

Facility Name & ID Number Lincoln Manor

0021501 Report Period Beginning: 1/1/2009 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>116</u>	Intermediate (ICF)	<u>116</u>	<u>42,340</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,100</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>0</u>	<u>0</u>	<u>4,451</u>	<u>4,451</u>	8	
9	SNF/PED					9	
10	ICF	<u>28,782</u>	<u>9,667</u>		<u>38,449</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>28,782</u>	<u>9,667</u>	<u>4,451</u>	<u>42,900</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.95%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

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

YES NO

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

Date started 04/01/75

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 24 and days of care provided 4,451

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2009 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
	A. General Services										
1	Dietary	275,523	26,630	9,075	311,228		311,228		311,228		1
2	Food Purchase		286,996		286,996		286,996	(3,511)	283,485		2
3	Housekeeping	171,046	8,007	23,466	202,519		202,519		202,519		3
4	Laundry	77,929	12,620	3,547	94,096		94,096		94,096		4
5	Heat and Other Utilities			122,281	122,281		122,281		122,281		5
6	Maintenance	64,963	4,695	37,358	107,016		107,016		107,016		6
7	Other (specify):*										7
8	TOTAL General Services	589,461	338,948	195,727	1,124,136		1,124,136	(3,511)	1,120,625		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,034,169	136,599	14,368	2,185,136		2,185,136		2,185,136		10
10a	Therapy			533,208	533,208		533,208		533,208		10a
11	Activities	60,447	430	7,030	67,907		67,907		67,907		11
12	Social Services	1,610		1,793	3,403		3,403		3,403		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,096,226	137,029	586,399	2,819,654		2,819,654		2,819,654		16
	C. General Administration										
17	Administrative	144,989			144,989		144,989		144,989		17
18	Directors Fees			31,000	31,000		31,000		31,000		18
19	Professional Services			93,153	93,153		93,153	(2,128)	91,025		19
20	Dues, Fees, Subscriptions & Promotions			18,136	18,136		18,136	(926)	17,210		20
21	Clerical & General Office Expenses	101,604	8,460	25,027	135,091		135,091		135,091		21
22	Employee Benefits & Payroll Taxes			385,974	385,974		385,974	3,112	389,086		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,580	2,580		2,580	(655)	1,925		24
25	Other Admin. Staff Transportation			7,559	7,559		7,559		7,559		25
26	Insurance-Prop.Liab.Malpractice			109,591	109,591		109,591	(3,678)	105,913		26
27	Other (specify):*										27
28	TOTAL General Administration	246,593	8,460	673,020	928,073		928,073	(4,275)	923,798		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,932,280	484,437	1,455,146	4,871,863		4,871,863	(7,786)	4,864,077		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lincoln Manor

#0021501

Report Period Beginning:

1/1/2009

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	
	D. Ownership											
30	Depreciation			152,383	152,383		152,383	8,204	160,587			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,762	8,762		8,762	(7,303)	1,459			32
33	Real Estate Taxes			55,747	55,747		55,747		55,747			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,537	6,537		6,537		6,537			35
36	Other (specify):*											36
37	TOTAL Ownership			223,429	223,429		223,429	901	224,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,405	128	130,533		130,533		130,533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,684	75,684		75,684		75,684			42
43	Other (specify):* Non-allowable cost	15,354		235,493	250,847		250,847	(250,847)				43
44	TOTAL Special Cost Centers	15,354	130,405	311,305	457,064		457,064	(250,847)	206,217			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,947,634	614,842	1,989,880	5,552,356		5,552,356	(257,732)	5,294,624			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lincoln Manor

ID# 0021501

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Part A	\$ (7,907)	43	1
2	X-Ray - Part A	(5,315)	43	2
3	Disallow Nonallowable Travel and Seminar Expenses	(655)	24	3
4	Disallow Nonallowable Legal Expenses	(2,128)	19	4
5	Yellow Pages Advertising	(926)	21	5
6	Pet Care	(1,041)	43	6
7	Donations	(230)	43	7
8	Resident Gifts	(15)	43	8
9	Marketing Salary	(15,354)	43	9
10	Miscellaneous Income	(3,678)	43	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	(37,249)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Manor# 0021501

Report Period Beginning:

1/1/2009

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(399)	0	0	0	0	0	0	0	0	0	0	(399)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(399)	0	0	0	0	0	0	0	0	0	0	(399)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,128)	0	0	0	0	0	0	0	0	0	0	(2,128)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(926)	0	0	0	0	0	0	0	0	0	0	(926)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(655)	0	0	0	0	0	0	0	0	0	0	(655)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,709)	0	0	0	0	0	0	0	0	0	0	(3,709)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,108)	0	0	0	0	0	0	0	0	0	0	(4,108)	29

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Manor# 0021501

Report Period Beginning:

1/1/2009

Ending:

Summary B

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)	
	D. Ownership													
30	Depreciation	8,204	0	0	0	0	0	0	0	0	0	0	8,204	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,303)	0	0	0	0	0	0	0	0	0	0	(7,303)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	901	0	0	0	0	0	0	0	0	0	0	901	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(254,525)	0	0	0	0	0	0	0	0	0	0	(254,525)	43
44	TOTAL Special Cost Centers	(254,525)	0	0	0	0	0	0	0	0	0	0	(254,525)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(257,732)	0	0	0	0	0	0	0	0	0	0	(257,732)	45

Facility Name & ID Number

Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	N/A						2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Owners
As of 12/31/09**

Schedule 6A

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

See Accountants' Compilation Report

Facility Name & ID Number

Lincoln Manor

#

0021501

Report Period Beginning:

1/1/2009

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	Vicki Pollard Evans	Director	Administrative	10.00	None	0.46	1.15	Director Fee	\$ 2,000	18(3)	1
2	William Glickauf	Director	Administrative	0.00	None	0.46	1.15	Director Fee	2,000	18(3)	2
3	Richard Rovnick	Director	Administrative	8.00	None	0.5	1.25	Director Fee	1,500	18(3)	3
4	Pam Ferris	Director	Administrative	0.00	None	0.23	0.58	Director Fee	2,000	18(3)	4
5	Kenneth Weinberger	Director	Administrative	3.00	None	0.53	1.35	Director Fee	4,000	18(3)	5
6	Mort Melnik	Director	Administrative	10.00	None	0.38	0.96	Director Fee	4,000	18(3)	6
7	Dr. Seymour Melnik	Director	Administrative	12.50	None	0.57	1.44	Director Fee	7,000	18(3)	7
8	Gayle Rovnick	Director	Administrative	3.00	None	0.23	0.58	Director Fee	2,500	18(3)	8
9	David Cohn	Director	Administrative	10.00	None	2.3	5.77	Director Fee	4,000	18(3)	9
10	Arlene Rubin	Director	Administrative	10.00	None	0.42	1.06	Director Fee	2,000	18(3)	10
11											11
12											12
13								TOTAL	\$ 31,000		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor

0021501 Report Period Beginning: 1/1/2009

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Busey Bank		X	Facilities Improvement	\$7,419.00	5/23/08	\$ 376,000	\$ 157,883	5/2023	0.0675	\$ 8,762	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Busey Bank		X	Line of Credit	Varies	1/2/08			11/10/09	0.0350		6							
7												7							
8												8							
9	TOTAL Facility Related				\$7,419.00		\$ 376,000	\$ 157,883			\$ 8,762	9							
B. Non-Facility Related*																			
10								Interest Income Offset			(7,303)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (7,303)	14							
15	TOTALS (line 9+line14)						\$ 376,000	\$ 157,883			\$ 1,459	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Lincoln Manor**# **0021501**Report Period Beginning: **1/1/2009**Ending: **12/31/2009****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					
1. Real Estate Tax accrual used on 2008 report.				\$	52,349	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2008			\$	54,096	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	1,747	3	
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	54,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	55,747	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2004	47,501	8	FOR BHF USE ONLY			
	2005	49,603	9	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	2006	50,462	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2007	52,355	11	15	LESS REFUND FROM LINE 6	\$	15
	2008	54,096	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2009 Accrual is based on the 2008 Real Estate Tax							

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	140	1975	1975	\$ 745,047	\$	35	\$	\$	\$ 745,047	4
5		1981	1981	369,094		35			369,094	5
6		1984	1984	368,408		35			368,408	6
7		1985	1985	5,143		35			5,143	7
8		1993	1993	47,097		35	1,177	1,177	19,081	8
Improvement Type**										
9	Various		1975	9,508		20			7,010	9
10	Various		1981	3,615		20			3,615	10
11	Various		1982	25,660		20			24,773	11
12	Various		1984	2,107		20			2,107	12
13	Various		1985	13,371		20			13,371	13
14	Various		1986	12,384		20	300	300	9,561	14
15	Various		1987	59,842		20	1,360	1,360	35,165	15
16	Various		1988	16,800		20	841	841	11,768	16
17	Various		1989	24,981		20	259	259	23,431	17
18	Various		1990	26,245		20	68	68	24,883	18
19	Various		1991	9,545		20			9,545	19
20	Various		1992	24,119		20	211	211	19,742	20
21	Various		1993	9,429		20	391	391	7,084	21
22	Various		1994	31,724		20	347	347	32,071	22
23	Various		1995	89,487		20	3,796	3,796	54,603	23
24	Various		1996	96,885		20	4,846	4,846	58,825	24
25	Various		1997	75,339		20	3,768	3,768	48,515	25
26	Various		1998	126,326		20	6,315	6,315	72,273	26
27	Various		1999	46,295		20	2,314	2,314	23,833	27
28	Various		2000	172,355		20	7,412	7,412	71,450	28
29	Various		2001	129,251		20	6,462	6,462	54,986	29
30	Various		2002	38,912		20	3,921	3,921	29,392	30
31	Various		2003	61,774		20	3,089	3,089	1,900	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69	Financial Statement Depreciation			152,383		(152,383)		69
70	TOTAL (lines 4 thru 69)	\$	2,640,743	\$	46,877	\$	2,146,676	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,640,743	\$ 152,383		\$ 46,877	\$ (105,506)	\$ 2,146,676	1
2	Window Treatment, Wall Covering	2004	3,416		20	171	171	854	2
3	Painting (Dining Room)	2004	1,960		20	98	98	580	3
4	Drywall repairs	2004	8,381		20	419	419	2,130	4
5	Flooring	2004	1,064		20	53	53	54	5
6	Plumbing	2004	183		20	9	9	54	6
7	Wall Covering	2004	3,701		20	185	185	1,110	7
8	Code Alert System	2004	1,613		20	81	81	431	8
9	Storage Room	2004	4,889		20	244	244	1,242	9
10	Faucets	2004	510		20	26	26	154	10
11	Painting - Labor	2005	7,100		20	355	355	1,568	11
12	Electrical Work	2005	623		20	31	31	137	12
13	Paint	2005	4,547		20	227	227	928	13
14	Storage Shed & Slab	2005	8,630		20	432	432	1,943	14
15	New Sidewalk	2005	6,066		20	303	303	1,314	15
16	Fencing	2005	775		20	39	39	168	16
17	Electrical - Lighting	2005	910		20	45	45	196	17
18	Carpet, Vinyl Flooring	2005	5,853		20	293	293	1,196	18
19	Carpet Installation	2005	675		20	34	34	138	19
20	Roof Top Heating Cooling Unit	2005	7,233		20	362	362	1,447	20
21	Roof Top Heating Cooling Parts	2005	7,812		20	391	391	1,824	21
22	Replace Heating Cooling Roof Top Units	2005	9,044		20	452	452	1,921	22
23	Flooring	2006	7,330		20	366	366	1,465	23
24	Windows	2006	3,678		20	184	184	659	24
25	Paint, Molding	2006	5,249		20	262	262	918	25
26	Tile	2006	9,085		20	454	454	1,589	26
27	Electrical / Fire Protection	2006	5,020		20	251	251	879	27
28	Remodeling / Redecorating	2006	14,333		20	717	717	2,509	28
29	Front Entrance	2006	2,333		20	117	117	399	29
30	Two Water Heaters	2006	15,475		20	774	774	3,096	30
31	Vanities, Marble Tops	2006	8,964		20	448	448	1,568	31
32	Faucets / Lavatories	2006	4,002		20	200	200	650	32
33	Blinds	2006	4,407		20	220	220	715	33
34	TOTAL (lines 1 thru 33)		\$ 2,805,604	\$ 152,383		\$ 55,120	\$ (97,263)	\$ 2,180,512	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,805,604	\$ 152,383		\$ 55,120	\$ (97,263)	\$ 2,180,512	1
2	Hand Rails	2006	3,220		20	161	161	523	2
3	Fabric, Rods, Brackets	2006	1,121		20	56	56	173	3
4	A/C Repair	2006	6,748		20	337	337	1,180	4
5	Code Alert - Smoking Room Door	2006	3,963		20	198	198	759	5
6	Bath Room Vanities	2006	7,572		20	379	379	1,294	6
7	Circulating Pump	2006	3,249		20	162	162	500	7
8	Decorating & Painting	2006	3,581		20	179	179	552	8
9	Lanscaping	2007	7,345		20	326	326	978	9
10	Lanscaping	2007	1,288		20	57	57	171	10
11	Interior Painting	2007	34,817		20	2,611	2,611	7,833	11
12	Decorating Valance	2007	650		20	65	65	195	12
13	Corner Guard	2007	3,477		20	348	348	1,044	13
14	Wallcoverings	2007	3,264		20	272	272	816	14
15	Privacy Curtains	2007	8,267		20	689	689	2,067	15
16	Sanding & Patching Walls	2007	3,200		20	240	240	720	16
17	Crowns In Foyer & Hallway	2007	6,739		20	618	618	1,854	17
18	Wallpaper	2007	22,540		20	1,503	1,503	4,509	18
19	Carpeting	2007	3,239		20	216	216	648	19
20	Flooring	2007	1,820		20	121	121	363	20
21	Wall Base & Cove Base	2007	12,904		20	860	860	2,580	21
22	Paneling & Wallpaper	2007	3,299		20	275	275	825	22
23	Paneling & Crown Molding	2007	3,699		20	308	308	924	23
24	Install & Caulk Cove Base	2007	3,598		20	300	300	900	24
25	Base & Crown	2007	5,772		20	433	433	1,299	25
26	Base & Crown	2007	7,320		20	488	488	1,464	26
27	Bases, Crowns & Drywall Repair	2007	7,203		20	480	480	1,440	27
28	Base, Drywall, Chair Rails, Crowns	2007	9,222		20	615	615	1,845	28
29	Flooring, Wall Fixtures, Signs, Tiling, Bathroom Vanities, Faucets	2007	103,555		20	5,178	5,178	15,534	29
30	Beauty Shop Remodel (Carpeting, Wallcoverings, Cove Base)	2008	6,279		20	314	314	628	30
31	Paint & Repair Resident Closets	2008	3,523		20	176	176	352	31
32	Five Ton Furnace	2009	5,000		20	250	250	250	32
33	Carpeting	2009	570		20	29	29	326	33
34	TOTAL (lines 1 thru 33)		\$ 3,103,648	\$ 152,383		\$ 73,364	\$ (79,019)	\$ 2,235,058	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,103,648	\$ 152,383		\$ 73,364	\$ (79,019)	\$ 2,235,058	1
2	2009	9,008		20	450	450	450	2
3	2009	8,000		20	400	400	400	3
4	2009	3,444		20	172	172	172	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	TOTAL (lines 1 thru 33)	\$ 3,124,100	\$ 152,383		\$ 74,386	\$ (77,997)	\$ 2,236,080	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 714,169	\$	\$ 69,346	\$ 69,346	10	\$ 485,156	71
72	Current Year Purchases	64,815		6,701	6,701	7	6,701	72
73	Fully Depreciated Assets	435,329				10	435,329	73
74								74
75	TOTALS	\$ 1,214,313	\$	\$ 76,047	\$ 76,047		\$ 927,186	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Chevy Van	1993	\$ 17,701	\$	\$	\$	5	\$ 17,701	76
77		2006 Southern Bus	2006	50,771		10,154	10,154	5	39,770	77
78										78
79										79
80	TOTALS			\$ 68,472	\$	\$ 10,154	\$ 10,154		\$ 57,471	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 4,475,855	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,383	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 160,587	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,204	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,220,737	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,537 Description: Postage Meter-\$2,189; Copier-\$2,593; Ice Machine-\$1,755

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,736	\$ 196,972	\$	2,736	\$ 196,972	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,263	90,958		1,263	90,958	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,407	245,278		3,407	245,278	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				130,405		130,405	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Physician Services</u>	39(3)				128			128	12
13	Other (specify):									13
14	TOTAL			\$	7,406	\$ 533,336	\$ 130,405	7,406	\$ 663,741	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor# 0021501Report Period Beginning: 1/1/2009Ending: 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 96,486	\$ 96,486	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	712,453	712,453	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,800	21,800	6
7	Other Prepaid Expenses	2,406	2,406	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 833,145	\$ 833,145	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	84,560	68,970	13
14	Buildings, at Historical Cost	2,093,029	3,080,205	14
15	Leasehold Improvements, at Historical Cost	43,895	43,895	15
16	Equipment, at Historical Cost	1,978,605	1,282,785	16
17	Accumulated Depreciation (book methods)	(3,587,746)	(3,220,737)	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)	\$ 612,343	\$ 1,255,118	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,445,488	\$ 2,088,263	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 163,707	\$ 163,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	89,028	89,028	29
30	Accrued Salaries Payable	59,539	59,539	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,215	11,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,000	54,000	32
33	Accrued Interest Payable	320	320	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Tax Withholding</u>	2,463	2,463	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 380,272	\$ 380,272	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	68,855	68,855	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)	\$ 68,855	\$ 68,855	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 449,127	\$ 449,127	46
47	TOTAL EQUITY(page 18, line 24)	\$ 996,361	\$ 1,639,136	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,445,488	\$ 2,088,263	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,072,700	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,072,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	398,661	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	(475,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (76,339)	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)	\$ 996,361	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor# 0021501Report Period Beginning: 1/1/2009Ending: 12/31/2009**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	\$ 5,977,744	1
2	Discounts and Allowances for all Levels	(38,449)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,939,295	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	399	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)	\$ 399	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,303	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,303	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	4,020	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,020	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,951,017	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,124,136	31
32	Health Care	2,819,654	32
33	General Administration	928,073	33
B. Capital Expense			
34	Ownership	223,429	34
C. Ancillary Expense			
35	Special Cost Centers	381,380	35
36	Provider Participation Fee	75,684	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,552,356	40
41	Income before Income Taxes (line 30 minus line 40)**	398,661	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 398,661	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Tax return is prepared on the cash basis

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

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	2,223	2,311	\$ 76,658	\$ 33.17	1
2	Assistant Director of Nursing	830	863	22,588	26.17	2
3	Registered Nurses	7,478	7,773	183,444	23.60	3
4	Licensed Practical Nurses	22,788	23,688	479,914	20.26	4
5	CNAs & Orderlies	85,879	89,271	1,051,615	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,784	1,854	24,215	13.06	9
10	Activity Assistants	3,394	3,528	36,232	10.27	10
11	Social Service Workers	93	97	1,610	16.60	11
12	Dietician					12
13	Food Service Supervisor	1,732	1,800	29,305	16.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,063	23,974	246,218	10.27	15
16	Dishwashers					16
17	Maintenance Workers	4,609	4,791	64,963	13.56	17
18	Housekeepers	18,182	18,900	171,046	9.05	18
19	Laundry	8,069	8,388	77,929	9.29	19
20	Administrator	2,253	2,342	100,863	43.07	20
21	Assistant Administrator	1,656	1,721	44,126	25.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,672	9,015	101,604	11.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,115	1,159	23,252	20.06	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	15,690	16,310	196,698	12.06	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Coord	1,400	1,450	15,354	10.59	33
34	TOTAL (lines 1 - 33)	210,909	219,235	\$ 2,947,634 *	\$ 13.45	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	218	\$ 8,942	1(3)	35
36	Medical Director	Monthly	30,000	9(3)	36
37	Medical Records Consultant			10(3)	37
38	Nurse Consultant	Monthly	13,000	10(3)	38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant			10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	86	4,713	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	304	\$ 57,255		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	24	768	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 768		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lincoln Manor

Provider #: 0021501
1/1/2009 to 12/31/2009

Schedule 21A

XIX. Support Schedule
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Winters, Fetherstun, Gaumer, Postlewait, Stocks & Flynn	Legal	12,746
Frost, Ruttenberg & Rothblatt, P.C.	Accounting	743
McGuire, Yuhas, Huffman & Buckley, P.C.	Accounting	65,431
Duane Morris, LLP	Legal	5,108
McGladrey	Cost Reports	9,125
Total (agree to Schedule V, Line 19, Column 3)		<u>93,153</u>
Nonallowable out of period Legal Expenses		<u>(2,128)</u>
Total (agree to Schedule V, Line 19, Column 8)		<u><u>91,025</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor

0021501

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. INHAA \$100
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,141 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 75,684
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. \$ 3,112 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT