

Facility Name & ID Number Lincoln Manor

0021501 Report Period Beginning: 1/1/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,784</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>116</u>	Intermediate (ICF)	<u>116</u>	<u>42,456</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,240</u>	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	<u>203</u>	<u>121</u>	<u>5,493</u>	<u>5,817</u>	8
9	SNF/PED					9
10	ICF	<u>27,099</u>	<u>11,207</u>		<u>38,306</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,302</u>	<u>11,328</u>	<u>5,493</u>	<u>44,123</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.11%

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
 Date started 04/01/75

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 24 and days of care provided 5,493

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	295,904	28,340	14,181	338,425		338,425		338,425		1
2	Food Purchase		229,974		229,974		229,974	(13,500)	216,474		2
3	Housekeeping	173,417	14,095	10,489	198,001		198,001		198,001		3
4	Laundry	95,674	10,916	2,520	109,110		109,110		109,110		4
5	Heat and Other Utilities			133,870	133,870		133,870		133,870		5
6	Maintenance	61,861		55,815	117,676		117,676		117,676		6
7	Other (specify):*										7
8	TOTAL General Services	626,856	283,325	216,875	1,127,056		1,127,056	(13,500)	1,113,556		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,876,080	106,873	199,508	2,182,461		2,182,461		2,182,461		10
10a	Therapy			545,945	545,945		545,945		545,945		10a
11	Activities	78,289	706	7,003	85,998		85,998		85,998		11
12	Social Services	27,010		2,454	29,464		29,464		29,464		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,981,379	107,579	784,910	2,873,868		2,873,868		2,873,868		16
	C. General Administration										
17	Administrative	149,914			149,914		149,914		149,914		17
18	Directors Fees			29,000	29,000		29,000		29,000		18
19	Professional Services			135,595	135,595		135,595	(1,050)	134,545		19
20	Dues, Fees, Subscriptions & Promotions			47,073	47,073		47,073	(895)	46,178		20
21	Clerical & General Office Expenses	112,793	13,975	32,020	158,788		158,788		158,788		21
22	Employee Benefits & Payroll Taxes			474,030	474,030		474,030	13,500	487,530		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,900	1,900		1,900		1,900		24
25	Other Admin. Staff Transportation			10,048	10,048		10,048		10,048		25
26	Insurance-Prop.Liab.Malpractice			99,824	99,824		99,824		99,824		26
27	Other (specify):*										27
28	TOTAL General Administration	262,707	13,975	829,490	1,106,172		1,106,172	11,555	1,117,727		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,870,942	404,879	1,831,275	5,107,096		5,107,096	(1,945)	5,105,151		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

Lincoln Manor

#0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			151,470	151,470		151,470	(692)	150,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,173	25,173		25,173	(4,206)	20,967			32
33	Real Estate Taxes			54,243	54,243		54,243		54,243			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,314	3,314		3,314		3,314			35
36	Other (specify):*											36
37	TOTAL Ownership			234,200	234,200		234,200	(4,898)	229,302			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,817	813	150,630		150,630		150,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,792	78,792		78,792		78,792			42
43	Other (specify):* Non-allowable cost			670,059	670,059		670,059	(670,059)				43
44	TOTAL Special Cost Centers		149,817	749,664	899,481		899,481	(670,059)	229,422			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,870,942	554,696	2,815,139	6,240,777		6,240,777	(676,902)	5,563,875			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(399)	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	(692)	30		9
10	Interest and Other Investment Income	(4,206)	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	(18,400)	43		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	(26,798)	43		24
25	Fund Raising, Advertising and Promotional	(3,716)	43		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	(622,691)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (676,902)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (676,902)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Lincoln Manor

ID# 0021501

Report Period Beginning: 1/1/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs - Part A	\$ (6,068)	43	1
2	X-Rays - Part A	(2,687)	43	2
3	Offset Billing Adjustments	(611,991)	43	3
4	Disallow Nonallowable Legal Expense	(1,050)	19	4
5	Yellow Pages Advertising	(895)	21	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	(622,691)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Manor# 0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,050)	0	0	0	0	0	0	0	0	0	0	(1,050)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(895)	0	0	0	0	0	0	0	0	0	0	(895)	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,945)	0	(1,945)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,945)	0	(1,945)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(692)	0	0	0	0	0	0	0	0	0	0	(692)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,206)	0	0	0	0	0	0	0	0	0	0	(4,206)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,898)	0	(4,898)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(670,059)	0	0	0	0	0	0	0	0	0	0	(670,059)	43
44	TOTAL Special Cost Centers	(670,059)	0	(670,059)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(676,902)	0	(676,902)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule 6A		N/A		N/A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	N/A						2
3	V							3
4	V							4
5	V							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		\$			\$	\$ *	14

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

**Owners
As of 12/31/08**

Schedule 6A

Name of Owner	Ownership %
Seymour Chazin Trust	10.00%
Gabriel Wolff	10.00%
Carlyle Weinberger	11.00%
Francy Melnik Starr	7.50%
David Cohn	10.00%
Vicki Pollard	10.00%
Seymour & Ann Melnik	12.50%
Arlene Rubin	10.00%
Morton Melnik	10.00%
Judith Nack	3.00%
Gayle Rovnick	3.00%
Kenneth Weinberger	3.00%
	<u>100.00%</u>

See Accountants' Compilation Report

Facility Name & ID Number

Lincoln Manor

#

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	Gershom Cohn	Director	Administrative	6.00	None	0.5	1.43	Director Fee	\$ 3,000	18(3)	1
2	David Cohn	Director	Administrative	8.00	None	10	28.57	Director Fee	4,000	18(3)	2
3	Arlene Rubin	Director	Administrative	8.00	None	0.5	1.43	Director Fee	2,000	18(3)	3
4	Morton Melnik	Director	Administrative	10.00	None	5	14.29	Director Fee	4,000	18(3)	4
5	Seymour Melnik	Director	Administrative	5.00	None	10	28.57	Director Fee	7,000	18(3)	5
6	William Glickauf	Director	Administrative	0.00	None	0.5	1.43	Director Fee	1,000	18(3)	6
7	Gayle Rovnick	Director	Administrative	3.00	None	0.5	1.43	Director Fee	3,000	18(3)	7
8	Kenneth Weinberger	Director	Administrative	3.00	None	1	2.86	Director Fee	4,000	18(3)	8
9	Pam Ferris	Director	Administrative	0.00	None	0.5	1.43	Director Fee	1,000	18(3)	9
10											10
11											11
12											12
13								TOTAL	\$ 29,000		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 **Lincoln Manor**

0021501 Report Period Beginning: **1/1/08** Ending: **12/31/08**

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Busey		X	Facilities Improvement	\$7,419.00	5/23/08	\$ 376,000	\$ 337,268	5/2023	0.0675	\$ 15,829	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Busey		X	Construction	Varies	11/20/06	391,000		5/12/08	0.0675	6,540	6								
7	Busey		X	Line of Credit	Varies	1/2/08		75,000	11/10/09	0.0350	2,804	7								
8												8								
9	TOTAL Facility Related				\$7,419.00		\$ 767,000	\$ 412,268			\$ 25,173	9								
B. Non-Facility Related*																				
10								Interest Income Offset			(4,206)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (4,206)	14								
15	TOTALS (line 9+line14)						\$ 767,000	\$ 412,268			\$ 20,967	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

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

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

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

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

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lincoln Manor COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0021501

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 875-1973 FAX #: (217) 875-2172

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>04-12-03-251-002</u>	<u>Long Term Care Property</u>	\$ <u>52,354.98</u>	\$ <u>52,354.98</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>52,354.98</u>	\$ <u>52,354.98</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,340 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1965</u>	\$ <u>55,770</u>	<u>1</u>
2	<u>Demolished House</u>		<u>1995</u>	<u>13,200</u>	<u>2</u>
3	TOTALS			\$ <u>68,970</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	140	1975	1975	\$ 745,047	\$	35	\$	\$	\$ 745,047	4
5		1981	1981	369,094		35			369,094	5
6		1984	1984	368,408		35			368,408	6
7		1985	1985	5,143		35			5,143	7
8		1993	1993	47,097	1,617	35	1,177	(440)	19,081	8
Improvement Type**										
9	Various		1975	9,508		20			7,010	9
10	Various		1981	3,615		20			3,615	10
11	Various		1982	25,660		20			24,773	11
12	Various		1984	2,107		20			2,107	12
13	Various		1985	13,371		20			13,371	13
14	Various		1986	12,384		20	300	300	9,261	14
15	Various		1987	59,842		20	1,360	1,360	33,805	15
16	Various		1988	16,800		20	841	841	10,927	16
17	Various		1989	24,981		20	259	259	23,172	17
18	Various		1990	26,245		20	68	68	24,815	18
19	Various		1991	9,545		20			9,545	19
20	Various		1992	24,119		20	211	211	19,531	20
21	Various		1993	9,429		20	391	391	6,693	21
22	Various		1994	31,724		20	347	347	31,724	22
23	Various		1995	89,487		20	3,796	3,796	50,807	23
24	Various		1996	96,885		20	4,846	4,846	53,979	24
25	Various		1997	75,339		20	3,768	3,768	44,747	25
26	Various		1998	126,326		20	6,315	6,315	65,958	26
27	Various		1999	46,295		20	2,314	2,314	21,519	27
28	Various		2000	172,355		20	7,412	7,412	64,038	28
29	Various		2001	129,251		20	6,462	6,462	48,524	29
30	Various		2002	38,912		20	3,921	3,921	25,471	30
31	Various		2003	61,774		20	3,089	3,089	16,811	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69	Financial Statement Depreciation		149,853			(149,853)		69				
70	TOTAL (lines 4 thru 69)	\$	2,640,743	\$	151,470	\$	46,877	\$	(104,593)	\$	2,118,976	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	
1	Totals from Page 12A, Carried Forward		\$ 2,640,743	\$ 151,470		\$ 46,877	\$ (104,593)	\$ 2,118,976	1
2	Window Treatment, Wall Covering	2004	3,416		20	171	171	854	2
3	Painting (Dining Room)	2004	1,960		20	98	98	482	3
4	Drywall repairs	2004	8,381		20	419	419	1,711	4
5	Flooring	2004	1,064		20	53	53	261	5
6	Plumbing	2004	183		20	9	9	45	6
7	Wall Covering	2004	3,701		20	185	185	925	7
8	Code Alert System	2004	1,613		20	81	81	350	8
9	Storage Room	2004	4,889		20	244	244	998	9
10	Faucets	2004	510		20	26	26	128	10
11	Painting - Labor	2005	7,100		20	355	355	1,213	11
12	Electrical Work	2005	623		20	31	31	106	12
13	Paint	2005	4,547		20	227	227	701	13
14	Storage Shed & Slab	2005	8,630		20	432	432	1,511	14
15	New Sidewalk	2005	6,066		20	303	303	1,011	15
16	Fencing	2005	775		20	39	39	129	16
17	Electrical - Lighting	2005	910		20	45	45	151	17
18	Carpet, Vinyl Flooring	2005	5,853		20	293	293	903	18
19	Carpet Installation	2005	675		20	34	34	104	19
20	Roof Top Heating Cooling Unit	2005	7,233		20	362	362	1,447	20
21	Roof Top Heating Cooling Parts	2005	7,812		20	391	391	1,433	21
22	Replace Heating Cooling Roof Top Units	2005	9,044		20	452	452	1,469	22
23	Flooring	2006	7,330		20	366	366	1,099	23
24	Windows	2006	3,678		20	184	184	475	24
25	Paint, Molding	2006	5,249		20	262	262	656	25
26	Tile	2006	9,085		20	454	454	1,135	26
27	Electrical / Fire Protection	2006	5,020		20	251	251	628	27
28	Remodeling / Redecorating	2006	14,333		20	717	717	1,792	28
29	Front Entrance	2006	2,333		20	117	117	282	29
30	Two Water Heaters	2006	15,475		20	774	774	2,322	30
31	Vanities, Marble Tops	2006	8,964		20	448	448	1,120	31
32	Faucets / Lavatories	2006	4,002		20	200	200	450	32
33	Blinds	2006	4,407		20	220	220	495	33
34	TOTAL (lines 1 thru 33)		\$ 2,805,604	\$ 151,470		\$ 55,120	\$ (96,350)	\$ 2,145,362	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	
1	Totals from Page 12B, Carried Forward		\$ 2,805,604	\$ 151,470		\$ 55,120	\$ (96,350)	\$ 2,145,362	1
2	Hand Rails	2006	3,220		20	161	161	362	2
3	Fabric, Rods, Brackets	2006	1,121		20	56	56	117	3
4	A/C Repair	2006	6,748		20	337	337	843	4
5	Code Alert - Smoking Room Door	2006	3,963		20	198	198	561	5
6	Bath Room Vanities	2006	7,572		20	379	379	915	6
7	Circulating Pump	2006	3,249		20	162	162	338	7
8	Decorating & Painting	2006	3,581		20	179	179	373	8
9	Lanscaping	2007	7,345		20	326	326	652	9
10	Lanscaping	2007	1,288		20	57	57	114	10
11	Interior Painting	2007	34,817		20	2,611	2,611	5,222	11
12	Decorating Valance	2007	650		20	65	65	130	12
13	Corner Guard	2007	3,477		20	348	348	696	13
14	Wallcoverings	2007	3,264		20	272	272	544	14
15	Privacy Curtains	2007	8,267		20	689	689	1,378	15
16	Sanding & Patching Walls	2007	3,200		20	240	240	480	16
17	Crowns In Foyer & Hallway	2007	6,739		20	618	618	1,236	17
18	Wallpaper	2007	22,540		20	1,503	1,503	3,006	18
19	Carpeting	2007	3,239		20	216	216	432	19
20	Flooring	2007	1,820		20	121	121	242	20
21	Wall Base & Cove Base	2007	12,904		20	860	860	1,720	21
22	Paneling & Wallpaper	2007	3,299		20	275	275	550	22
23	Paneling & Crown Molding	2007	3,699		20	308	308	616	23
24	Install & Caulk Cove Base	2007	3,598		20	300	300	600	24
25	Base & Crown	2007	5,772		20	433	433	866	25
26	Base & Crown	2007	7,320		20	488	488	976	26
27	Bases, Crowns & Drywall Repair	2007	7,203		20	480	480	960	27
28	Base, Drywall, Chair Rails, Crowns	2007	9,222		20	615	615	1,230	28
29	Flooring, Wall Fixtures, Signs, Tiling, Bathroom Vanities, Faucets	2007	103,555		20	5,178	5,178	10,356	29
30	Beauty Shop Remodel (Carpeting, Wallcoverings, Cove Base)	2008	6,279		20	314	314	314	30
31	Paint & Repair Resident Closets	2008	3,523		20	176	176	176	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,098,078	\$ 151,470		\$ 73,085	\$ (78,385)	\$ 2,181,367	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 647,161	\$	\$ 60,838	\$ 60,838	10	\$ 404,956	71
72	Current Year Purchases	67,008		6,701	6,701	10	6,701	72
73	Fully Depreciated Assets	435,329				10	435,329	73
74								74
75	TOTALS	\$ 1,149,498	\$	\$ 67,539	\$ 67,539		\$ 846,986	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		Chevy Van	1993	\$ 17,701	\$	\$	\$	5	\$ 17,701	76
77		2006 Southern Bus	2006	50,771		10,154	10,154	5	29,616	77
78										78
79										79
80	TOTALS			\$ 68,472	\$	\$ 10,154	\$ 10,154		\$ 47,317	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)	\$ 4,385,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,470	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,778	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (692)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,075,670	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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: \$ 3,314 Description: Postage Meter-\$499; Copier-\$1,330; Ice Machine-\$1,485

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,495	\$ 269,686	\$	4,495	\$ 269,686	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,266	195,944		3,266	195,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,234	74,030		1,234	74,030	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				149,817		149,817	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Physician Services</u>	39(2)				813			813	12
13	Other (specify):									13
14	TOTAL			\$	8,995	\$ 540,473	\$ 149,817	8,995	\$ 690,290	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lincoln Manor**

0021501

Report Period Beginning: **1/1/08**

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/08**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,816	\$ 19,816	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,055,596	1,055,596	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,260	15,260	6
7	Other Prepaid Expenses	2,406	2,406	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,093,078	\$ 1,093,078	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	84,560	68,970	13
14	Buildings, at Historical Cost	2,083,451	3,054,183	14
15	Leasehold Improvements, at Historical Cost	43,895	43,895	15
16	Equipment, at Historical Cost	1,891,130	1,217,970	16
17	Accumulated Depreciation (book methods)	(3,435,363)	(3,075,670)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 667,673	\$ 1,309,348	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,760,751	\$ 2,402,426	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 147,806	\$ 147,806	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	164,028	164,028	29
30	Accrued Salaries Payable	47,297	47,297	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,184	5,184	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,350	52,350	32
33	Accrued Interest Payable	1,411	1,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Taxes Payable</u>	3,735	3,735	36
37	<u>401k Payable</u>	18,000	18,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 439,811	\$ 439,811	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	248,240	248,240	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)	\$ 248,240	\$ 248,240	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 688,051	\$ 688,051	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,072,700	\$ 1,714,375	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,760,751	\$ 2,402,426	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,343,935	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,343,935	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,239)	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	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (271,235)	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)	\$ 1,072,700	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,196,720	1
2	Discounts and Allowances for all Levels	(38,306)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,158,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,206	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,206	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	6,704	28
28a	<u>Finance Charge</u>	214	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,918	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,169,538	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,127,056	31
32	Health Care	2,873,868	32
33	General Administration	1,106,172	33
	B. Capital Expense		
34	Ownership	234,200	34
	C. Ancillary Expense		
35	Special Cost Centers	820,689	35
36	Provider Participation Fee	78,792	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,240,777	40
41	Income before Income Taxes (line 30 minus line 40)**	(71,239)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (71,239)	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 is prepared on the 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 Lincoln Manor

0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,192	2,376	\$ 78,827	\$ 33.18	1
2	Assistant Director of Nursing	760	760	19,900	26.18	2
3	Registered Nurses	2,256	2,371	55,947	23.60	3
4	Licensed Practical Nurses	32,022	34,049	689,788	20.26	4
5	CNAs & Orderlies	73,748	78,802	928,674	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,760	2,100	27,436	13.06	9
10	Activity Assistants	4,742	4,951	50,853	10.27	10
11	Social Service Workers	1,409	1,625	27,010	16.62	11
12	Dietician					12
13	Food Service Supervisor	1,226	1,666	27,121	16.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,844	26,166	268,783	10.27	15
16	Dishwashers					16
17	Maintenance Workers	4,193	4,562	61,861	13.56	17
18	Housekeepers	17,698	19,170	173,417	9.05	18
19	Laundry	9,559	10,296	95,674	9.29	19
20	Administrator	2,800	3,052	131,451	43.07	20
21	Assistant Administrator	720	720	18,463	25.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,174	10,004	112,793	11.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,232	1,400	28,080	20.06	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,790	6,208	74,864	12.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,125	210,278	\$ 2,870,942 *	\$ 13.65	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	315	\$ 14,159	1(3)	35
36	Medical Director	Monthly	30,000	9(3)	36
37	Medical Records Consultant	Monthly	2,100	10(3)	37
38	Nurse Consultant	Monthly	12,090	10(3)	38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant	105	6,285	10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,287	11(3)	44
45	Social Service Consultant				45
46	Other(specify) <u>Quality Assurance</u>	Monthly	13,500	10(3)	46
47	<u>Podiatry Consultant</u>	Monthly	2,500	10(3)	47
48	<u>Dermatological Consultant</u>	Monthly	2,100	10(3)	48
49	TOTAL (lines 35 - 48)	466	\$ 85,621		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	182	\$ 8,119	10(3)	50
51	Licensed Practical Nurses	2,894	69,266	10(3)	51
52	Certified Nurse Assistants/Aides	4,421	88,931	10(3)	52
53	TOTAL (lines 50 - 52)	7,497	\$ 166,316		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Cindy Russell	Administrator	0	\$ 60,368	Workers' Compensation Insurance	\$ 85,751	IDPH License Fee	\$		
Jan Pasier	Asst. Administrator	0	18,463	Unemployment Compensation Insurance	24,654	Advertising: Employee Recruitment	41,149		
Sheila McClung	Administrator	0	49,223	FICA Taxes	224,019	Health Care Worker Background Check (Indicate # of checks performed <u>83</u>)	1,328		
Darin Wall	Administrator	0	21,860	Employee Health Insurance	109,056	Patient Background Checks <u>137</u>	1,648		
				Employee Meals	13,500	Miscellaneous Licenses & Fees	1,010		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	943		
				Employee Drug Screening	1,116	INHAA Dues	100		
				Employee Appreciation	8,362	Yellow Pages Advertising	895		
				Employee Physicals	2,034				
				Retirement Expense	19,038	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	(895)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 149,914	TOTAL (agree to Schedule V, line 22, col.8)		\$ 487,530	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 46,178
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	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	1,123	
							Seminar Expense	777	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,900
C. Professional Services									
Vendor/Payee	Type					Amount			
See Schedule 21A			\$ 135,595						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 135,595						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lincoln Manor

Provider #: 0021501
1/1/2008 to 12/31/2008

Schedule 21A

XIX. Support Schedule
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Winters, Fetherstun, Gaumer, Postlewait, Stocks & Flyn	Legal	12,048
Frost, Ruttenberg & Rothblatt, P.C.	Accounting	10,161
McGuire, Yuhas, Huffman & Buckley, P.C.	Accounting	80,117
Duane Morris, LLP	Legal	30,319
American Healthcare	Reimbursement Consulting	2,950
Total (agree to Schedule V, Line 19, Column 3)		<u>135,595</u>
Nonallowable Legal Expenses		(1,050)
Total (agree to Schedule V, Line 19, Column 8)		<u><u>134,545</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor# 0021501

Report Period Beginning:

1/1/08

Ending:

12/31/08**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. INHAA - \$100
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,676 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. \$ 78,792
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. \$ 13,500 Has any meal income been offset against related costs? No 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. N/A
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT