		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047746

Facility Name: Lena Living Center

Address: 1010 South Logan Street (Number) Lena (City) 61048 (Zip Code)

County: Stephenson

Telephone Number: (815) 369-4561 **Fax #** (815) 369-2900

HFS ID Number:

Date of Initial License for Current Owners: 2/27/06

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address: mike.martin@mcgladrey.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	374	501	6,419	7,294	8
9	SNF/PED					9
10	ICF	9,714	13,225		22,939	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,088	13,726	6,419	30,233	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.03%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 2/27/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/27/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 3,550

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	213,311	20,990	10,532	244,833		244,833		244,833			1
2	Food Purchase		189,055		189,055		189,055		189,055			2
3	Housekeeping	92,020	17,060		109,080		109,080		109,080			3
4	Laundry	55,452	9,271		64,723		64,723		64,723			4
5	Heat and Other Utilities			132,890	132,890		132,890	789	133,679			5
6	Maintenance	47,924	17,643	29,126	94,693		94,693		94,693			6
7	Other (specify):*											7
8	TOTAL General Services	408,707	254,019	172,548	835,274		835,274	789	836,063			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,312,527	100,419	3,090	1,416,036		1,416,036	218,842	1,634,878			10
10a	Therapy	1,078		335,825	336,903		336,903		336,903			10a
11	Activities	64,883	10,330		75,213		75,213		75,213			11
12	Social Services	16,281			16,281		16,281		16,281			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,394,769	110,749	347,315	1,852,833		1,852,833	218,842	2,071,675			16
	C. General Administration											
17	Administrative	126,619		95,797	222,416		222,416	(95,797)	126,619			17
18	Directors Fees											18
19	Professional Services			189,997	189,997		189,997	(126,284)	63,713			19
20	Dues, Fees, Subscriptions & Promotions			11,539	11,539		11,539	1,779	13,318			20
21	Clerical & General Office Expenses	55,810	15,011	8,070	78,891		78,891	9,988	88,879			21
22	Employee Benefits & Payroll Taxes			251,749	251,749		251,749		251,749			22
23	Inservice Training & Education							233	233			23
24	Travel and Seminar			807	807		807	27,297	28,104			24
25	Other Admin. Staff Transportation			50,053	50,053		50,053	(4,278)	45,775			25
26	Insurance-Prop.Liab.Malpractice			56,856	56,856		56,856	1,700	58,556			26
27	Other (specify):* Alloc. Benefits Mgmt (							24,362	24,362			27
28	TOTAL General Administration	182,429	15,011	664,868	862,308		862,308	(161,000)	701,308			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,985,905	379,779	1,184,731	3,550,415		3,550,415	58,631	3,609,046			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: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,333	20,333		20,333	69,922	90,255			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,093	6,093		6,093	162,721	168,814			32
33	Real Estate Taxes			65,145	65,145		65,145		65,145			33
34	Rent-Facility & Grounds			505,495	505,495		505,495	(497,884)	7,611			34
35	Rent-Equipment & Vehicles			13,851	13,851		13,851	6,912	20,763			35
36	Other (specify):*											36
37	TOTAL Ownership			610,917	610,917		610,917	(258,329)	352,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,252		159,252		159,252		159,252			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 Cos	69,595	3,573	66,365	139,533		139,533	(139,533)				43
44	TOTAL Special Cost Centers	69,595	162,825	116,735	349,155		349,155	(139,533)	209,622			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,055,500	542,604	1,912,383	4,510,487		4,510,487	(339,231)	4,171,256			45

***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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,035)	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	(122,784)	30		9
10	Interest and Other Investment Income	(218)	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	(33,000)	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 Pg 5A	(107,578)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (270,615)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(68,616)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (68,616)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (339,231)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lena Living Center

ID# 0047746

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-allowable marketing events	$ (84,400)	43	1
2	Labs Part A	(9,864)	43	2
3	X-Rays-Part A	(5,234)	43	3
4	Marketing Expenses	(8,080)	19	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**	(107,578)		49

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	Mgmt. Co.

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

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 505,495	Lena Property Partners, LLC		$	$ (505,495)	1
2	V		20	License & Permits		Lena Property Partners, LLC		250	250	2
3	V		21	Clerical		Lena Property Partners, LLC		146	146	3
4	V		32	Interest Expense		Lena Property Partners, LLC		161,408	161,408	4
5	V		30	Depreciation		Lena Property Partners, LLC		191,541	191,541	5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 505,495			$ 353,345	$ * (152,150)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	SAK Management Services, LLC	100.00%	$ 789	$ 789	15
16	V	10	Nursing - Salaries		SAK Management Services, LLC	100.00%	218,842	218,842	16
17	V	17	Administrative - Salaries	95,797	SAK Management Services, LLC	100.00%		(95,797)	17
18	V	19	Professional Fees	143,696	SAK Management Services, LLC	100.00%	25,492	(118,204)	18
19	V	20	Dues,Fees & Subs		SAK Management Services, LLC	100.00%	1,529	1,529	19
20	V	21	Clerical		SAK Management Services, LLC	100.00%	9,842	9,842	20
21	V	23	Training/Education		SAK Management Services, LLC	100.00%	233	233	21
22	V	24	Travel/Seminar		SAK Management Services, LLC	100.00%	27,297	27,297	22
23	V	25	Other Admin. Transp		SAK Management Services, LLC	100.00%	1,186	1,186	23
24	V	26	Insurance - Prop/Liability		SAK Management Services, LLC	100.00%	1,700	1,700	24
25	V	27	EE Benefits		SAK Management Services, LLC	100.00%	24,362	24,362	25
26	V	30	Depreciation Expense		SAK Management Services, LLC	100.00%	1,164	1,164	26
27	V	32	Interest		SAK Management Services, LLC	100.00%	1,532	1,532	27
28	V	34	Rent - Facility & Grounds		SAK Management Services, LLC	100.00%	7,611	7,611	28
29	V	35	Rent - Eqpt. & Vehicles		SAK Management Services, LLC	100.00%	1,448	1,448	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 239,493			$ 323,027	$ * 83,534	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Related Nursing Homes **Schedule 6A**

As of 12/31/10

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
	Parkview Terrace	East Moline

See Accountants' Compilation Report

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	SAK Management Fees	1,673,164	16	$ 5,514	$	239,494	$ 789	1
2	10	Nursing - Salaries	SAK Management Fees	1,673,164	16	1,528,886	1,528,886	239,494	218,842	2
3	17	Administrative - Salaries	SAK Management Fees	1,673,164	16			239,494	0	3
4	19	Professional Fees	SAK Management Fees	1,673,164	16	178,094		239,494	25,492	4
5	20	Dues,Fees & Subs	SAK Management Fees	1,673,164	16	10,680		239,494	1,529	5
6	21	Clerical	SAK Management Fees	1,673,164	16	68,758		239,494	9,842	6
7	21	Clerical - Salaries	SAK Management Fees	1,673,164	16			239,494	0	7
8	23	Training/Education	SAK Management Fees	1,673,164	16	1,630		239,494	233	8
9	24	Travel/Seminar	SAK Management Fees	1,673,164	16	199,549		239,494	28,563	9
10	25	Other Admin. Transp	SAK Management Fees	1,673,164	16	8,286		239,494	1,186	10
11	26	Insurance - Prop/Liability	SAK Management Fees	1,673,164	16	11,874		239,494	1,700	11
12	27	EE Benefits	SAK Management Fees	1,673,164	16	170,199		239,494	24,362	12
13	30	Depreciation Expense	SAK Management Fees	1,673,164	16	8,130		239,494	1,164	13
14	34	Rent - Facility & Grounds	SAK Management Fees	1,673,164	16	53,174		239,494	7,611	14
15	35	Rent - Eqpt. & Vehicles	SAK Management Fees	1,673,164	16	10,117		239,494	1,448	15
16	43	Other	SAK Management Fees	1,673,164	16			239,494	0	16
17	32	Interest	SAK Management Fees	1,673,164	16	10,705		239,494	1,532	17
18										18
19	24	Travel/Seminar	Direct	225,034					(1,266)	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,265,596	$ 1,528,886		$ 323,027	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Choice Bank		X	Mortgage	$24,170.00	2/27/06	$ 3,000,000	$ 2,664,824	3/31/10	7.5000	$ 174,470	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Choice Bank		X	Working Capital	Variable	2/06			2/19/10	Variable	6,093	6
7												7
8												8
9	TOTAL Facility Related				$24,170.00		$ 3,000,000	$ 2,664,824			$ 180,563	9
	B. Non-Facility Related*											
10								Offset Interest Income			(13,281)	10
11								Allocated from Mgmt Co.			1,532	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,749)	14
15	TOTALS (line 9+line14)						$ 3,000,000	$ 2,664,824			$ 168,814	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' 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: 1/1/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 74,049	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 64,076	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,973)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,918	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Unreconciled Difference**	(800)	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 65,145	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	59,359	8
2006	59,723	9
2007	59,821	10
2008	63,076	11
2009	64,076	12

Real estate tax accrual based on prior year taxes plus inflation.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 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 Koenig

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-12-04-102-001	Long-Term Care Property	$ 45,552.50	$ 45,552.50
2.	10-12-04-101-006	Long-Term Care Property	$ 567.30	$ 567.30
3.	10-12-04-101-001	Long-Term Care Property	$ 17,956.64	$ 17,956.64
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,076.44	$ 64,076.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 1/1/10 Ending: 12/31/10

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		2006		$ 1,310,000	$	40	$ 32,750	$ 32,750	$ 206,603	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Station			2006	2,370	580	20	119	(461)	1,276	9
10	Heartland Fire & Security Call System			2006	5,453	1,335	20	273	(1,062)	2,933	10
11	Quality Electric			2007	3,640	263	20	182	(81)	809	11
12	Carpet Replacement			2007	2,535	419	20	127	(292)	800	12
13	Fire System Upgrade			2007	4,756	680	20	238	(442)	1,394	13
14	Rewire Nurse Station			2007	2,953	422	20	148	(274)	866	14
15	Water Heater			2007	11,416	1,631	7	1,631		6,524	15
16	New Doors			2008	2,784	139	20	139		348	16
17	Boiler			2008	22,208	1,110	20	1,110		2,775	17
18	Door & Related Repairs			2008	4,293	429	20	215	(214)	537	18
19	Carpentry and plumbing			2009	13,167	2,633	5	2,633	0	3,950	19
20	Leaks in water heater			2009	12,987	2,597	5	2,597	0	3,896	20
21	Install Heating Pumps			2009	4,494	899	5	899	(0)	1,348	21
22											22
23	Carpentry and Plumbing			2010	20,510	2,051	5	2,051		2,051	23
24	Heating and Air Conditioning			2010	6,777	678	5	678		678	24
25	Plumbing			2010	3,177	318	5	318		318	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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,433,520	$ 16,183		$ 46,108	$ 29,925	$ 237,105	70

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: 1/1/10 Ending: 12/31/10

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	$ 415,045	$ 2,299	$ 41,889	$ 39,590	10/5	$ 175,338	71
72	Current Year Purchases	10,941	1,851	1,094	(757)	5	1,094	72
73	Fully Depreciated Assets							73
74	Alloc Mgmt Co.			1,164	1,164		1,164	74
75	TOTALS	$ 425,986	$ 4,150	$ 44,147	$ 39,997		$ 177,596	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)	$	2,149,506	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	20,333	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	90,255	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	69,922	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	414,701	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

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Mgmt. Co.				7,611			6
7	TOTAL				$ 7,611 **			7

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

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 15,299 Description: Copier Lease-$3,409;Nursing Equip-$10,442;Alloc. Mgmt Co.-$1,448
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2010 Lexus RX350	$ 731.68	$ 5,464	17
18					18
19					19
20					20
21	TOTAL		$ 731.68	$ 5,464	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A,3	hrs	$	2,120	$ 146,285	$	2,120	$ 146,285	1
2	Licensed Speech and Language Development Therapist	L10A,3	hrs		288	19,895		288	19,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,1&3	hrs		2,459	169,645		2,459	169,645	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				156,564		156,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Oxygen	L39,2					2,688		2,688	13
14	TOTAL			$	4,867	$ 335,825	$ 159,252	4,867	$ 495,077	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

STATE OF ILLINOIS

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 360,115	$ 523,479	1
2	Cash-Patient Deposits	8,296	8,296	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 134,000)	393,330	393,330	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,612	52,181	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Sch 17A	14,292	301,878	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 797,645	$ 1,279,164	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	103,717	1,433,520	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	44,871	425,986	16
17	Accumulated Depreciation (book methods)	(58,010)	(414,701)	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): Construction Reserve		1,029,405	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 90,578	$ 2,764,210	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 888,223	$ 4,043,374	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,261	$ 57,261	26
27	Officer's Accounts Payable	287,586	287,586	27
28	Accounts Payable-Patient Deposits	8,296	8,296	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,337	121,337	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,781	10,781	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,918	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Medicaid Audit Liability	50,000	50,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 535,261	$ 611,179	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,664,824	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)**	$	$ 2,664,824	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 535,261	$ 3,276,003	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 352,962	$ 767,371	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 888,223	$ 4,043,374	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lena Living Center
Provider # 0047746
1/1/10-12/31/10

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Other Current Assets-Line 9		
Cost Report Settlement	14,292	14,292
Due from Lessor/Prior owner	0	287,586
	14,292	301,878

See Accountants' Compilation Report

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 167,898	1
2	Restatements (describe):		2
3	Prior period adjustment	(76,737)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 91,161	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	281,801	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	(20,000)	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)**	$ 261,801	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)**	$ 352,962	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,716,672	1
2	Discounts and Allowances for all Levels	(247,125)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,469,547	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	931,679	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 931,679	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	156,271	16
17	Sale of Drugs	181,509	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	50,864	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 388,644	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	218	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 218	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	2,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,792,288	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	835,274	31
32	Health Care	1,852,833	32
33	General Administration	862,308	33
	B. Capital Expense		
34	Ownership	610,917	34
	C. Ancillary Expense		
35	Special Cost Centers	298,785	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)***	$ 4,510,487	40
41	**Income before Income Taxes (line 30 minus line 40)****	281,801	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 281,801	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: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,080	$ 78,771	$ 37.87	1
2	Assistant Director of Nursing	1,960	2,080	45,762	22.00	2
3	Registered Nurses	10,797	11,657	251,261	21.55	3
4	Licensed Practical Nurses	19,332	20,533	366,422	17.85	4
5	CNAs & Orderlies	56,981	59,735	516,064	8.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	153	153	1,078	7.05	8
9	Activity Director					9
10	Activity Assistants	6,399	6,782	64,883	9.57	10
11	Social Service Workers	1,051	1,261	16,281	12.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,480	21,646	213,311	9.85	15
16	Dishwashers					16
17	Maintenance Workers	4,256	4,658	47,924	10.29	17
18	Housekeepers	10,983	11,879	92,020	7.75	18
19	Laundry	4,869	5,519	55,452	10.05	19
20	Administrator	2,032	2,080	82,113	39.48	20
21	Assistant Administrator	1,237	1,333	44,506	33.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,771	4,377	55,810	12.75	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	1,706	1,896	19,625	10.35	31
32	Other Health Ca MDS Coordinator	1,376	1,720	34,622	20.13	32
33	Other(specify) Marketing	3,208	3,400	69,595	20.47	33
34	TOTAL (lines 1 - 33)	152,543	162,789	$ 2,055,500 *	$ 12.63	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	280	$ 10,532	L1,C3	35
36	Medical Director	Monthly	8,400	L10,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,082	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	$ 21,014		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Lenzo	Administrator	0	$ 82,113
Ruth Kruse	Asst. Administrator	0	44,506
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,619

B. Administrative - Other

Description	Amount
SAK Management Services	$ 95,797
(Eliminated in Col. 7 on page 3)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 95,797
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aronberg Goldgehn Davis & Garmis	Legal	$ 150
Richard Peelo & Associates, Inc.	Cost Report Prep	4,200
McGladrey & Pullen, LLP	Cost Report Prep/Acctg.	6,992
Sharon Lofgren	Medicare Billing	3,600
Personnel Planners, Inc.	HR Consulting	950
HDSI	A/R System Services	5,514
LTC Solutions	Licensure	1,800
Payday USA	P/R Checks	3,449
Midwest Renovation & Restoration	Renovation Consulting	11,316
ADP	P/R Checks	250
See Schedule 21C		151,776
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 189,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,675
Unemployment Compensation Insurance	18,541
FICA Taxes	130,486
Employee Health Insurance	37,587
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	118
Other Employee Benefits	3,342
TOTAL (agree to Schedule V, line 22, col.8)	$ 251,749

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,730
Health Care Worker Background Check	1,300
(Indicate # of checks performed 193)	
Patient Background Checks 201	1,360
Illinois Council on Long Term Care	4,057
Miscellaneous Licenses & Fees	865
Miscellaneous Dues & Subscriptions	237
Alloc. From Mgmt Co.	1,529
Alloc. From RE Entity	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,318

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	807
Allocated from Mgmt Co.	27,297
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,104

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 21C

XIX. Support Schedule

C. Professional Services

From Page 21 Lines 28-37			38,221
	SAK Management	Accouting	143,696
	Kay Wallin	Marketing Consulting	2,280
	Valerie S. Kretchmer Assoc., Inc.	Market Study	5,800
Total (agree to Schedule V, line 19, column 3)			189,997
Allocation from Management Compnay			
	Management Fees to remove related party charges		(143,696)
	Legal Fees		2,200
	Accounting Fees		7,410
	Consulting Fees		14,757
	Data Processing Fees		1,125
Less: Non-Allowable			
	Kay Wallin	Marketing Consulting	(2,280)
	Valerie S. Kretchmer Assoc., Inc.	Market Study	(5,800)
Total (agree to Schedule V, line 19, column 8)			253,710

See Accountants' Complilation Report

Facility Name & ID Number Lena Living Center # 0047746 Report Period Beginning: 1/1/10 Ending: 12/31/10

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 1/1/10 Ending: 12/31/10

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 - $ 4,057**

(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. $ **17,368** Line **10-2**

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.