

Facility Name & ID Number Lena Living Center

0047746 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	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 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	541	348	2,280	3,169	8
9	SNF/PED					9
10	ICF	8,036	16,989	837	25,862	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,577	17,337	3,117	29,031	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.22%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

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

Note: 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

I. On what date did you start providing long term care at this location?

Date started 02/27/2006

J. Was the facility purchased or leased after January 1, 1978?

YES Date 02/27/2006 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 40 and days of care provided 2,280

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	222,584	10,543	8,913	242,040		242,040		242,040		1
2	Food Purchase		161,386		161,386		161,386		161,386		2
3	Housekeeping	103,988	15,419		119,407		119,407		119,407		3
4	Laundry	51,615	10,277		61,892		61,892		61,892		4
5	Heat and Other Utilities			165,895	165,895		165,895	606	166,501		5
6	Maintenance	43,790	11,103	23,579	78,472		78,472		78,472		6
7	Other (specify):*										7
8	TOTAL General Services	421,977	208,728	198,387	829,092		829,092	606	829,698		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,245,495	65,861	2,465	1,313,821		1,313,821	226	1,314,047		10
10a	Therapy	6,846		224,564	231,410		231,410		231,410		10a
11	Activities	59,541	6,459	1,838	67,838		67,838		67,838		11
12	Social Services	23,620		3,150	26,770		26,770		26,770		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,335,502	72,320	240,417	1,648,239		1,648,239	226	1,648,465		16
	C. General Administration										
17	Administrative	80,508		86,653	167,161		167,161	(86,653)	80,508		17
18	Directors Fees										18
19	Professional Services			155,593	155,593		155,593	(126,087)	29,506		19
20	Dues, Fees, Subscriptions & Promotions			14,834	14,834		14,834	1,265	16,099		20
21	Clerical & General Office Expenses	52,971	10,818	55,170	118,959		118,959	978	119,937		21
22	Employee Benefits & Payroll Taxes			588,957	588,957		588,957		588,957		22
23	Inservice Training & Education							1,444	1,444		23
24	Travel and Seminar			2,037	2,037		2,037	9,730	11,767		24
25	Other Admin. Staff Transportation			22,159	22,159		22,159	991	23,150		25
26	Insurance-Prop.Liab.Malpractice			56,791	56,791		56,791	1,241	58,032		26
27	Other (specify):* Home Office Benefits							39,300	39,300		27
28	TOTAL General Administration	133,479	10,818	982,194	1,126,491		1,126,491	(157,791)	968,700		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,890,958	291,866	1,420,998	3,603,822		3,603,822	(156,959)	3,446,863		29

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

SEE ACCOUNTANTS' COMPILATION 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:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			12,332	12,332		12,332	65,457	77,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,666	23,666		23,666	181,576	205,242			32
33	Real Estate Taxes			65,957	65,957		65,957		65,957			33
34	Rent-Facility & Grounds			273,308	273,308		273,308	(266,212)	7,096			34
35	Rent-Equipment & Vehicles			6,047	6,047		6,047	1,884	7,931			35
36	Other (specify):*											36
37	TOTAL Ownership			381,310	381,310		381,310	(17,295)	364,015			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,149		86,149		86,149		86,149			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,508	50,508		50,508		50,508			42
43	Other (specify):* Non-allowable cost	12,638	2,658	35,680	50,976		50,976	(50,976)				43
44	TOTAL Special Cost Centers	12,638	88,807	86,188	187,633		187,633	(50,976)	136,657			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,903,596	380,673	1,888,496	4,172,765		4,172,765	(225,230)	3,947,535			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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				4
5	Telephone, TV & Radio in Resident Rooms	(7,241)	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	(158,416)	30		9
10	Interest and Other Investment Income	(38,615)	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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(50,367)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,639)		\$	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)	29,409	Vari.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 29,409		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (225,230)		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.		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

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lena Living Center

ID# 0047746

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-Allowable Lab Expense	\$ (5,063)	43	1
2	Non-Allowable Radiology Expense	(2,039)	43	2
3	Non-Allowabl Marketing Expense	(36,633)	43	3
4	Misc Income offset	(5,799)	21	4
5	Offset Nonallowable Travel/Seminar Exp	(833)	24	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	(50,367)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lena Living Center# 0047746

