



Facility Name & ID Number LINCOLN HOME

# 0034678 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	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			5,380	5,380	8
9	SNF/PED					9
10	ICF	30,620	6,557	2,531	39,708	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,620	6,557	7,911	45,088	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.27%**

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

0 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

**F. Does the facility maintain a daily midnight census?**

YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**

YES  NO

**I. On what date did you start providing long term care at this location?**

Date started 09/88

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

YES  Date 09/88 NO

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

YES  NO  If YES, enter number

of beds certified 62 and days of care provided 5,380

Medicare Intermediary ADMINISTAR

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	248,952	25,269	8,734	282,955		282,955		282,955		1
2	Food Purchase		245,180		245,180		245,180		245,180		2
3	Housekeeping	184,358	35,760		220,118		220,118		220,118		3
4	Laundry	88,459	17,140	1,306	106,905		106,905		106,905		4
5	Heat and Other Utilities			132,842	132,842		132,842		132,842		5
6	Maintenance	76,888	42,260	21,198	140,346		140,346		140,346		6
7	Other (specify):*			13,702	13,702		13,702		13,702		7
8	<b>TOTAL General Services</b>	598,657	365,609	177,782	1,142,048		1,142,048		1,142,048		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,043,728	230,731	215,182	2,489,641		2,489,641	(5,000)	2,484,641		10
10a	Therapy										10a
11	Activities	112,104	10,207	1,770	124,081		124,081		124,081		11
12	Social Services	64,478	2,443	1,809	68,730		68,730		68,730		12
13	CNA Training										13
14	Program Transportation			2,212	2,212		2,212		2,212		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,220,310	243,381	250,973	2,714,664		2,714,664	(5,000)	2,709,664		16
	<b>C. General Administration</b>										
17	Administrative	92,990		315,000	407,990		407,990	181,839	589,829		17
18	Directors Fees										18
19	Professional Services			422,571	422,571		422,571	(299,513)	123,058		19
20	Dues, Fees, Subscriptions & Promotions			69,093	69,093		69,093	(34,010)	35,083		20
21	Clerical & General Office Expenses	172,616	19,609	62,796	255,021		255,021	23,276	278,297		21
22	Employee Benefits & Payroll Taxes			513,239	513,239		513,239		513,239		22
23	Inservice Training & Education							1,770	1,770		23
24	Travel and Seminar			27,645	27,645		27,645		27,645		24
25	Other Admin. Staff Transportation							2,162	2,162		25
26	Insurance-Prop.Liab.Malpractice			182,484	182,484		182,484	15,750	198,234		26
27	Other (specify):*			453,597	453,597		453,597	(424,874)	28,723		27
28	<b>TOTAL General Administration</b>	265,606	19,609	2,046,425	2,331,640		2,331,640	(533,600)	1,798,040		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,084,573	628,599	2,475,180	6,188,352		6,188,352	(538,600)	5,649,752		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,659
	REPAIRS & MAINTENANCE	75
		0
		8,734
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,306
		0
		1,306
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	22,961
	ELECTRICITY	70,079
	WATER	38,094
	CABLE TV - LOBBY	1,708
		0
		132,842
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	8,424
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,196
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,176
	FIRE SERVICE	3,402
		0
		0
		0
		0
		21,198
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	13,702
	SECURITY SERVICE	0
		0
		0
		13,702
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,900
	PHARMACY CONSULTANT XVIII B 39-2	3,359
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	208,923
		0
		0
		215,182
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,770
		0
		1,770
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,809
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,809
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	2,212
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	315,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	7,264
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	115,307
	BOOKKEPING/ADMINISTRATIVE SERVICE	300,000
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	422,571
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	28,284
	EMPLOYEE WANT ADS XIX F	16,217
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,306
	LICENSES & PERMITS XIX F	2,003
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,823
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,300
	PATIENT BACKGROUND CHECKS XIX F	6,160
		69,093
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	126
	EQUIPMENT REPAIR & MAINTENANCE	22,581
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	13,000
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,621
	MESSENGER SERVICE	3,468
		0
		62,796

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	227,915
	UNEMPLOYMENT COMPENSATION XIX D	98,275
	WORKERS COMPENSATION INSURANCE XIX D	129,082
	HOSPITALIZATION INSURANCE XIX D	52,358
	EMPLOYEE BENEFITS - OTHER XIX D	5,609
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		513,239
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	630
	TRAVEL XIX G	27,015
		27,645
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	0
		0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	182,484
		182,484
27	<b>OTHER</b>	
	BAD DEBTS VI 24	453,597
		453,597

GRAND TOTAL COLUMN 3 OTHER

2,475,180

LINCOLN HOME  
SCHEDULES  
12/31/2009

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

TOTAL FOOD PURCHASE	245,180
LESS SALES TAX	<u>0</u>
NET FOOD	245,180

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5???

TOTAL PATIENT CENSUS	45,088
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	135,264

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	135,264
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	135,264

NET FOOD	245,180
DIVIDE TOTAL MEALS/YEAR	<u>135,264</u>

COST PER MEAL	1.81
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

LINCOLN HOME

#0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			29,257	29,257		29,257	177,190	206,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,644	22,644		22,644	229,774	252,418			32
33	Real Estate Taxes			2,752	2,752		2,752	51,071	53,823			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(470,780)	9,220			34
35	Rent-Equipment & Vehicles			10,065	10,065		10,065	22,637	32,702			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			544,718	544,718		544,718	9,892	554,610			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,284	783,886	829,170		829,170		829,170			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,220	83,220		83,220		83,220			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		45,284	867,106	912,390		912,390		912,390			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,084,573	673,883	3,887,004	7,645,460		7,645,460	(528,708)	7,116,752			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,175)	30		9
10	Interest and Other Investment Income	(14,092)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,000)	21		18
19	Entertainment		20		19
20	Contributions	(5,823)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,975)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(453,597)	27		24
25	Fund Raising, Advertising and Promotional	(28,284)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(27,319)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (565,265)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)	36,557		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 36,557		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (528,708)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

LINCOLN HOME

ID# 0034678

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2	MARKETING SALARIES	(27,319)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(27,319)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number LINCOLN HOME# 0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(5,000)	0	0	0	0	0	0	0	0	(5,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	(5,000)	0	0	0	0	0	0	0	0	(5,000)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	181,839	0	0	0	0	0	0	0	0	181,839	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,975)	0	(294,538)	0	0	0	0	0	0	0	0	(299,513)	19
20	Fees, Subscriptions & Promotions	(34,107)	0	97	0	0	0	0	0	0	0	0	(34,010)	20
21	Clerical & General Office Expenses	(40,319)	0	63,595	0	0	0	0	0	0	0	0	23,276	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	1,770	0	0	0	0	0	0	0	0	1,770	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	2,162	0	0	0	0	0	0	0	0	2,162	25
26	Insurance-Prop.Liab.Malpractice	0	14,651	1,099	0	0	0	0	0	0	0	0	15,750	26
27	Other (specify):*	(453,597)	0	28,723	0	0	0	0	0	0	0	0	(424,874)	27
28	<b>TOTAL General Administration</b>	(532,998)	14,651	(15,253)	0	0	0	0	0	0	0	0	(533,600)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(532,998)	14,651	(20,253)	0	0	0	0	0	0	0	0	(538,600)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number LINCOLN HOME# 0034678

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(18,175)	195,365	0	0	0	0	0	0	0	0	0	177,190	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,092)	243,866	0	0	0	0	0	0	0	0	0	229,774	32
33	Real Estate Taxes	0	51,071	0	0	0	0	0	0	0	0	0	51,071	33
34	Rent-Facility & Grounds	0	(480,000)	9,220	0	0	0	0	0	0	0	0	(470,780)	34
35	Rent-Equipment & Vehicles	0	0	22,637	0	0	0	0	0	0	0	0	22,637	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(32,267)</b>	<b>10,302</b>	<b>31,857</b>	<b>0</b>	<b>9,892</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(565,265)</b>	<b>24,953</b>	<b>11,604</b>	<b>0</b>	<b>(528,708)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ATRIUM HEALTH CARE & REHABILITATION		WEISS MGMT.		
		CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC.	SKOKIE	MGMT/CLERICAL
SEE ATTACHED SCHEDULE						
				LINCOLN		
				ASSOC., L.P.	SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 480,000	LINCOLN ASSOCIATES, L.P.		\$	\$ (480,000)	1
2	V	30 DEPRECIATION		" " "		195,365	195,365	2
3	V	32 INTEREST EXPENSE		" " "		222,450	222,450	3
4	V	33 REAL ESTATE TAXES		" " "		51,071	51,071	4
5	V	32 MORTGAGE INSURANCE		" " "		21,416	21,416	5
6	V	26 INSURANCE		" " "		14,651	14,651	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 504,953	\$ * 24,953	14

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

Facility Name & ID Number LINCOLN HOME# 0034678Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING CONSULTANT	\$ 5,000	WEISS MANAGEMENT GROUP, INC.		\$	\$ (5,000)
16	V	17 MANAGEMENT FEES	315,000				(315,000)
17	V	19 ADMIN./BKCP. FEES	300,000				(300,000)
18	V						
19	V						
20	V						
21	V						
22	V	17 ADMINISTRATIVE SALARIES				496,839	496,839
23	V	19 PROFESSIONAL FEES				5,462	5,462
24	V	21 OFFICE EXPENSES				63,595	63,595
25	V	23 SEMINARS				1,770	1,770
26	V	25 TRANSPORTATION				2,162	2,162
27	V	26 INSURANCE				1,099	1,099
28	V	27 EMPLOYEE BENEFITS				28,723	28,723
29	V	34 OFFICE RENT				9,220	9,220
30	V	35 AUTO LEASE				22,637	22,637
31	V	20 LICENSES & PERMITS				97	97
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 620,000			\$ 631,604	\$ * 11,604

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

Facility Name &amp; ID Number

LINCOLN HOME

#

0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARTIN WEISS	PRESIDENT	ADMINISTRATO	45.10		20		SALARY	\$ 143,993	17-7	1
2					SEE						2
3	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	ATTACHED	12		SALARY	186,846	17-7	3
4					SCHEDULE						4
5	NATAN WEISS	CONTROLLER	BOOKKEEPING	8.39		16		SALARY	166,000	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 496,839		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 HOME

# 0034678

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	89,439	2	\$ 985,556	\$ 985,556	45,088	\$ 496,839	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	89,439	2	10,834		45,088	5,462	2
3	21	OFFICE EXPENSES	PATIENT CENSUS	89,439	2	126,151	96,549	45,088	63,595	3
4	23	SEMINARS	PATIENT CENSUS	89,439	2	3,512		45,088	1,770	4
5	25	TRANSPORTATION	PATIENT CENSUS	89,439	2	4,289		45,088	2,162	5
6	26	INSURANCE	PATIENT CENSUS	89,439	2	2,181		45,088	1,099	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	89,439	2	56,977		45,088	28,723	7
8	34	OFFICE RENT	PATIENT CENSUS	89,439	2	18,289		45,088	9,220	8
9	35	AUTO LEASE	PATIENT CENSUS	89,439	2	44,904		45,088	22,637	9
10	20	LICENSES & PERMITS	PATIENT CENSUS	89,439	2	192		45,088	97	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,252,885	\$ 1,082,105		\$ 631,604	25

Facility Name &amp; ID Number

LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	<b>RELATED PARTY: THE LINCOLN ASSOCIATION, LLC</b>											
2	CAMBRIDGE REALTY		X	MORTGAGE	\$31,065.72	04/04	4,528,900	4,224,633	04/39	5.1400	219,066	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER COSTS		118,455	98,997			3,384	3
4	MIP INSURANCE										21,416	4
5												5
	<b>Working Capital</b>											
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND			194,461		PRIME+	20,898	6
7			X	INSURANCE FINANCING							1,746	7
8												8
9	TOTAL Facility Related				\$31,065.72		\$ 4,647,355	\$ 4,518,091			\$ 266,510	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,647,355	\$ 4,518,091			\$ 266,510	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,416 Line # 32-7

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>46,279</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>51,185</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,906</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,917</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>53,823</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>37,967</b>	<b>8</b>
	2005	<b>44,310</b>	<b>9</b>
	2006	<b>47,114</b>	<b>10</b>
	2007	<b>48,929</b>	<b>11</b>
	2008	<b>51,185</b>	<b>12</b>

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**  
**THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME LINCOLN HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-20.0-204-015</u>	<u>NURSING HOME</u>	\$ <u>2,751.82</u>	\$ <u>2,751.82</u>
2. <u>08-20.0-210-029</u>	<u>NURSING HOME</u>	\$ <u>47,270.70</u>	\$ <u>47,270.70</u>
3. <u>08-20.0-207-025</u>	<u>NURSING HOME</u>	\$ <u>867.14</u>	\$ <u>867.14</u>
4. <u>08-20.0-210-028</u>	<u>NURSING HOME</u>	\$ <u>295.28</u>	\$ <u>295.28</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>51,184.94</u>	\$ <u>51,184.94</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

N/A

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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>NURSING HOME</u>	<u>3+ACRES</u>	<u>1987</u>	<u>\$ 148,649</u>	<u>1</u>
2	<u>PARKING LOT</u>	<u>2+ACRES</u>	<u>2005</u>	<u>50,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 198,649</b>	<b>3</b>

Facility Name &amp; ID Number LINCOLN HOME

# 0034678

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152		1988		\$ 2,011,351	\$ 63,852	31.5	\$ 63,852	\$	\$ 1,333,985	4
5			2003		1,249,221	45,426	27.5	45,426		293,376	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	VARIOUS		1990		11,158	354	31.5	354		6,820	9
10	VARIOUS		1993		6,676	171	39	171		3,608	10
11	VARIOUS		1994		7,797	200	39	200		4,058	11
12	VARIOUS		1995		13,072	335	39	335		5,922	12
13	CARPET		1996		907	23	39	23		351	13
14	BILLBOARD		1996		900	23	39	23		354	14
15	SMOKE DETECTORS		1996		602	15	39	15		235	15
16	PARKING LOT		1996		8,006	205	39	205		3,255	16
17	AWNING		1996		905	23	39	23		369	17
18	CARPETING		1996		1,512	39	39	39		638	18
19	DOOR LOCKS		1997		2,100	54	39	54		760	19
20	WALL PAPER		1997		2,012	52	39	52		742	20
21	HANDRAIL		1997		3,217	83	39	83		1,108	21
22	FIRE ALARM SYSTEM		1998		11,636	298	39	298		3,569	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION		1998		9,227	236	39	236		2,833	23
24	PAINTING/WALLPAPERING		1998		2,988	77	39	77		922	24
25	REPLACE PVC PIPE IN BASEMENT		1998		1,074	28	39	28		335	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD		1999		6,144	158	39	158		1,348	26
27	INSTALLED A NEW DURO-LAST ROOF		1999		56,400	1,446	39	1,446		12,286	27
28	WALLPAPER		2000		14,896	382	39	382		4,183	28
29	SEWER LINE REPAIR		2000		11,743	301	39	301		2,853	29
30	AIR CONDITIONING UNITS		2000		8,848	227	39	227		2,151	30
31	CONDENSING UNIT ON FREEZER		2000		2,693	69	39	69		657	31
32	NEW NURSES STATION		2000		20,379	522	39	522		4,969	32
33	FIRE ALARM SYSTEM		2000		1,826	47	39	47		447	33
34	HOT WATER SYSTEM		2000		3,849	99	20	99		1,955	34
35	TILED FLOORS		2000		54,185	1,389	39	1,389		13,205	35
36	REMODELING OF BATHROOMS		2000		18,490	474	39	474		4,501	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	\$ 13,369	\$ 726	20	\$ 668	\$ (58)	\$ 8,670	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		11,102	38
39	ROOF	2001	47,500	1,727	27.5	1,727		14,680	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		2,838	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		3,774	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		3,510	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		16,855	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		11,612	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159	2,346	20	1,558	(788)	12,464	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		1,920	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		4,772	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTRY	2002	7,245	263	27.5	263		2,027	48
49	LANDSCAPING	2004	7,759	1,358	15	517	(841)	2,779	49
50	REPLACEMENT WINDOWS	2004	32,853	5,749	20	1,643	(4,106)	9,858	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270	1,098	20	314	(784)	1,884	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250	18,420	20	5,263	(13,157)	31,578	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		517	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		410	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		4,932	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		1,533	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		1,364	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		6,402	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		3,027	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906	3,581	5	3,581		12,534	60
61	AIR CONDITIONERS	2007	7,968	1,530	5	1,530		5,674	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	1,997	27.5	1,997		5,123	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		769	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		349	64
65	PAINTING	2007	9,986	1,917	5	1,917		7,110	65
66	GARDEN	2007	60,172	2,155	15	4,012	1,857	9,695	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		302	67
68	PAINTING - 30 ROOMS	2008	2,550	816	5	816		1,326	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		188	69
70	TOTAL (lines 4 thru 69)		\$ 4,265,246	\$ 171,869		\$ 153,992	\$ (17,877)	\$ 1,913,373	70

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

Facility Name &amp; ID Number LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,265,246	\$ 171,869		\$ 153,992	\$ (17,877)	\$ 1,913,373	1
2	2008	1,473	98	15	98		172	2
3	2008	4,672	170	27.5	170		276	3
4	2009	1,599	41	27.5	41		41	4
5	2009	5,187	1,037	5	1,037		1,037	5
6	2009	3,195	73	27.5	73		73	6
7	2009	8,048	159	27.5	159		159	7
8	2009	1,865	62	15	62		62	8
9	2009	114,376	2,599	27.5	2,599		2,599	9
10	2009	29,344	5,869	5	5,869		5,869	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,435,005	\$ 181,977		\$ 164,100	\$ (17,877)	\$ 1,923,661	34

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

Facility Name & ID Number LINCOLN HOME

# 0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 107,807	\$ 12,142	\$ 12,404	\$ 262	10-Mar	\$ 44,303	71
72	Current Year Purchases	27,188	5,438	1,359	(4,079)	10	1,359	72
73	Fully Depreciated Assets	89,692					89,692	73
74	<b>RELATED PARTY DEPRECIATION</b>		20,284	20,284				74
75	<b>TOTALS</b>	\$ 224,687	\$ 37,864	\$ 34,047	\$ (3,817)		\$ 135,354	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	<b>FACILITY</b>	<b>2005 FORD ECONOCARE</b>	<b>2005</b>	\$ 41,500	\$ 4,781	\$ 8,300	\$ 3,519	5	\$ 41,500	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 41,500	\$ 4,781	\$ 8,300	\$ 3,519		\$ 41,500	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)	\$ 4,899,841	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,622	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 206,447	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,175)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,100,515	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	<b>TOTALS</b>	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ 10,065 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ \$ \_\_\_\_\_

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

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

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 288,492	\$		\$ 288,492	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			83,781			83,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			255,641			255,641	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			155,972			155,972	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					26,853		26,853	12
13	Other (specify): <b>RADIOLOGY, LAB</b>	39-2					18,431		18,431	13
14	<b>TOTAL</b>			\$		\$ 783,886	\$ 45,284		\$ 829,170	14

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

Facility Name &amp; ID Number LINCOLN HOME

# 0034678

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (13,423)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,848,143		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,849		6
7	Other Prepaid Expenses	8,465		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,941,034	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	69,577		15
16	Equipment, at Historical Cost	267,838		16
17	Accumulated Depreciation (book methods)	(241,152)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 220,289	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,161,323	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 564,319	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	787,600		29
30	Accrued Salaries Payable	113,718		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,155		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,477,792	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,477,792	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 683,531	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,161,323	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,284,012</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>IL REPLACEMENT TAX 2008</b>	<b>(9,855)</b>	<b>3</b>
<b>4</b>	<b>PRIOR YEAR W/O</b>	<b>(377,994)</b>	<b>4</b>
<b>5</b>	<b>ROUNDING</b>	<b>1</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>896,164</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(192,633)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(20,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(212,633)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>683,531</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,155,715	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,155,715	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,020	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 283,020	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,092	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,092	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,452,827	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,142,048	31
32	Health Care	2,714,664	32
33	General Administration	2,331,640	33
<b>B. Capital Expense</b>			
34	Ownership	544,718	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	829,170	35
36	Provider Participation Fee	83,220	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,645,460	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(192,633)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (192,633)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 HOME

# 0034678

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,694	1,718	\$ 63,987	\$ 37.25	1
2	Assistant Director of Nursing	2,399	2,439	61,640	25.27	2
3	Registered Nurses	11,318	11,836	295,877	25.00	3
4	Licensed Practical Nurses	25,726	26,579	528,562	19.89	4
5	CNAs & Orderlies	94,562	97,252	913,909	9.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,162	11,586	112,104	9.68	10
11	Social Service Workers	5,235	5,413	64,478	11.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,041	27,269	248,952	9.13	15
16	Dishwashers					16
17	Maintenance Workers	4,949	5,340	76,888	14.40	17
18	Housekeepers	20,326	20,629	184,358	8.94	18
19	Laundry	10,948	11,098	88,459	7.97	19
20	Administrator	1,184	1,200	50,000	41.67	20
21	Assistant Administrator	1,040	1,104	42,990	38.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,300	12,803	172,616	13.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: SEE ATTACHED	9,360	9,945	179,753	18.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,244	246,211	\$ 3,084,573 *	\$ 12.53	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,659	1-3	35
36	Medical Director	O	30,000	9-3	36
37	Medical Records Consultant	N	2,900	10-3	37
38	Nurse Consultant	T	208,923	10-3	38
39	Pharmacist Consultant	H	3,359	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,770	11-3	44
45	Social Service Consultant	E	1,809	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 257,420		49

C. CONTRACT NURSES

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



Facility Name & ID Number LINCOLN HOME

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8						N/A						
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$7,421
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,892 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,220  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - d. Have vehicle usage logs been maintained? NO
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.