238,531.00)</u>		
			-	<i>tie out to PG17, s/b 0</i>	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,688,753)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,688,753)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,787,024)	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) PY ADJUSTMENT	9,246	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,777,778)	17
	B. Transfers (Itemize):		
18	ILU net asset activity for the year		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)	\$ (5,466,531)	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,727,327	1
2	Discounts and Allowances for all Levels	(1,461,033)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,266,294	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,920,275	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,920,275	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,952	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,560	19
20	Radiology and X-Ray	3,099	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 97,611	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/IL</u>		28
28a	<u>Misc Revenue</u>	(6,342)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (6,342)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,277,838	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,440,675	31
32	Health Care	3,552,507	32
33	General Administration	2,488,931	33
B. Capital Expense			
34	Ownership	1,197,973	34
C. Ancillary Expense			
35	Special Cost Centers	98,214	35
36	Provider Participation Fee	286,562	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,064,862	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,787,024)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,787,024)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,841,034	44
45	Private Pay - Net Inpatient Revenue	1,173,180	45
46	Medicare - Net Inpatient Revenue	1,471,482	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	372,160	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(2,591,562)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,266,294	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 **St Anthonys Nsg & Rehab Ctr**

0047126

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,959	2,021	\$ 85,216	\$ 42.17	1
2	Assistant Director of Nursing	3,694	4,082	116,569	28.56	2
3	Registered Nurses	5,897	6,306	171,522	27.20	3
4	Licensed Practical Nurses	35,762	38,560	895,957	23.24	4
5	CNAs & Orderlies	88,769	94,396	1,145,263	12.13	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,280	1,360	19,040	14.00	9
10	Activity Assistants	3,390	3,633	33,154	9.13	10
11	Social Service Workers	1,542	1,810	29,409	16.25	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	1,964	2,111	40,290	19.09	14
15	Cook Helpers/Assistants	23,085	24,707	222,328	9.00	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	8,081	8,949	129,557	14.48	17
18	Housekeepers	19,466	20,849	188,619	9.05	18
19	Laundry	5,983	6,660	67,024	10.06	19
20	Administrator	1,941	2,226	93,709	42.10	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	7,842	8,585	165,604	19.29	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	1,119	1,176	18,948	16.11	31
32	Other Health C: Security	4,448	4,662	41,929	8.99	32
33	Other(specify) Marketing	2,063	2,146	45,636	21.27	33
34	TOTAL (lines 1 - 33)	218,285	234,239	\$ 3,509,774 *	\$ 14.98	34

* 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	\$ 12,046	01 - 03	35
36	Medical Director	25,000	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant	8,224	10 - 03	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,706	12 - 3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 48,976		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Cindy Brill	Administrator	0	\$ 63,376	Workers' Compensation Insurance	\$ 41,616	IDPH License Fee	\$	
Jeff Wollum	Administrator	0	25,729	Unemployment Compensation Insurance	43,360	Advertising: Employee Recruitment		
Rachel May	Administrator	0	4,604	FICA Taxes	236,118	Health Care Worker Background Check (Indicate # of checks performed)	6,689	
				Employee Health Insurance	53,952	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	21,321	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,980	
				Other Misc Benefits	5,295	Help Wanted	1,924	
				SAK Management Services, LLC Allocation	18,958	Recruiting Fee	13,436	
				Less Marketing Benefits	(4,945)	SAK Management Services, LLC Allocation	9,926	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,709	TOTAL (agree to Schedule V, line 22, col.8)		\$ 56,276		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SAK Management Services - Management Fees			\$ 384,563				Out-of-State Travel	\$
SAK Management Services - Administrative Consultant			55,507					
SAK Management Services - Data Processing			9,159				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 449,229				Seminar Expense	491
C. Professional Services				TOTAL			SAK Management Services, LLC Allocation	
Vendor/Payee	Type		Amount				19,423	
Resolute	Administrative consultant		\$ 10,994				Entertainment Expense	
Personnel Planners, Inc	Unemployment Consultant		1,050				()	
Polsinelli Shughart PC	Legal Fees		48,582				TOTAL (agree to Sch. V, line 24, col. 8)	
Sher, LLP	Legal Fees		1,893				\$ 19,914	
Plante & Moran, PLLC	Accounting Services		24,843					
Collections	Collections		495					
Point Click Care	Data Processing		17,645					
Compu-Solutions Inc	Data Processing		20,746					
Proliant	Data Processing		12,840					
Future Wave Tech, Inc	Data Processing		18,912					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 158,000					

* Attach copy of IMRF notifications

**See instructions.

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 - 20,410
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,573 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 286,562
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 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? Ln. 14
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Code	Description	Rate	Amount	Balance
1000	1000			
1001	1001			
1002	1002			
1003	1003			
1004	1004			
1005	1005			
1006	1006			
1007	1007			
1008	1008			
1009	1009			
1010	1010			
1011	1011			
1012	1012			
1013	1013			
1014	1014			
1015	1015			
1016	1016			
1017	1017			
1018	1018			
1019	1019			
1020	1020			
1021	1021			
1022	1022			
1023	1023			
1024	1024			
1025	1025			
1026	1026			
1027	1027			
1028	1028			
1029	1029			
1030	1030			
1031	1031			
1032	1032			
1033	1033			
1034	1034			
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Item	Quantity	Unit	Price	Total
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3.000	3.000	kg	3.000	3.000
4.000	4.000	kg	4.000	4.000
5.000	5.000	kg	5.000	5.000
6.000	6.000	kg	6.000	6.000
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15.000	15.000	kg	15.000	15.000
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