

Facility Name & ID Number Lena Living Center

0047746 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	52	186	2,788	3,026	8
9	SNF/PED					9
10	ICF	9,581	15,142	691	25,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,633	15,328	3,479	28,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.69%

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 2/27/06

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

YES Date 2/27/06 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 2,788

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	233,955	10,178	7,904	252,037		252,037		252,037		1
2	Food Purchase		177,858		177,858		177,858		177,858		2
3	Housekeeping	90,012	14,796		104,808		104,808		104,808		3
4	Laundry	59,849	10,675		70,524		70,524		70,524		4
5	Heat and Other Utilities			105,632	105,632		105,632	790	106,422		5
6	Maintenance	54,089	15,301	23,020	92,410		92,410		92,410		6
7	Other (specify):*										7
8	TOTAL General Services	437,905	228,808	136,556	803,269		803,269	790	804,059		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,260,840	75,744	3,845	1,340,429		1,340,429	107,362	1,447,791		10
10a	Therapy	6,897		324,377	331,274		331,274		331,274		10a
11	Activities	64,163	10,528		74,691		74,691		74,691		11
12	Social Services	28,390		4,697	33,087		33,087		33,087		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,360,290	86,272	341,319	1,787,881		1,787,881	107,362	1,895,243		16
	C. General Administration										
17	Administrative	146,890		87,408	234,298		234,298	(87,408)	146,890		17
18	Directors Fees										18
19	Professional Services			157,524	157,524		157,524	(109,566)	47,958		19
20	Dues, Fees, Subscriptions & Promotions			13,009	13,009		13,009	1,423	14,432		20
21	Clerical & General Office Expenses	54,457	12,095	7,513	74,065		74,065	10,840	84,905		21
22	Employee Benefits & Payroll Taxes			258,732	258,732		258,732		258,732		22
23	Inservice Training & Education							425	425		23
24	Travel and Seminar							22,791	22,791		24
25	Other Admin. Staff Transportation			29,542	29,542		29,542	1,028	30,570		25
26	Insurance-Prop.Liab.Malpractice			56,856	56,856		56,856	2,056	58,912		26
27	Other (specify):* Alloc. Benefits Mgmt							23,963	23,963		27
28	TOTAL General Administration	201,347	12,095	610,584	824,026		824,026	(134,448)	689,578		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,999,542	327,175	1,088,459	3,415,176		3,415,176	(26,296)	3,388,880		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:

1/1/09

Ending:

12/31/09

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			15,825	15,825		15,825	67,645	83,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,235	11,235		11,235	176,953	188,188			32
33	Real Estate Taxes			65,957	65,957		65,957		65,957			33
34	Rent-Facility & Grounds			273,307	273,307		273,307	(265,264)	8,043			34
35	Rent-Equipment & Vehicles			6,042	6,042		6,042	1,937	7,979			35
36	Other (specify):*											36
37	TOTAL Ownership			372,366	372,366		372,366	(18,729)	353,637			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,463		108,463		108,463		108,463			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):* Non-allowable cost	41,836	3,410	49,937	95,183		95,183	(95,183)				43
44	TOTAL Special Cost Centers	41,836	111,873	100,307	254,016		254,016	(95,183)	158,833			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,041,378	439,048	1,561,132	4,041,558		4,041,558	(140,208)	3,901,350			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

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(7,995)	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	(132,093)	30		9
10	Interest and Other Investment Income	(232)	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	(30,320)	43		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 PG5A	(58,688)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (229,328)		\$	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)	89,120		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 89,120		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (140,208)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Lena Living Center

ID# 0047746

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-allowable marketing events	\$ (51,738)	43	1
2	Labs Part A	(5,330)	43	2
3	X-Rays-Part A	(1,620)	43	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				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	(58,688)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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 Compr

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	\$ 273,307	Lena Property Partners, LLC		\$	(273,307)	1	
2	V	19 Legal		Lena Property Partners, LLC		12,370	12,370	2	
3	V	20 License & Permits		Lena Property Partners, LLC		250	250	3	
4	V	21 Clerical		Lena Property Partners, LLC		105	105	4	
5	V	32 Interest Expense		Lena Property Partners, LLC		176,049	176,049	5	
6	V	30 Depreciation		Lena Property Partners, LLC		198,152	198,152	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		\$ 273,307			\$ 386,926	\$ *	113,619	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	5 Utilities	\$	SAK Management Services, LLC	100.00%	\$ 790	\$	790	15
16	V	10 Nursing - Salaries		SAK Management Services, LLC	100.00%	107,362		107,362	16
17	V	17 Administrative - Salaries	87,408	SAK Management Services, LLC	100.00%			(87,408)	17
18	V	19 Professional Fees	131,112	SAK Management Services, LLC	100.00%	11,923		(119,189)	18
19	V	20 Dues,Fees & Subs		SAK Management Services, LLC	100.00%	1,173		1,173	19
20	V	21 Clerical		SAK Management Services, LLC	100.00%	7,988		7,988	20
21	V	21 Clerical - Salaries		SAK Management Services, LLC	100.00%				21
22	V	23 Training/Education		SAK Management Services, LLC	100.00%	425		425	22
23	V	24 Travel/Seminar		SAK Management Services, LLC	100.00%	22,791		22,791	23
24	V	25 Other Admin. Transp		SAK Management Services, LLC	100.00%	1,028		1,028	24
25	V	26 Insurance - Prop/Liability		SAK Management Services, LLC	100.00%	2,056		2,056	25
26	V	27 EE Benefits		SAK Management Services, LLC	100.00%	23,963		23,963	26
27	V	30 Depreciation Expense		SAK Management Services, LLC	100.00%	1,586		1,586	27
28	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	100.00%	8,044		8,044	28
29	V	35 Rent - Eqpt. & Vehicles		SAK Management Services, LLC	100.00%	1,937		1,937	29
30	V	43 Other		SAK Management Services, LLC	100.00%	1,819		1,819	30
31	V	32 Interest		SAK Management Services, LLC	100.00%	1,136		1,136	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 218,520			\$ 194,021	\$ *	(24,499)	39

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

**Related Nursing Homes
As of 12/31/08**

Schedule 6A

Group Name	Facility Name	City
SAK Management	Lena Living Center	Lena
	The Lincoln Home	Belleville
	St. Anthony's Nursing & Rehab Ctr	Rock Island
	Thornton Heights Terrace	Chicago Heights
	Coventry Living Center, LLC	Sterling
	Parkview Terrace	East Moline
	Walnut Grove Village, LLC	Morris
	Woodbine Nursing Home, LLC	Oak Park

See Accountants' Compilation Report

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	SAK Management Fees	1,513,288	7	\$ 6,164	\$ 194,021	\$ 790	1	
2	10	Nursing - Salaries	SAK Management Fees	1,513,288	7	837,385	837,385	194,021	107,362	2
3	17	Administrative - Salaries	SAK Management Fees	1,513,288	7		194,021	0	3	
4	19	Professional Fees	SAK Management Fees	1,513,288	7	92,992	194,021	11,923	4	
5	20	Dues,Fees & Subs	SAK Management Fees	1,513,288	7	9,149	194,021	1,173	5	
6	21	Clerical	SAK Management Fees	1,513,288	7	62,308	194,021	7,989	6	
7	21	Clerical - Salaries	SAK Management Fees	1,513,288	7		194,021	0	7	
8	23	Training/Education	SAK Management Fees	1,513,288	7	3,317	194,021	425	8	
9	24	Travel/Seminar	SAK Management Fees	1,513,288	7	177,763	194,021	22,791	9	
10	25	Other Admin. Transp	SAK Management Fees	1,513,288	7	8,017	194,021	1,028	10	
11	26	Insurance - Prop/Liability	SAK Management Fees	1,513,288	7	16,036	194,021	2,056	11	
12	27	EE Benefits	SAK Management Fees	1,513,288	7	186,903	194,021	23,963	12	
13	30	Depreciation Expense	SAK Management Fees	1,513,288	7	12,368	194,021	1,586	13	
14	34	Rent - Facility & Grounds	SAK Management Fees	1,513,288	7	62,736	194,021	8,043	14	
15	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,513,288	7	15,106	194,021	1,937	15	
16	43	Other	SAK Management Fees	1,513,288	7	14,184	194,021	1,819	16	
17	32	Interest	SAK Management Fees	1,513,288	7	8,860	194,021	1,136	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,513,288	\$ 837,385	\$ 194,021	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lena Living Center

0047746

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	Name of Lender	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	2/27/06	\$ 3,000,000	\$ 2,747,429	3/31/10	7.5000	\$ 201,492	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	First Choice Bank		X	Working Capital	Variable	2/06		135,237	2/19/10	Variable	11,235	6						
7												7						
8												8						
9	TOTAL Facility Related				\$24,170.00		\$ 3,000,000	\$ 2,882,666			\$ 212,727	9						
B. Non-Facility Related*																		
10								Offset Interest Income			(25,675)	10						
11								Allocated from Mgmt Co.			1,136	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (24,539)	14						
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,882,666			\$ 188,188	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.)

Facility Name & ID Number Lena Living Center

0047746 Report Period Beginning:

1/1/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,546 B. General Construction Type: Exterior Brick/Stucco Frame Wood Number of Stories 1

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:

A. Land.

	1	2	3	4	
	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

Facility Name & ID Number Lena Living Center

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	\$ 173,853	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Nurse Call Station	2006		2,370	580	20	119	(462)	1,157	9
10	Heartland Fire & Security Call System	2006		5,453	1,335	20	273	(1,062)	2,660	10
11	Champion Roofing Services	2006		3,800	274	20	190	(84)	654	11
12	Quality Electric	2007		3,640	263	20	182	(81)	627	12
13	Carpet Replacement	2007		2,535	419	20	127	(292)	673	13
14	Fire System Upgrade	2007		4,756	680	20	238	(442)	1,156	14
15	Rewire Nurse Station	2007		2,953	422	20	148	(274)	718	15
16	Water Heater	2007		11,416	1,631	7	1,631	(0)	4,893	16
17	New Doors	2008		2,784	139	20	139	0	209	17
18	Boiler	2008		22,208	1,110	20	1,110	0	1,665	18
19	Door & Related Repairs	2008		4,293	429	20	215	(214)	322	19
20	Carpentry and plumbing	2009		13,167	2,633	5	1,317	(1,316)	1,317	20
21	Leaks in water heater	2009		12,987	2,597	5	1,299	(1,298)	1,299	21
22	Install Heating Pumps	2009		4,494	899	5	449	(450)	449	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
			1,406,856		40,185	26,774	191,650	
			13,411					

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lena Living Center

0047746

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 412,064	\$ 1,882	\$ 41,401	\$ 39,519		\$ 131,565	71
72	Current Year Purchases	2,981	532	298	(234)		298	72
73	Fully Depreciated Assets							73
74	Alloc Mgmt Co.			1,586	1,586		1,586	74
75	TOTALS	\$ 415,045	\$ 2,414	\$ 43,285	\$ 40,871		\$ 133,449	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)	\$ 2,111,901	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,470	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,645	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 325,099	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	<u>Alloc. From Mgmt. Co.</u>			<u>8,043</u>			6
7	TOTAL			\$ <u>8,043</u>			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 N/A
by the length of the lease N/A.

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: \$ 7,979 Description: Copier Lease-\$2,786;Nursing Equip-\$3,256;Alloc. Mgmt Co.-1937

(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. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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? <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. <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.
- 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,3	hrs	\$	424	\$ 29,226	\$	424	\$ 29,226	1
2	Licensed Speech and Language Development Therapist	L10A,3	hrs		2,179	150,378		2,179	150,378	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,1&3	96 hrs	6,897	2,098	144,773		2,194	151,670	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,2	# of prescrpts				101,433		101,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Oxygen</u>	L39,2					7,030		7,030	13
14	TOTAL			\$ 6,897	4,701	\$ 324,377	\$ 108,463	4,797	\$ 439,737	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 123,896	\$ 127,565	1
2	Cash-Patient Deposits	5,325	5,325	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>101,000</u>)	452,779	452,779	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,175	32,801	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached Sch 17A</u>	57,465	158,798	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 645,640	\$ 777,268	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	72,014	1,406,856	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	38,969	415,045	16
17	Accumulated Depreciation (book methods)	(37,677)	(325,099)	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>		1,016,342	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 73,306	\$ 2,803,144	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 718,946	\$ 3,580,412	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 141,110	\$ 141,110	26
27	Officer's Accounts Payable	101,333	101,333	27
28	Accounts Payable-Patient Deposits	5,325	5,325	28
29	Short-Term Notes Payable	135,237	135,237	29
30	Accrued Salaries Payable	156,802	156,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,864	8,864	31
32	Accrued Real Estate Taxes(Sch.IX-B)		74,049	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</u>	2,377	2,377	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 551,048	\$ 625,097	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,747,429	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,747,429	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 551,048	\$ 3,372,526	46
47	TOTAL EQUITY(page 18, line 24)	\$ 167,898	\$ 207,886	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 718,946	\$ 3,580,412	48

Lena Living Center
Provider # 0047746
1/1/09-12/31/09

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Other Current Assets-Line 9		
Cost Report Settlement	53,285	53,285
Due from Lessor/Prior owner	4,180	105,513
	<u>57,465</u>	<u>158,798</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (72,282)	1
2	Restatements (describe):		2
3	Prior period adjustment	(72,352)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (144,634)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	332,532	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) Partner Draws	(20,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 312,532	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)	\$ 167,898	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	\$ 3,488,335	1
2	Discounts and Allowances for all Levels	(51,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,436,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	633,699	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 633,699	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	165,209	16
17	Sale of Drugs	99,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	35,448	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 299,762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	232	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 232	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Income</u>	3,449	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,449	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,374,090	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	803,269	31
32	Health Care	1,787,881	32
33	General Administration	824,026	33
	B. Capital Expense		
34	Ownership	372,366	34
	C. Ancillary Expense		
35	Special Cost Centers	203,646	35
36	Provider Participation Fee	50,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,041,558	40
41	Income before Income Taxes (line 30 minus line 40)**	332,532	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 332,532	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:

1/1/09

Ending:

12/31/09

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	801	1,054	\$ 34,107	\$ 32.36	1
2	Assistant Director of Nursing	2,145	2,306	48,685	21.11	2
3	Registered Nurses	7,777	8,396	195,357	23.27	3
4	Licensed Practical Nurses	18,644	20,048	364,650	18.19	4
5	CNAs & Orderlies	54,784	59,424	546,464	9.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	746	773	6,897	8.92	8
9	Activity Director					9
10	Activity Assistants	6,454	7,005	64,163	9.16	10
11	Social Service Workers	1,956	2,141	28,390	13.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,562	25,617	233,955	9.13	15
16	Dishwashers					16
17	Maintenance Workers	4,741	5,098	54,089	10.61	17
18	Housekeepers	8,897	9,680	90,012	9.30	18
19	Laundry	6,648	7,243	59,849	8.26	19
20	Administrator	2,192	2,463	99,563	40.42	20
21	Assistant Administrator	1,108	1,288	47,327	36.74	21
22	Other Administrative					22
23	Office Manager	2,097	2,330	23,882	10.25	23
24	Clerical	3,020	3,226	30,575	9.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,821	2,023	20,941	10.35	31
32	Other Health C: MDS Coordinator	2,291	2,518	50,636	20.11	32
33	Other(specify) <u>Marketing</u>	1,744	1,897	41,836	22.05	33
34	TOTAL (lines 1 - 33)	151,428	164,530	\$ 2,041,378 *	\$ 12.41	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	198	\$ 7,904	L1,C3	35
36	Medical Director	120	8,400	L10,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	81	3,252	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				44
45	Social Service Consultant	235	4,697	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	634	\$ 24,253		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: **1/1/09**

Ending: **12/31/09**

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		
David Lenzo	Administrator	0%	\$ 99,563	Workers' Compensation Insurance	\$ 61,673	IDPH License Fee	\$		
Ruth Kruse	Assistant Administrator	0%	47,327	Unemployment Compensation Insurance	21,788	Advertising: Employee Recruitment	1,888		
				FICA Taxes	119,444	Health Care Worker Background Check	1,430		
				Employee Health Insurance	53,019	(Indicate # of checks performed <u>212</u>)			
				Employee Meals		Patient Background Checks	92.5 1,110		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	7,562		
				Employee Physicals	112	Miscellaneous Licenses & Fees	729		
				Other Employee Benefits	2,696	Miscellaneous Dues & Subscriptions	290		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 146,890	TOTAL (agree to Schedule V, line 22, col.8)		\$ 258,732	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,432
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 (Eliminated in Col. 7 on page 3)			\$ 87,408	N/A			Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Allocated from Mgmt Co.	22,791	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 87,408	TOTAL		\$	Entertainment Expense	()	
C. Professional Services									
Vendor/Payee	Type	Amount							
Aronberg Goldgehn Davis & Garmis	Legal	\$ 290							
Richard Peelo & Associates, Inc.	Cost Report Prep	4,200							
McGladrey & Pullen, LLP	Cost Report Prep	5,010							
RSM McGladrey, Inc.	Tax Prep	2,500							
Sharon Lofgren	Medicare Billing	3,600							
Personnel Planners, Inc.	HR Consulting	300							
HDSI	A/R System Services	5,530							
LTC Solutions	Licensure	1,500							
Payday USA	P/R Checks	3,482							
SAK Management	Accounting	131,112							
See Schedule 21C									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 157,524	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 22,791

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lena Living Center
Provider # 0047746
1/1/09-12/31/09

Schedule 21C

XIX. Support Schedule
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	157,524
Allocation from Management Company	
Management Fees to remove related party charges	(131,112)
Legal Fees	9,429
Accounting Fees	294
Consulting Fees	1,588
Data Processing Fees	612
Real Estate Entity	
Legal	9,623
Total (agree to Schedule V, line 19, column 8)	<u><u>47,958</u></u>

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	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
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# 0047746

Report Period Beginning:

1/1/09

Ending:

12/31/09**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-\$7,562
- (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. \$ 16,338 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
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? 0
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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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