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	0	0	606	0	0	0	0	0	0	0	0	606	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	606	0	0	0	0	0	0	0	0	606	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	226	0	0	0	0	0	0	0	0	226	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	226	0	0	0	0	0	0	0	0	226	16
	C. General Administration													
17	Administrative	0	0	(86,653)	0	0	0	0	0	0	0	0	(86,653)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(126,087)	0	0	0	0	0	0	0	0	(126,087)	19
20	Fees, Subscriptions & Promotions	0	250	1,015	0	0	0	0	0	0	0	0	1,265	20
21	Clerical & General Office Expenses	(5,799)	6	6,771	0	0	0	0	0	0	0	0	978	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,444	0	0	0	0	0	0	0	0	1,444	23
24	Travel and Seminar	(833)	0	10,563	0	0	0	0	0	0	0	0	9,730	24
25	Other Admin. Staff Transportation	0	0	991	0	0	0	0	0	0	0	0	991	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,241	0	0	0	0	0	0	0	0	1,241	26
27	Other (specify):*	0	0	39,300	0	0	0	0	0	0	0	0	39,300	27
28	TOTAL General Administration	(6,632)	256	(151,415)	0	0	0	0	0	0	0	0	(157,791)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,632)	256	(150,583)	0	0	0	0	0	0	0	0	(156,959)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lena Living Center# 0047746

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(316,832)	222,543	1,330	0	0	0	0	0	0	0	0	(92,959)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(77,230)	220,191	0	0	0	0	0	0	0	0	0	142,961	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(273,308)	7,096	0	0	0	0	0	0	0	0	(266,212)	34
35	Rent-Equipment & Vehicles	0	0	1,884	0	0	0	0	0	0	0	0	1,884	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(394,062)	169,426	10,310	0	(214,326)	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):*	(58,217)	0	0	0	0	0	0	0	0	0	0	(58,217)	43
44	TOTAL Special Cost Centers	(58,217)	0	0	0	0	0	0	0	0	0	0	(58,217)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(458,911)	169,682	(140,273)	0	(429,502)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	100	See Sch 6A		Lena Property Partner	Lena	Real Estate Entity
				SAK Management Ser	Chicago	Management Compa

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 273,308	Lena Property Partners, LLC		\$	\$ (273,308)	1
2	V	19 Legal		Lena Property Partners, LLC				2
3	V	20 License & Permits		Lena Property Partners, LLC		250	250	3
4	V	21 Clerical		Lena Property Partners, LLC		6	6	4
5	V	32 Interest Expense		Lena Property Partners, LLC		220,191	220,191	5
6	V	30 Depreciation		Lena Property Partners, LLC		222,543	222,543	6
7	V	36 Amortization		Lena Property Partners, LLC				7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 273,308			\$ 442,990	\$ * 169,682	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	5 Utilities	\$	SAK Management Services, LLC	100.00%	\$ 606	\$ 606
16	V	10 Nursing - Salaries		SAK Management Services, LLC	100.00%	226	226
17	V	17 Administrative - Salaries	86,653	SAK Management Services, LLC	100.00%	0	(86,653)
18	V	19 Professional Fees	129,980	SAK Management Services, LLC	100.00%	3,893	(126,087)
19	V	20 Dues, Fees & Subs		SAK Management Services, LLC	100.00%	1,015	1,015
20	V	21 Clerical		SAK Management Services, LLC	100.00%	6,771	6,771
21	V	21 Clerical - Salaries		SAK Management Services, LLC	100.00%	0	
22	V	23 Training/Education		SAK Management Services, LLC	100.00%	1,444	1,444
23	V	24 Travel/Seminar		SAK Management Services, LLC	100.00%	9,665	9,665
24	V	25 Other Admin. Transp		SAK Management Services, LLC	100.00%	991	991
25	V	26 Insurance - Prop/Liability		SAK Management Services, LLC	100.00%	1,241	1,241
26	V	27 EE Benefits		SAK Management Services, LLC	100.00%	39,300	39,300
27	V	30 Depreciation Expense		SAK Management Services, LLC	100.00%	1,330	1,330
28	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	100.00%	7,096	7,096
29	V	35 Rent - Eqpt. & Vehicles		SAK Management Services, LLC	100.00%	1,884	1,884
30	V						
31	V						
32	V	24 Travel & Seminar		SAK Management Services, LLC	100.00%	898	898
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 216,633			\$ 76,360	\$ * (140,273)

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

Facility Name & ID Number

Lena Living Center

0047746

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	Suzanne Koenig	Owner	Administrative	100.00	See Attached	0	0.00	N/A	\$ 0	N/A	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 SAK Management Services,LLC
 Street Address 4055 w. Peterson, Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (773) 267-0111

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	5	Utilities	SAX Management Fees	1,915,081	8	\$ 5,361	\$ 216,633	\$ 606	1
2	10	Nursing - Salaries	SAX Management Fees	1,915,081	8	1,998	216,633	226	2
3	17	Administrative - Salaries	SAX Management Fees	1,915,081	8	0	216,633	0	3
4	19	Professional Fees	SAX Management Fees	1,915,081	8	34,415	216,633	3,893	4
5	20	Dues,Fees & Subs	SAX Management Fees	1,915,081	8	8,974	216,633	1,015	5
6	21	Clerical	SAX Management Fees	1,915,081	8	59,856	216,633	6,771	6
7	21	Clerical - Salaries	SAX Management Fees	1,915,081	8	0	216,633	0	7
8	23	Training/Education	SAX Management Fees	1,915,081	8	12,762	216,633	1,444	8
9	24	Travel/Seminar	SAX Management Fees	1,915,081	8	85,442	216,633	9,665	9
10	25	Other Admin. Transp	SAX Management Fees	1,915,081	8	8,757	216,633	991	10
11	26	Insurance - Prop/Liability	SAX Management Fees	1,915,081	8	10,969	216,633	1,241	11
12	27	EE Benefits	SAX Management Fees	1,915,081	8	347,424	216,633	39,300	12
13	30	Depreciation Expense	SAX Management Fees	1,915,081	8	11,758	216,633	1,330	13
14	34	Rent - Facility & Grounds	SAX Management Fees	1,915,081	8	62,727	216,633	7,096	14
15	35	Rent - Eqpt. & Vehicles	SAX Management Fees	1,915,081	8	16,653	216,633	1,884	15
16									16
17									17
18	24	Travel & Seminar	Direct Costs	20,014	8	20,014	898	898	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 687,110	\$	\$ 76,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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										
										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	First Choice Bank		X	Mortgage	\$24,170.00	2/27/2006	\$ 3,000,000	\$ 2,825,031	2/19/2009	0.0750	\$ 197,895	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	First Choice Bank		X	Line of Credit	Varies	2/27/2006	422,000	422,000	2/19/2009	Variable	23,666	6							
7	SAK Mgmt Services, LLC.	X		Line of Credit	Varies	2/27/2006	170,000	20,000	Demand	0.0925	22,296	7							
8												8							
9	TOTAL Facility Related				\$24,170.00		\$ 3,592,000	\$ 3,267,031			\$ 243,857	9							
B. Non-Facility Related*																			
10								Interest Income			(38,615)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (38,615)	14							
15	TOTALS (line 9+line14)						\$ 3,592,000	\$ 3,267,031			\$ 205,242	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lena Living Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0047746

CONTACT PERSON REGARDING THIS REPORT Suzanne Koening

TELEPHONE (773) 202-0000 FAX #: (773) 267-0111

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-12-04-102-001</u>	<u>Long-Term Care Property</u>	\$ <u>42,527.00</u>	\$ <u>42,527.00</u>
2. <u>10-12-04-101-006</u>	<u>Long-Term Care Property</u>	\$ <u>530.00</u>	\$ <u>530.00</u>
3. <u>10-12-04-101-001</u>	<u>Long-Term Care Property</u>	\$ <u>16,764.00</u>	\$ <u>16,764.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>59,821.00</u>	\$ <u>59,821.00</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 X NO

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center

0047746 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,546 B. General Construction Type: Exterior Brick/Stucco Frame Wood Number of Stories _____

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).

16 apartments - cost not included on cost report

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2006</u>	<u>\$ 290,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 290,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	92	2006		\$ 1,310,000	\$	40	\$ 32,750	\$ 32,750	\$ 141,103	4
5										5
6										6
7										7
8										8
Improvement Type**										
9										9
10	Nurse Call Station	2006		2,370	580	20	119	(462)	1,038	10
11	Heartland Fire & Security Call System	2006		5,453	1,335	20	273	(1,062)	2,387	11
12	Champion Roofing Services	2006		3,800	274	20	190	(84)	464	12
13	Quality Electric	2007		3,640	263	20	182	(81)	445	13
14	Carpet Replacement	2007		2,535	419	20	127	(292)	546	14
15	Fire System Upgrade	2007		4,756	680	20	238	(442)	918	15
16	Rewire Nurse Station	2007		2,953	422	20	148	(274)	570	16
17	Water Heater	2007		11,416	1,631	7	1,631	(0)	3,262	17
18	New Doors	2008		2,784	139	20	70	(69)	70	18
19	Boiler	2008		22,208	1,110	20	555	(555)	555	19
20	Door & Related Repairs	2008		4,293	429	20	107	(322)	107	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

*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' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70	
			1,376,208		7,282		36,388	29,106	151,465

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 410,118	\$ 4,661	\$ 41,012	\$ 36,351	10	\$ 89,775	71
72	Current Year Purchases	1,946	389	389		5	389	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 412,064	\$ 5,050	\$ 41,401	\$ 36,351		\$ 90,164	75

D. Vehicle Depreciation (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		N/A		\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,078,272	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,789	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,457	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 241,629	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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								5
6	Alloc. From SAK Mgmt.				7,096			6
7	TOTAL				\$ 7,096			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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: \$ 7,931 Description: Nurse Supplies 2658, Copier 3389, SAK Mgmt Allocation 1884

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	L10A C3	hrs	\$	932	\$ 87,431	\$	932	\$ 87,431	1
2	Licensed Speech and Language Development Therapist	L10AC3	hrs		251	24,410		251	24,410	2
3	Licensed Recreational Therapist		hrs		1,222	112,723		1,222	112,723	3
4	Licensed Physical Therapist	L10A C3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescrpts				86,149		86,149	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			\$	2,405	\$ 224,564	\$ 86,149	2,405	\$ 310,713	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' COMPILATION REPORT

Facility Name & ID Number **Lena Living Center**

0047746

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(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	\$ 123,982	\$ 127,434	1
2	Cash-Patient Deposits	8,788	8,788	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	667,293	667,293	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,171	57,887	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	31,652	40,106	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 859,886	\$ 901,508	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	39,260	1,376,208	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	37,849	412,064	16
17	Accumulated Depreciation (book methods)	(21,851)	(241,629)	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>Construction Reserve</u>		1,130,552	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 55,258	\$ 2,967,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 915,144	\$ 3,868,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 394,885	\$ 394,885	26
27	Officer's Accounts Payable	8,454	8,454	27
28	Accounts Payable-Patient Deposits	8,788	8,788	28
29	Short-Term Notes Payable	422,000	442,000	29
30	Accrued Salaries Payable	150,799	150,799	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,582	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Liabilities - Current</u>	2,000	2,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 986,926	\$ 1,085,508	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,825,031	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Other Liabilities - LT</u>	500	500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 500	\$ 2,825,531	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 987,426	\$ 3,911,039	46
47	TOTAL EQUITY(page 18, line 24)	\$ (72,282)	\$ (42,336)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 915,144	\$ 3,868,703	48

Lena Living Center

Provider #: 0047746

1/1/2008 to 12/31/2008

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Other Current Assets - Line 9		
Due From Lessor/Prior Owner	4,180	12,634
Due From Lena Living Center	27,472	27,472
	<u>31,652</u>	<u>40,106</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (231,791)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(379)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (232,170)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	159,888	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)	\$ 159,888	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)	\$ (72,282)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,608,582	1
2	Discounts and Allowances for all Levels	(65,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,542,997	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	476,857	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 476,857	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	159,481	16
17	Sale of Drugs	85,768	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	61,751	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 307,000	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>Misc Income</u>	5,799	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,799	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,332,653	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	829,092	31
32	Health Care	1,648,239	32
33	General Administration	1,126,491	33
	B. Capital Expense		
34	Ownership	381,310	34
	C. Ancillary Expense		
35	Special Cost Centers	137,125	35
36	Provider Participation Fee	50,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,172,765	40
41	Income before Income Taxes (line 30 minus line 40)**	159,888	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 159,888	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is on cash basis.

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

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

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	2,008	2,080	\$ 55,133	\$ 26.51	1
2	Assistant Director of Nursing	2,008	2,080	44,767	21.52	2
3	Registered Nurses	5,257	5,761	135,657	23.55	3
4	Licensed Practical Nurses	20,714	22,233	406,065	18.26	4
5	CNAs & Orderlies	54,440	57,974	564,178	9.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	694	730	6,846	9.38	8
9	Activity Director					9
10	Activity Assistants	5,837	6,250	59,541	9.53	10
11	Social Service Workers	1,496	1,724	23,620	13.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,224	22,722	222,584	9.80	15
16	Dishwashers					16
17	Maintenance Workers	4,126	4,471	43,790	9.79	17
18	Housekeepers	10,170	11,003	103,988	9.45	18
19	Laundry	5,905	6,425	51,615	8.03	19
20	Administrator	2,743	2,884	80,508	27.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,660	4,298	52,971	12.32	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					31
32	Care Plan Coordinator	1,920	2,080	39,696	19.08	32
33	Marketing	1,744	1,897	12,638	6.66	33
34	TOTAL (lines 1 - 33)	143,946	154,612	\$ 1,903,596 *	\$ 12.31	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	180	\$ 8,913	L1,C3	35
36	Medical Director	Monthly	8,400	L10,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,465	L10, C3	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	31	1,838	L11,C3	44
45	Social Service Consultant	53	3,150	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	264	\$ 24,766		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lena Living Center**

0047746

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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	
Robin Lemasters	Administrator	0	\$ 32,304	Workers' Compensation Insurance	\$ 68,778	IDPH License Fee	\$ 1,990	
Kathleen Copeland	Administrator	0	13,078	Unemployment Compensation Insurance	44,982	Advertising: Employee Recruitment	2,986	
Ruth Kruse	Administrator CS	0	35,126	FICA Taxes	131,681	Health Care Worker Background Check	0	
				Employee Health Insurance	340,991	(Indicate # of checks performed <u>79</u>)	950	
				Employee Meals	0	Patient Background Checks	63	
				Illinois Municipal Retirement Fund (IMRF)*	0	IL Council on Long Term Care	7,378	
				Employee Drug Screening	56	Misc License Fees	2,035	
				Employee Relations	2,469			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 80,508					
B. Administrative - Other								
Description			Amount					
SAK Management Services (Eliminated in Column 7 on Page 3)			\$ 86,653					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 86,653					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SAK Management Services	Accounting		\$ 129,980	N/A			Out-of-State Travel	\$
Aronberg Goldgehn, Davis	Legal		201					
HDSI	A/R System Services		5,465				In-State Travel	
LTC Solutions	Licensure		1,500					
Alpha Data Services	P/R Checks		592				Seminar Expense	1,204
Payday-USA	P/R Checks		3,110				SAK Allocation	10,563
Richard Peelo and Associates	Consulting		8,470					
RSM McGladrey	Accounting		2,375				Entertainment Expense	()
Misc Small Amounts	Consulting		300				(agree to Sch. V,	
Sharon Haugh	Accounting		3,600				line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 11,767
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 155,593					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lena Living Center

Provider #: 0047746

1/1/2008 to 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 155,593

Allocation from Management Company

Management Fees	(129,980)
Legal Fees	1,098
Accounting Fees	1,178
Consultanting Fees	799
Data Process Fees	817

Total (agree to Schedule V, line 19, column 8) 29,506

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center# 0047746Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$7,378
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,344 Line 10, C2
- (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. \$ 50,508
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? _____
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- 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? _____
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT