

Facility Name & ID Number Lincoln Square# 0037044 Report Period Beginning: 01/01/08 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 5490

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>15</u>	ICF/DD 16 or Less	<u>15</u>	<u>5,490</u>	6
7	<u>15</u>	TOTALS	<u>15</u>	<u>5,490</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,399</u>			<u>5,399</u>
14	TOTALS	<u>5,399</u>			<u>5,399</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.34%

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

11 (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)

NoneF. 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 01/01/1991

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

YES Date 01/01/1991 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL 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 Square # 0037044 Report Period Beginning: 01/01/08 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	25,367	2,219	1,524	29,110		29,110		29,110		1
2	Food Purchase		43,972		43,972		43,972		43,972		2
3	Housekeeping		3,472	450	3,922		3,922	66	3,988		3
4	Laundry		370		370		370		370		4
5	Heat and Other Utilities			15,065	15,065		15,065	236	15,301		5
6	Maintenance	624	2,458	4,500	7,582		7,582	4,312	11,894		6
7	Other (specify):*										7
8	TOTAL General Services	25,991	52,491	21,539	100,021		100,021	4,614	104,635		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	181,491	2,639	1,115	185,245		185,245	894	186,139		10
10a	Therapy		894	2,365	3,259		3,259		3,259		10a
11	Activities	18,964		199	19,163		19,163		19,163		11
12	Social Services		2,754	3,285	6,039		6,039	(1,962)	4,077		12
13	CNA Training	698		245	943		943		943		13
14	Program Transportation		3,351	2,976	6,327		6,327	463	6,790		14
15	Other (specify):* Day Training Expense			200,023	200,023		200,023	(200,023)			15
16	TOTAL Health Care and Programs	201,153	9,638	213,808	424,599		424,599	(200,628)	223,971		16
	C. General Administration										
17	Administrative			6,000	6,000		6,000	4,329	10,329		17
18	Directors Fees			1,000	1,000		1,000	416	1,416		18
19	Professional Services			26,480	26,480		26,480	(25,376)	1,104		19
20	Dues, Fees, Subscriptions & Promotions			1,789	1,789		1,789	(404)	1,385		20
21	Clerical & General Office Expenses	10,403	2,860	3,929	17,192		17,192	7,843	25,035		21
22	Employee Benefits & Payroll Taxes			32,436	32,436		32,436	3,182	35,618		22
23	Inservice Training & Education			239	239		239		239		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,523	2,523		2,523	201	2,724		26
27	Other (specify):*										27
28	TOTAL General Administration	10,403	2,860	74,396	87,659		87,659	(9,809)	77,850		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	237,547	64,989	309,743	612,279		612,279	(205,823)	406,456		29

*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.

Facility Name & ID Number Lincoln Square #0037044 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			4,852	4,852	4,852	11,441	16,293			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,220	1,220	1,220	167	1,387			32
33	Real Estate Taxes			7,484	7,484	7,484	117	7,601			33
34	Rent-Facility & Grounds			43,300	43,300	43,300	(42,869)	431			34
35	Rent-Equipment & Vehicles			293	293	293	165	458			35
36	Other (specify):*			368	368	368	(368)				36
37	TOTAL Ownership			57,517	57,517	57,517	(31,347)	26,170			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops		3,377		3,377	3,377	(2,418)	959			41
42	Provider Participation Fee			29,200	29,200	29,200		29,200			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		3,377	29,200	32,577	32,577	(2,418)	30,159			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	237,547	68,366	396,460	702,373	702,373	(239,588)	462,785			45

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

Facility Name & ID Number Lincoln Square

0037044

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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	\$ (200,023)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(373)	22		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	10,771	30		9
10	Interest and Other Investment Income	(149)	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)	(1,425)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(195)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164)	36		24
25	Fund Raising, Advertising and Promotional	(81)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(204)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg. 5A	(4,366)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (196,209)		\$	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)	(43,379)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,379)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (239,588)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Lincoln Square

ID# 0037044

Report Period Beginning: 01/01/08

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Personal Items / Clothing, etc.	\$ (1,962)	12	1
2	PAC Dues	(72)	20	2
3	Chamber Dues	(72)	20	3
4	Vending Expense Offset by Vending Revenue	(2,418)	41	4
5	Building Interest	158	32	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	(4,366)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	66	0	0	0	0	0	0	0	0	0	66	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	236	0	0	0	0	0	0	0	0	0	236	5
6	Maintenance	0	221	4,091	0	0	0	0	0	0	0	0	4,312	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	523	4,091	0	0	0	0	0	0	0	0	4,614	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	894	0	0	0	0	0	0	0	0	894	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	(1,962)	0	0	0	0	0	0	0	0	0	0	(1,962)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	463	0	0	0	0	0	0	0	0	0	463	14
15	Other (specify):*	(200,023)	0	0	0	0	0	0	0	0	0	0	(200,023)	15
16	TOTAL Health Care and Programs	(201,985)	463	894	0	0	0	0	0	0	0	0	(200,628)	16
	C. General Administration													
17	Administrative	0	0	4,329	0	0	0	0	0	0	0	0	4,329	17
18	Directors Fees	0	416	0	0	0	0	0	0	0	0	0	416	18
19	Professional Services	(1,425)	49	(24,000)	0	0	0	0	0	0	0	0	(25,376)	19
20	Fees, Subscriptions & Promotions	(420)	16	0	0	0	0	0	0	0	0	0	(404)	20
21	Clerical & General Office Expenses	0	934	6,909	0	0	0	0	0	0	0	0	7,843	21
22	Employee Benefits & Payroll Taxes	(373)	3,555	0	0	0	0	0	0	0	0	0	3,182	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	201	0	0	0	0	0	0	0	0	0	201	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,218)	5,171	(12,762)	0	0	0	0	0	0	0	0	(9,809)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(204,203)	6,157	(7,777)	0	0	0	0	0	0	0	0	(205,823)	29

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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	10,771	670	0	0	0	0	0	0	0	0	0	11,441	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	9	0	158	0	0	0	0	0	0	0	0	167	32
33	Real Estate Taxes	0	117	0	0	0	0	0	0	0	0	0	117	33
34	Rent-Facility & Grounds	0	431	(43,300)	0	0	0	0	0	0	0	0	(42,869)	34
35	Rent-Equipment & Vehicles	0	0	165	0	0	0	0	0	0	0	0	165	35
36	Other (specify):*	(368)	0	0	0	0	0	0	0	0	0	0	(368)	36
37	TOTAL Ownership	10,412	1,218	(42,977)	0	(31,347)	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	(2,418)	0	0	0	0	0	0	0	0	0	0	(2,418)	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	TOTAL Special Cost Centers	(2,418)	0	0	0	0	0	0	0	0	0	0	(2,418)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,209)	7,375	(50,754)	0	(239,588)	45							

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
Jacob L. Alley	50	Mulberry Manor	Anna	JR's Centre	Anna	Workshop
Diana Alley	50	Holly Hill	Anna	kel-Tech Mgmt Co	Anna	Acct/Mgmt
		Glen Brook	Vienna	ILS 1-3	Anna	CILA
		Pilot House	Cairo	ILS 4	Metropolis	CILA
		Krypton	Metropolis	LS Land Trust	Anna	Land Trust
		Liberty House	Marion			
		New Way	Anna			

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	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 66	\$ 66 1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	236	236 2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	221	221 3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	463	463 4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	416	416 5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	49	49 6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	16	16 7
8	V	21 Clerical & General		kel-Tech Management Co.	25.00%	934	934 8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,555	3,555 9
10	V	26 Insurance		kel-Tech Management Co.	25.00%	201	201 10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	670	670 11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	117	117 12
13	V	34 Rent		kel-Tech Management Co.	25.00%	431	431 13
14	Total		\$			\$ 7,375	\$ * 7,375 14

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

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/08Ending: 12/31/08**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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	35	Equipment Rental	\$	kel-Tech Management Co.	25.00%	\$ 165	\$ 165	15	
16	V	10	Nursing		kel-Tech Management Co.	25.00%	894	894	16	
17	V	17	Administration		kel-Tech Management Co.	25.00%	4,329	4,329	17	
18	V	21	Clerical		kel-Tech Management Co.	25.00%	6,909	6,909	18	
19	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,091	4,091	19	
20	V								20	
21	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	21	
22	V	34	Building Lease	43,300	Lincoln Square Land Trust	100.00%		(43,300)	22	
23	V	32	Building Interest		Lincoln Square Land Trust	100.00%	158	158	23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 67,300			\$ 16,546	\$ * (50,754)	39	

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/08 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	Diana Alley	DON/ Owner	DON	50.00	37,035	8	20.00	Nursing	\$ 22,019	10-1	1
2	Jacob L. Alley	Owner		50.00					624	6-1	2
3	Diana Alley	Director						Director	500	18-3	3
4	Jacob L. Alley	Director						Director	500	18-3	4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation:										7
8	Diana Alley							Nursing	894	10-1	8
9	Jacob L. Alley							Maintenance	4,091	6-1	9
10	James A. Keller							Admin	4,329	17-1	10
11											11
12											12
13								TOTAL	\$ 32,957		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 Lincoln Square# 0037044 Report Period Beginning: 01/01/08 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

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	400,583	10	\$ 1,100	\$ 24,000	\$ 66	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	400,583	10	3,573	24,000	214	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	400,583	10	365	24,000	22	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	400,583	10	500	24,000	30	4
5	6	MAINT BUILDING	Mgmt Fee Contribution	400,583	10	67	24,000	4	5
6	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	400,583	10	540	24,000	32	6
7	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	400,583	10	257	24,000	15	7
8	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	400,583	10	1,934	24,000	116	8
9	6	REPAIRS BLDG-B	Mgmt Fee Contribution	400,583	10	(409)	24,000	(25)	9
10	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	400,583	10	796	24,000	48	10
11	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	400,583	10	721	24,000	43	11
12	14	TRANSPORTATION-B	Mgmt Fee Contribution	400,583	10	7,009	24,000	420	12
13	18	DIRECTOR'S FEES	Mgmt Fee Contribution	400,583	10	6,950	24,000	416	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	400,583	10	825	24,000	49	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	400,583	10	272	24,000	16	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	400,583	10	24	24,000	1	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	400,583	10	85	24,000	5	17
18	21	CONTRACT SERVICES-B	Mgmt Fee Contribution	400,583	10	873	24,000	52	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	400,583	10	103	24,000	6	19
20	21	G & A MISC-B	Mgmt Fee Contribution	400,583	10	198	24,000	12	20
21	21	G & A SUPPLIES-B	Mgmt Fee Contribution	400,583	10	6,832	24,000	409	21
22	21	POSTAGE-B	Mgmt Fee Contribution	400,583	10	2,703	24,000	162	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	400,583	10	961	24,000	58	23
24	21	TELEPHONE-B	Mgmt Fee Contribution	400,583	10	1,922	24,000	115	24
25	TOTALS					\$ 38,199	\$	\$ 2,286	25

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08

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

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	400,583	10	\$ 1,478	\$ 24,000	\$ 89	1	
2	21	UTILITIES-INTERNET	Mgmt Fee Contribution	400,583	10	408	24,000	24	2	
3	22	INS EMP GROUP-B	Mgmt Fee Contribution	400,583	10	36,354	24,000	2,178	3	
4	22	INSURANCE W/C-B	Mgmt Fee Contribution	400,583	10	1,051	24,000	63	4	
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	400,583	10	21,940	24,000	1,314	5	
6	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	400,583	10	1,266	24,000	76	6	
7	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	400,583	10	2,117	24,000	127	7	
8	30	DEPRECIATION-B	Mgmt Fee Contribution	400,583	10	11,179	24,000	670	8	
9	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	400,583	10	1,945	24,000	117	9	
10	34	LEASE BLDG-B	Mgmt Fee Contribution	400,583	10	7,200	24,000	431	10	
11	35	LEASE EQUIP-B	Mgmt Fee Contribution	400,583	10	2,757	24,000	165	11	
12	10	Nursing	Mgmt Fee Contribution	400,583	10	14,917	14,917	24,000	894	12
13	17	Administration	Mgmt Fee Contribution	400,583	10	72,258	72,258	24,000	4,329	13
14	21	Clerical	Mgmt Fee Contribution	400,583	10	115,314	115,314	24,000	6,909	14
15	6	Maintenance	Mgmt Fee Contribution	400,583	10	68,277	68,277	24,000	4,091	15
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 358,460	\$ 270,766	\$ 21,477	25	

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Capaha Bank		X	Working Capital - LOC		8/20/08			08/20/09	5.0000	1,220	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$ 1,220	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$			\$ 1,220	15								

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

* 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.)

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 Square COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037044

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

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>14-00-07-353</u>	<u>Lot 69 Grammer's Addition</u>	\$ <u>6,369.14</u>	\$ <u>6,369.14</u>
2. <u>14-00-07-418</u>	<u>W 1/2 Lot 120 Grammer's Addition</u>	\$ <u>1,233.10</u>	\$ <u>1,233.10</u>
3. <u>14-00-07-408</u>	<u>Lot 111 Grammer's Addition</u>	\$ <u>65.80</u>	\$ <u>65.80</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,668.04</u>	\$ <u>7,668.04</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 Lincoln Square

0037044 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,200 B. General Construction Type: Exterior Wood Frame Wood 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).

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	Healthcare	8,000	1987	\$ 7,800	1
2	Healthcare	7,056	2006	2,200	2
3	TOTALS	15,056		\$ 10,000	3

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15		2005	1987	\$ 231,909	\$	27.5	\$ 7,730	\$ 7,730	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Carpeting		1997	4,056		7	271	271	4,056	9
10		Living Room Carpwt		1998	571		7	29	29	571	10
11		Carpeting		2001	3,640		7	260	260	3,640	11
12		Tile Floor		2002	3,922	162	15	261	99	2,544	12
13		Fire Alarm Panel		2005	1,835	211	5	367	156	1,412	13
14		Wood Deck		2005	2,100	162	15	140	(22)	842	14
15		Tile Floor - Living Room		2006	2,177	189	15	145	(44)	481	15
16		Tile Floor - Hall		2006	2,804	249	15	187	(62)	561	16
17		Carpeting		2008	1,309	1,309	7	93	(1,216)	1,309	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

*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 & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 254,323	\$ 2,282		\$ 9,483	\$ 7,201	\$ 15,416	70

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 2,113	\$ 264	\$ 302	\$ 38	7	\$ 1,453	71
72	Current Year Purchases	1,811	1,811	181	(1,630)	7	1,811	72
73	Fully Depreciated Assets	31,124		2,675	2,675	7	31,124	73
74								74
75	TOTALS	\$ 35,048	\$ 2,075	\$ 3,158	\$ 1,083		\$ 34,388	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	Healthcare	2001 Ford Van	2000	\$ 26,232	\$	\$	\$	5	\$ 26,232	76
77	Healthcare	2004 Ford Focus	2004	14,909	495	2,982	2,487	5	13,801	77
78										78
79										79
80	TOTALS			\$ 41,141	\$ 495	\$ 2,982	\$ 2,487		\$ 40,033	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)		\$ 340,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 4,852	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 15,623	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 10,771	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 89,837	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.

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning: 01/01/08

Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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

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	\$ _____

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: \$ 293 Description: Copier Lease

(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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</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)	94			94
4	Clinical Wages (b)	183			183
5	In-House Trainer Wages (c)	421			421
6	Transportation				
7	Contractual Payments	245			245
8	CNA Competency Tests				
9	TOTALS	\$ 943	\$	\$	\$ 943
10	SUM OF line 9, col. 1 and 2 (e)	\$ 943			

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	1
2. From other facilities (f)	
TOTAL TRAINED	1

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/08

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 81,723	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	37,591		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	99,075		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 218,389	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	22,414		15
16	Equipment, at Historical Cost	76,188		16
17	Accumulated Depreciation (book methods)	(89,834)		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)	\$ 8,768	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 227,157	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,791	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,494		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,881		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,860		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 26,026	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 26,026	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 201,131	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 227,157	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 227,437	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 227,437	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	34,190	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	(60,496)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (26,306)	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)	\$ 201,131	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 533,567	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 533,567	3
B. Ancillary Revenue			
4	Day Care	200,023	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 200,023	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	406	11
12	Gift and Coffee Shop	2,418	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)	\$ 2,824	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	149	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 736,563	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	100,021	31
32	Health Care	424,599	32
33	General Administration	87,659	33
B. Capital Expense			
34	Ownership	57,517	34
C. Ancillary Expense			
35	Special Cost Centers	3,377	35
36	Provider Participation Fee	29,200	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 702,373	40
41	Income before Income Taxes (line 30 minus line 40)**	34,190	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 34,190	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.

*** 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 Lincoln Square

0037044

Report Period Beginning:

01/01/08

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	416	416	\$ 22,019	\$ 52.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,049	18,964	9.26	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,149	2,194	25,367	11.56	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	25	25	624	24.96	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,140	1,138	10,403	9.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,202	1,226	23,005	18.76	28
29	Resident Services Coordinator	802	817	15,336	18.77	29
30	Habilitation Aides (DD Homes)	12,564	13,176	121,829	9.25	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,202	21,041	\$ 237,547 *	\$ 11.29	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	30	\$ 1,524	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	26	1,275	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	20	900	10a-3	46
47	<u>Administrator Consultant</u>	133	6,000	17-3	47
48	<u>Social Work Consultant</u>	60	3,285	12-3	48
49	TOTAL (lines 35 - 48)	325	\$ 16,784		49

C. CONTRACT NURSES

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

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 Healthcare Assoc. \$900
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Lincoln Square #0032469 1/6/88
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 29,200
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? N/A
- (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. \$ 373 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? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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. \$ _____
- (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. Not required of this facility
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Owners Compensation
Jan 1, 2008 - Dec 31, 2008

	Totals / Entity	Holly Hill	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 82,896	32,400					9,138		41,358
Denise Pippins	\$ 32,493	32,000	493						
Diana Alley	\$ 73,971	21,600	15,435		22,019	14,917			
Jo Ann Keller	\$ 129,702		104,927	24,775					
James K. Keller	\$ 14,877		14,877						
Jacob Alley	\$ 56,048					56,048			
Jake Alley	\$ -								
James A. Keller	\$ 88,866					72,258		16,608	
	\$ 478,853	\$ 86,000	\$ 135,732	\$ 24,775	\$ 22,019	\$ 143,223	\$ 9,138	\$ 16,608	\$ 41,358

Lincoln Square
Analysis of Sch XIX, Section F.
2008

Resident Acct Bond Renewal	\$	240
IL Health Care Assoc Dues		828
P.O. Box Rental		37
IL Corp Ann Report		130
Help Wanted Advertising		118
Advertising		81
Contributions		195
Chamber Dues		72
IHCA PAC Dues		72

Less:

Chamber Due	(72)
Advertising	(81)
Contributions	(195)
IHCA PAC Dues	(72)
	<u>\$ 1,353</u>

Lincoln Square
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2008

Sch IX	\$ 15,623
kel-Tech Mgmt. Co. Alloc.	<u>670</u>
Sch V	<u>\$ 16,293</u>

Lincoln Square
Detail of Sch. V, Line 36, Col. 3
2008

Bad Debt	\$	164
State Income Tax		<u>204</u>
Total	\$	<u>368</u>

Lincoln Square
Allocation of Cost for Employee
Schedule XX, Question 12
2008

Anita Beatty, RSD/QMRP

Salary		\$ 38,341
	RSD	40% 15,336
	QMRP	60% 23,005