

		FOR BHF USE					

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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

<p><b>I. IDPH License ID Number:</b> <u>0034678</u></p> <p><b>Facility Name:</b> <u>THE LINCOLN HOME</u></p> <p><b>Address:</b> <u>150 NORTH 27TH STREET</u> <u>BELLEVILLE</u> <u>62226</u>          Number City Zip Code</p> <p><b>County:</b> <u>SINCLAIR</u></p> <p><b>Telephone Number:</b> <u>( 618 ) 235-6600</u> <b>Fax #</b> <u>( 618 ) 235-7555</u></p> <p><b>HFS ID Number:</b> <u>37-1237031001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/88</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARTIN WEISS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u></td> <td></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>MARTIN WEISS</u>			(Title) <u>PRESIDENT</u>		<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>	
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Facility Name & ID Number THE LINCOLN HOME

# 0034678 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	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	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,940	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,632	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			7,648	7,648	8
9	SNF/PED					9
10	ICF	33,016	7,914	2,039	42,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,016	7,914	9,687	50,617	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

D. How many bed-hold days during this year were paid by the Department? 0 (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

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 09/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 09/88 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 62 and days of care provided 7,648

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number **THE LINCOLN HOME** # **0034678** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	243,769	29,497	12,320	285,586		285,586		285,586		1
2	Food Purchase		251,182		251,182		251,182	(954)	250,228		2
3	Housekeeping	79,254	32,199		111,453		111,453		111,453		3
4	Laundry	32,082	20,537	2,743	55,362		55,362		55,362		4
5	Heat and Other Utilities			161,655	161,655		161,655		161,655		5
6	Maintenance	84,399	38,818	186,927	310,144		310,144		310,144		6
7	Other (specify):*			12,649	12,649		12,649		12,649		7
8	<b>TOTAL General Services</b>	<b>439,504</b>	<b>372,233</b>	<b>376,294</b>	<b>1,188,031</b>		<b>1,188,031</b>	<b>(954)</b>	<b>1,187,077</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,132,880	175,496	37,628	2,346,004		2,346,004	(30,000)	2,316,004		10
10a	Therapy										10a
11	Activities	95,590	6,872	1,285	103,747		103,747		103,747		11
12	Social Services	62,664	1,506	1,365	65,535		65,535		65,535		12
13	CNA Training										13
14	Program Transportation			7,156	7,156		7,156		7,156		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,291,134</b>	<b>183,874</b>	<b>77,434</b>	<b>2,552,442</b>		<b>2,552,442</b>	<b>(30,000)</b>	<b>2,522,442</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	106,105		420,000	526,105		526,105	52,619	578,724		17
18	Directors Fees										18
19	Professional Services			406,366	406,366		406,366	(296,540)	109,826		19
20	Dues, Fees, Subscriptions & Promotions			59,937	59,937		59,937	(34,700)	25,237		20
21	Clerical & General Office Expenses	173,281	26,239	50,725	250,245		250,245	(31,196)	219,049		21
22	Employee Benefits & Payroll Taxes			489,854	489,854		489,854		489,854		22
23	Inservice Training & Education							540	540		23
24	Travel and Seminar			17,945	17,945		17,945	282	18,227		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			138,847	138,847		138,847	15,278	154,125		26
27	Other (specify):*							34,148	34,148		27
28	<b>TOTAL General Administration</b>	<b>279,386</b>	<b>26,239</b>	<b>1,583,674</b>	<b>1,889,299</b>		<b>1,889,299</b>	<b>(259,569)</b>	<b>1,629,730</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,010,024</b>	<b>582,346</b>	<b>2,037,402</b>	<b>5,629,772</b>		<b>5,629,772</b>	<b>(290,523)</b>	<b>5,339,249</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,959
	REPAIRS & MAINTENANCE	361
		0
		12,320
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,743
		0
		2,743
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	36,615
	ELECTRICITY	85,788
	WATER	37,282
	CABLE TV - LOBBY	1,970
		0
		161,655
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	21,268
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,289
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	158,575
	EXTERMINATING SERVICE	0
	FIRE SERVICE	5,795
		0
		0
		0
		0
		186,927
<b>7</b>	<b>OTHER</b>	
	SCAVENGER & EXTERMINATING SERVICE	12,649
	SECURITY SERVICE	0
		0
		0
		12,649
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	838
	PHARMACY CONSULTANT XVIII B 39-2	4,100
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	
	PSYCHIATRIC XVIII B ___-2	2,000
	RN CONSULTANT XVIII B 38-2	30,690
		0
		0
		37,628
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,285
		0
		1,285
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,365
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,365
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	7,156
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	420,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	6,728
	ADMINISTRATIVE CONSULTANTS XIX C	300,000
	PROFESSIONAL FEES XIX C	99,638
		0
		406,366
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	27,691
	EMPLOYEE WANT ADS XIX F	7,892
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,965
	LICENSES & PERMITS XIX F	1,850
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,009
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,885
	PATIENT BACKGROUND CHECKS XIX F	2,645
		59,937
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,085
	EQUIPMENT REPAIR & MAINTENANCE	22,587
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	105
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	24,243
	MESSENGER SERVICE	2,705
		0
		50,725

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	236,783
	UNEMPLOYMENT COMPENSATION XIX D	69,007
	WORKERS COMPENSATION INSURANC XIX D	108,800
	HOSPITALIZATION INSURANCE XIX D	69,308
	EMPLOYEE BENEFITS - OTHER XIX D	5,956
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		489,854
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	550
	TRAVEL XIX G	17,395
		17,945
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	0
		0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	138,847
		138,847
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,037,402

**THE LINCOLN HOME  
SCHEDULES  
12/31/2008**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	251,182
LESS SALES TAX	<u>(954)</u>
NET FOOD	250,228

TOTAL PATIENT CENSUS	50,617
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	151,851

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	151,851
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	151,851

NET FOOD	250,228
DIVIDE TOTAL MEALS/YEAR	<u>151,851</u>

COST PER MEAL	1.65
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

=====

Facility Name &amp; ID Number

THE LINCOLN HOME

#0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			40,339	40,339		40,339	158,685	199,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,822	32,822		32,822	245,089	277,911			32
33	Real Estate Taxes			2,650	2,650		2,650	47,974	50,624			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(468,239)	11,761			34
35	Rent-Equipment & Vehicles			9,004	9,004		9,004	18,481	27,485			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			564,815	564,815		564,815	1,990	566,805			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,569	659,666	931,235		931,235		931,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,448	83,448		83,448		83,448			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		271,569	743,114	1,014,683		1,014,683		1,014,683			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,010,024	853,915	3,345,331	7,209,270		7,209,270	(288,533)	6,920,737			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,452)	30		9
10	Interest and Other Investment Income	(1,902)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(954)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(105)	21		18
19	Entertainment		20		19
20	Contributions	(7,009)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,182)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(27,691)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(39,758)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (115,053)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(173,480)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (173,480)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (288,533)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

THE LINCOLN HOME

ID# 0034678

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	MARKETING SALARIES	(39,758)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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	<b>Total</b>	(39,758)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(954)	0	0	0	0	0	0	0	0	0	0	(954)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(954)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(954)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(30,000)	0	0	0	0	0	0	0	0	(30,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>(30,000)</b>	<b>0</b>	<b>(30,000)</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	52,619	0	0	0	0	0	0	0	0	52,619	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,182)	0	(294,358)	0	0	0	0	0	0	0	0	(296,540)	19
20	Fees, Subscriptions & Promotions	(34,700)	0	0	0	0	0	0	0	0	0	0	(34,700)	20
21	Clerical & General Office Expenses	(39,863)	0	8,667	0	0	0	0	0	0	0	0	(31,196)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	540	0	0	0	0	0	0	0	0	540	23
24	Travel and Seminar	0	0	282	0	0	0	0	0	0	0	0	282	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	14,710	568	0	0	0	0	0	0	0	0	15,278	26
27	Other (specify):*	0	0	34,148	0	0	0	0	0	0	0	0	34,148	27
28	<b>TOTAL General Administration</b>	<b>(76,745)</b>	<b>14,710</b>	<b>(197,534)</b>	<b>0</b>	<b>(259,569)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(77,699)</b>	<b>14,710</b>	<b>(227,534)</b>	<b>0</b>	<b>(290,523)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE LINCOLN HOME# 0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(35,452)	194,137	0	0	0	0	0	0	0	0	0	158,685	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,902)	246,991	0	0	0	0	0	0	0	0	0	245,089	32
33	Real Estate Taxes	0	47,974	0	0	0	0	0	0	0	0	0	47,974	33
34	Rent-Facility & Grounds	0	(480,000)	11,761	0	0	0	0	0	0	0	0	(468,239)	34
35	Rent-Equipment & Vehicles	0	0	18,481	0	0	0	0	0	0	0	0	18,481	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(37,354)</b>	<b>9,102</b>	<b>30,242</b>	<b>0</b>	<b>1,990</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(115,053)</b>	<b>23,812</b>	<b>(197,292)</b>	<b>0</b>	<b>(288,533)</b>	<b>45</b>							

Facility Name & ID Number

THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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
		ATRIUM HEALTH CARE & REHABILITATION		WEISS MGMT.		
		CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC.	SKOKIE	MGMT/CLERICAL
SEE ATTACHED SCHEDULE						
				LINCOLN		
				ASSOC., L.P.	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 480,000	LINCOLN ASSOCIATES, L.P.	100.00%	\$	\$ (480,000)	1
2	V	30 DEPRECIATION		" "		194,137	194,137	2
3	V	32 INTEREST EXPENSE		" "		225,436	225,436	3
4	V	33 REAL ESTATE TAXES		" "		47,974	47,974	4
5	V	32 MORTGAGE INSURANCE		" "		21,555	21,555	5
6	V	26 INSURANCE		" "		14,710	14,710	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 503,812	\$ * 23,812	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	10 NURSING CONSULTANT	\$ 30,000	WEISS MANAGEMENT GROUP, INC.	100.00%	\$	\$ (30,000)
16	V	17 MANAGEMENT FEES	420,000				(420,000)
17	V	19 ADMIN./BKKP. FEES	300,000				(300,000)
18	V						
19	V						
20	V						
21	V						
22	V	17 ADMINISTRATIVE SALARIES				472,619	472,619
23	V	19 PROFESSIONAL FEES				5,642	5,642
24	V	21 OFFICE EXPENSES				8,667	8,667
25	V	23 SEMINARS				540	540
26	V	24 TRAVEL				282	282
27	V	26 INSURANCE				568	568
28	V	27 EMPLOYEE BENEFITS				34,148	34,148
29	V	34 OFFICE RENT				11,761	11,761
30	V	35 EQUIPMENT RENT				18,481	18,481
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 750,000			\$ 552,708	\$ * (197,292)

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

Facility Name &amp; ID Number

THE LINCOLN HOME

#

0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARTIN WEISS	PRESIDENT	ADMINISTR.	45.10	SEE ATTACHED	20		SALARY	\$ 149,132	17-7	1
2					SCHEDULE						2
3											3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31		12		SALARY	179,142	17-7	4
5											5
6	NATAN WEISS	CONTROLLER	BOOKKEEPING	8.39		16		SALARY	144,345	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 472,619		13

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

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

Facility Name & ID Number **THE LINCOLN HOME**

# **0034678** Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization WEISS MANAGEMENT GROUP, INC  
 Street Address 3856 OAKTON STREET  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 933-9200  
 Fax Number ( 847) 933-9765

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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	93,914	2	\$ 876,890	\$ 876,890	50,617	\$ 472,619	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	93,914	2	10,469	50,617		5,642	2
3	21	OFFICE EXPENSES	PATIENT CENSUS	93,914	2	16,081	50,617		8,667	3
4	23	SEMINARS	PATIENT CENSUS	93,914	2	1,002	50,617		540	4
5	24	TRAVEL	PATIENT CENSUS	93,914	2	524	50,617		282	5
6	26	INSURANCE	PATIENT CENSUS	93,914	2	1,053	50,617		568	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	93,914	2	63,358	50,617		34,148	7
8	34	OFFICE RENT	PATIENT CENSUS	93,914	2	21,822	50,617		11,761	8
9	35	EQUIPMENT RENT	PATIENT CENSUS	93,914	2	34,289	50,617		18,481	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,025,488	\$ 876,890		\$ 552,708	25

Facility Name & ID Number

THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$31,065.72	04/04	4,528,900	4,284,948	04/39	5.1400	222,052	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER COSTS		118,455	102,381			3,384	3						
4	MIP INSURANCE										21,555	4						
5												5						
<b>Working Capital</b>																		
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND	DEMAN		699,248		PRIME+	32,822	6						
7												7						
8												8						
9	TOTAL Facility Related				\$31,065.72		\$ 4,647,355	\$ 5,086,577			\$ 279,813	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,647,355	\$ 5,086,577			\$ 279,813	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 21,555      Line # 32-7

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2007 report.		\$	<b>44,584</b>	<b>1</b>
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.)		\$	<b>48,929</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,345</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>46,279</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,624</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>29,752</b>	<b>8</b>
	<b>2004</b>	<b>37,967</b>	<b>9</b>
	<b>2005</b>	<b>44,310</b>	<b>10</b>
	<b>2006</b>	<b>47,114</b>	<b>11</b>
	<b>2007</b>	<b>48,929</b>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**IMPORTANT NOTICE**

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

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

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

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

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME THE LINCOLN HOME COUNTY SINCLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-20.0-204-015</u>	<u>NURSING HOME</u>	\$ <u>2,650.46</u>	\$ <u>2,650.46</u>
2. <u>08-20.0-210-029</u>	<u>NURSING HOME</u>	\$ <u>45,170.26</u>	\$ <u>45,170.26</u>
3. <u>08-20.0-207-025</u>	<u>NURSING HOME</u>	\$ <u>828.64</u>	\$ <u>828.64</u>
4. <u>08-20.0-210-028</u>	<u>NURSING HOME</u>	\$ <u>280.02</u>	\$ <u>280.02</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>48,929.38</u>	\$ <u>48,929.38</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 2

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>3+ACRES</u>	<u>1987</u>	<u>\$ 148,649</u>	<u>1</u>
2	<u>PARKING LOT</u>	<u>2+ACRES</u>	<u>2005</u>	<u>50,000</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 198,649</b>	<b>3</b>

Facility Name &amp; ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	152	1988		\$ 2,011,351	\$ 63,852	31.5	\$ 63,852	\$	\$ 1,270,133	4
5		2003		1,249,221	45,426	27.5	45,426		247,950	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	VARIOUS		1990	11,158	354	31.5	354		6,466	9
10	VARIOUS		1993	6,676	171	39	171		3,437	10
11	VARIOUS		1994	7,797	200	39	200		3,858	11
12	VARIOUS		1995	13,072	335	39	335		5,587	12
13	CARPET		1996	907	23	39	23		328	13
14	BILLBOARD		1996	900	23	39	23		331	14
15	SMOKE DETECTORS		1996	602	15	39	15		220	15
16	PARKING LOT		1996	8,006	205	39	205		3,050	16
17	AWNING		1996	905	23	39	23		346	17
18	CARPETING		1996	1,512	39	39	39		599	18
19	DOOR LOCKS		1997	2,100	54	39	54		706	19
20	WALL PAPER		1997	2,012	52	39	52		690	20
21	HANDRAIL		1997	3,217	83	39	83		1,025	21
22	FIRE ALARM SYSTEM		1998	11,636	298	39	298		3,271	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION		1998	9,227	236	39	236		2,597	23
24	PAINTING/WALLPAPERING		1998	2,988	77	39	77		845	24
25	REPLACE PVC PIPE IN BASEMENT		1998	1,074	28	39	28		307	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD		1999	6,144	158	39	158		1,190	26
27	INSTALLED A NEW DURO-LAST ROOF		1999	56,400	1,446	39	1,446		10,840	27
28	WALLPAPER		2000	14,896	382	39	382		3,801	28
29	SEWER LINE REPAIR		2000	11,743	301	39	301		2,552	29
30	AIR CONDITIONING UNITS		2000	8,848	227	39	227		1,924	30
31	CONDENSING UNIT ON FREEZER		2000	2,693	69	39	69		588	31
32	NEW NURSES STATION		2000	20,379	522	39	522		4,447	32
33	FIRE ALARM SYSTEM		2000	1,826	47	39	47		400	33
34	HOT WATER SYSTEM		2000	3,849	99	20	99		1,856	34
35	TILED FLOORS		2000	54,185	1,389	39	1,389		11,816	35
36	REMODELING OF BATHROOMS		2000	18,490	474	39	474		4,027	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	\$ 13,369	\$ 726	20	\$ 668	\$ (58)	\$ 8,002	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		9,796	38
39	ROOF	2001	47,500	1,727	27.5	1,727		12,953	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		2,504	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		3,330	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		3,097	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		14,872	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		10,246	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159	2,346	20	1,558	(788)	10,906	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		1,671	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		4,153	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		1,764	48
49	LANDSCAPING	2004	7,759	1,551	15	517	(1,034)	2,262	49
50	REPLACEMENT WINDOWS	2004	32,853	6,571	20	1,643	(4,928)	8,215	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270	1,254	20	314	(940)	1,570	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250	21,050	20	5,263	(15,787)	26,315	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		401	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		318	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		3,826	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		1,189	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		1,058	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		4,966	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		2,348	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906	3,581	5	3,581		8,953	60
61	AIR CONDITIONERS	2007	7,968	2,550	5	2,550		4,144	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	1,997	27.5	1,997		3,126	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		427	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		207	64
65	PAINTING	2007	9,986	3,196	5	3,196		5,193	65
66	GARDEN	2007	60,172	2,155	15	4,012	1,857	5,683	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	106	27.5	106		106	67
68	PAINTING - 30 ROOMS	2008	2,550	510	5	510		510	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	83	27.5	83		83	69
70	TOTAL (lines 4 thru 69)		\$ 4,265,246	\$ 177,551		\$ 155,873	\$ (21,678)	\$ 1,759,381	70

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

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	
1		\$ 4,265,246	\$ 177,551		\$ 155,873	\$ (21,678)	\$ 1,759,381	1
2	2008	1,473	74	15	74		74	2
3	208	4,672	106	27.5	106		106	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		\$ 4,271,391	\$ 177,731		\$ 156,053	\$ (21,678)	\$ 1,759,561	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 85,711	\$ 14,982	\$ 9,488	\$ (5,494)	3-10	\$ 30,439	71
72	Current Year Purchases	22,096	13,259	1,460	(11,799)	5-10	1,460	72
73	Fully Depreciated Assets	89,692					89,692	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		23,723	23,723				74
75	TOTALS	\$ 197,499	\$ 51,964	\$ 34,671	\$ (17,293)		\$ 121,591	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	FACILITY	2005 FORD ECONOLINE	2005	\$ 41,500	\$ 4,781	\$ 8,300	\$ 3,519	5	\$ 33,200	76
77										77
78										78
79										79
80	TOTALS			\$ 41,500	\$ 4,781	\$ 8,300	\$ 3,519		\$ 33,200	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)	\$ 4,709,039	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 234,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,024	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (35,452)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,914,352	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A - RELATED PARTY

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								6
7	TOTAL				\$			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ 9,004 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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>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>
<p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 308,441	\$		\$ 308,441	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			70,513			70,513	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			280,712			280,712	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				211,923		211,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					30,629		30,629	12
13	Other (specify): <b>RADIOLOGY, LAB</b>	39-2					29,017		29,017	13
14	<b>TOTAL</b>			\$		\$ 659,666	\$ 271,569		\$ 931,235	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.

Facility Name &amp; ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 37,848	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,853,031		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,773		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,958,652	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	49,683		15
16	Equipment, at Historical Cost	238,999		16
17	Accumulated Depreciation (book methods)	(211,895)		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):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 200,813	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,159,465	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 470,864	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,258,668		29
30	Accrued Salaries Payable	132,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,875,453	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,875,453	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,284,012	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,159,465	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>256,347</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>IL PERLACEMENT TAX 2007</b>	<b>(1,526)</b>	<b>3</b>
<b>4</b>	<b>ACCUMULATED DEPRECIATION 2007</b>	<b>2,800</b>	<b>4</b>
<b>5</b>	<b>ROUNDING</b>	<b>(1)</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>257,620</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,026,392</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,026,392</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,284,012</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 8,010,392	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,010,392	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	223,368	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 223,368	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,902	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,902	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,235,662	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,188,031	31
32	Health Care	2,552,442	32
33	General Administration	1,889,299	33
	<b>B. Capital Expense</b>		
34	Ownership	564,815	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	931,235	35
36	Provider Participation Fee	83,448	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,209,270	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,026,392	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,026,392	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.

TAX RETURN PREPARED 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.

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

Facility Name & ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,936	2,113	\$ 75,134	\$ 35.56	1
2	Assistant Director of Nursing	3,332	3,524	82,304	23.36	2
3	Registered Nurses	6,149	6,363	163,072	25.63	3
4	Licensed Practical Nurses	31,171	32,778	668,461	20.39	4
5	CNAs & Orderlies	99,469	105,190	989,500	9.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,976	2,080	32,349	15.55	9
10	Activity Assistants	7,328	7,592	63,241	8.33	10
11	Social Service Workers	2,024	2,080	62,664	30.13	11
12	Dietician					12
13	Food Service Supervisor	2,200	2,224	39,456	17.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,686	24,486	204,313	8.34	15
16	Dishwashers					16
17	Maintenance Workers	5,482	5,790	84,399	14.58	17
18	Housekeepers	7,800	7,838	79,254	10.11	18
19	Laundry	3,944	3,967	32,082	8.09	19
20	Administrator	2,360	2,488	106,105	42.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,031	14,649	173,281	11.83	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	3,577	3,697	44,508	12.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord</u>	3,999	4,143	109,901	26.53	33
34	TOTAL (lines 1 - 33)	220,464	231,002	\$ 3,010,024 *	\$ 13.03	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	M	\$ 11,959	1-3	35
36	Medical Director	O	30,000	9-3	36
37	Medical Records Consultant	N	838	10-3	37
38	Nurse Consultant	T	30,690	10-3	38
39	Pharmacist Consultant	H	4,100	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,285	11-3	44
45	Social Service Consultant	E	1,365	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,237		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MICHAEL BUTLER	ADMINISTRATOR	0	\$ 32,905	Workers' Compensation Insurance	\$ 108,800	IDPH License Fee	\$ 995	
KAY ROSS	ADMINISTRATOR	0	73,200	Unemployment Compensation Insurance	69,007	Advertising: Employee Recruitment	7,892	
				FICA Taxes	236,783	Health Care Worker Background Check	2,885	
				Employee Health Insurance	69,308	(Indicate # of checks performed 288 )		
				Employee Meals	0	Patient Background Checks	264	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	7,009	
				EMPLOYEE BENEFITS - OTHER	5,956	MARKETING/ADV/PROMO	27,691	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,820	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(7,009)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(27,691)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,105	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 489,854		\$ 25,237		
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
WEISS MANAGEMENT GROUP MANAGEMENT FEES			\$ 420,000				Out-of-State Travel	\$
							In-State Travel	
								17,395
							MGMT CO ALLOC	282
							Seminar Expense	
								550
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 420,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 18,227	
C. Professional Services								
Vendor/Payee	Type		Amount					
ALPHA DATA SERVICE	DATA PROCESSING		\$ 6,728					
KRUPNICK,BOKOR,KAGDA	ACCOUNTING		12,700					
GARY WEINTRAUB. P.C.	LEGAL FEES		29,410					
MYERS, MILLER & KRAUSKOPF	LEGAL FEES		26,338					
HEPLER,BROOM,MACDONALD	LEGAL FEES		13,730					
PERSONNEL PLANNERS	UC CONSULTANT		9,960					
WEISS MANAGEMENT GROUP	BOOKKEEP./ADM.SERV		300,000					
RICHARD PEELO & ASSOC	MEDICARE CONSULTANT		4,500					
SHARON HAUGH	MEDICARE CONSULTANT		3,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 406,366					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number THE LINCOLN HOME

# 0034678

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$9,015
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,714 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,448  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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