

Facility Name & ID Number Lincoln Square

0037044 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 5475

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	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	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,473			5,473	13
14	TOTALS	5,473			5,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.96%

D. How many bed-hold days during this year were paid by the Department? 2 (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 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/1991 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Lincoln Square # 0037044 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	26,065	1,776	1,591	29,432		29,432		29,432		1
2	Food Purchase		45,229		45,229		45,229		45,229		2
3	Housekeeping		4,234	500	4,734		4,734	87	4,821		3
4	Laundry		547		547		547		547		4
5	Heat and Other Utilities			13,581	13,581		13,581	223	13,804		5
6	Maintenance		2,398	3,678	6,076		6,076	4,299	10,375		6
7	Other (specify):*										7
8	TOTAL General Services	26,065	54,184	19,350	99,599		99,599	4,609	104,208		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	173,522	1,973	3,450	178,945		178,945	973	179,918		10
10a	Therapy		493	2,655	3,148		3,148		3,148		10a
11	Activities	16,761		352	17,113		17,113		17,113		11
12	Social Services		1,941	2,190	4,131		4,131	(1,470)	2,661		12
13	CNA Training	4,259		980	5,239		5,239		5,239		13
14	Program Transportation		1,702	2,730	4,432		4,432	515	4,947		14
15	Other (specify):* Day Training Expense			117,198	117,198		117,198	(117,198)			15
16	TOTAL Health Care and Programs	194,542	6,109	133,155	333,806		333,806	(117,180)	216,626		16
	C. General Administration										
17	Administrative			2,400	2,400		2,400	4,698	7,098		17
18	Directors Fees							80	80		18
19	Professional Services			26,795	26,795		26,795	(25,481)	1,314		19
20	Dues, Fees, Subscriptions & Promotions			1,521	1,521		1,521	(217)	1,304		20
21	Clerical & General Office Expenses	13,610	2,641	4,889	21,140		21,140	8,291	29,431		21
22	Employee Benefits & Payroll Taxes			34,888	34,888		34,888	2,753	37,641		22
23	Inservice Training & Education			362	362		362		362		23
24	Travel and Seminar			39	39		39		39		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,739	3,739		3,739	302	4,041		26
27	Other (specify):* See pg. 25			6	6		6	(6)			27
28	TOTAL General Administration	13,610	2,641	74,639	90,890		90,890	(9,580)	81,310		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	234,217	62,934	227,144	524,295		524,295	(122,151)	402,144		29

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

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

Facility Name & ID Number

Lincoln Square

#0037044

Report Period Beginning:

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			4,724	4,724		4,724	8,734	13,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			641	641		641		641			32
33	Real Estate Taxes			8,899	8,899		8,899	135	9,034			33
34	Rent-Facility & Grounds			36,300	36,300		36,300	(35,822)	478			34
35	Rent-Equipment & Vehicles			1,447	1,447		1,447	174	1,621			35
36	Other (specify):* See pg. 25			2,000	2,000		2,000	(2,000)				36
37	TOTAL Ownership			54,011	54,011		54,011	(28,779)	25,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,493	3,493		3,493	(3,250)	243			41
42	Provider Participation Fee			29,360	29,360		29,360		29,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,853	32,853		32,853	(3,250)	29,603			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	234,217	62,934	314,008	611,159		611,159	(154,180)	456,979			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	\$ (117,198)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(562)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,513	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,570)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(177)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg. 5A	(4,797)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,797)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,383)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,383)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (154,180)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Lincoln Square

ID# 0037044

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PAC Dues	\$ (48)	20	1
2	Personal Items	(1,470)	12	2
3	Vending Expense offset by Vending Revenue	(3,250)	41	3
4	NFIB Dues	(29)	20	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	Total	(4,797)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square# 0037044

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	87	0	0	0	0	0	0	0	0	0	87	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	223	0	0	0	0	0	0	0	0	0	223	5
6	Maintenance	0	114	4,185	0	0	0	0	0	0	0	0	4,299	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	424	4,185	0	4,609	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	973	0	0	0	0	0	0	0	0	973	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,470)	0	0	0	0	0	0	0	0	0	0	(1,470)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	515	0	0	0	0	0	0	0	0	0	515	14
15	Other (specify):*	(117,198)	0	0	0	0	0	0	0	0	0	0	(117,198)	15
16	TOTAL Health Care and Programs	(118,668)	515	973	0	(117,180)	16							
	C. General Administration													
17	Administrative	0	0	4,698	0	0	0	0	0	0	0	0	4,698	17
18	Directors Fees	0	80	0	0	0	0	0	0	0	0	0	80	18
19	Professional Services	(1,570)	89	(24,000)	0	0	0	0	0	0	0	0	(25,481)	19
20	Fees, Subscriptions & Promotions	(254)	37	0	0	0	0	0	0	0	0	0	(217)	20
21	Clerical & General Office Expenses	0	1,033	7,258	0	0	0	0	0	0	0	0	8,291	21
22	Employee Benefits & Payroll Taxes	(562)	3,315	0	0	0	0	0	0	0	0	0	2,753	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	302	0	0	0	0	0	0	0	0	0	302	26
27	Other (specify):*	(6)	0	0	0	0	0	0	0	0	0	0	(6)	27
28	TOTAL General Administration	(2,392)	4,856	(12,044)	0	(9,580)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,060)	5,795	(6,886)	0	(122,151)	29							

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Square# 0037044

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	8,513	221	0	0	0	0	0	0	0	0	0	8,734	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	135	0	0	0	0	0	0	0	0	0	135	33
34	Rent-Facility & Grounds	0	478	(36,300)	0	0	0	0	0	0	0	0	(35,822)	34
35	Rent-Equipment & Vehicles	0	0	174	0	0	0	0	0	0	0	0	174	35
36	Other (specify):*	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	36
37	TOTAL Ownership	6,513	834	(36,126)	0	(28,779)	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	(3,250)	0	0	0	0	0	0	0	0	0	0	(3,250)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(3,250)	0	0	0	0	0	0	0	0	0	0	(3,250)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(117,797)	6,629	(43,012)	0	0	0	0	0	0	0	0	(154,180)	45

Facility Name & ID Number

Lincoln Square

0037044

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
Jacob L. Alley	50	Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
Diana Alley	50	Holly Hill	Anna	JR's Centre	Anna	Workshop
		Pilot House	Cairo	ILS 1-3 & 5-6	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis	LS Land Trust	Anna	Land Trust
		New Way	Anna			
		Liberty House	Marion			

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	3 House keeping	\$	kel-Tech Management Co.	25.00%	\$ 87	\$	87	1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	223		223	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	114		114	3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	515		515	4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	80		80	5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	89		89	6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	37		37	7
8	V	21 Clerical & General		kel-Tech Management Co.	25.00%	1,033		1,033	8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,315		3,315	9
10	V	26 Insurance		kel-Tech Management Co.	25.00%	302		302	10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	221		221	11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	135		135	12
13	V	34 Rent		kel-Tech Management Co.	25.00%	478		478	13
14	Total		\$			\$ 6,629	\$ *	6,629	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 <u>Equipment Rental</u>	\$	<u>kel-Tech Management Co.</u>	25.00%	\$ 174	\$	174	15
16	V	10 <u>Nursing</u>		<u>kel-Tech Management Co.</u>	25.00%	973		973	16
17	V	17 <u>Administration</u>		<u>kel-Tech Management Co.</u>	25.00%	4,698		4,698	17
18	V	21 <u>Clerical</u>		<u>kel-Tech Management Co.</u>	25.00%	7,258		7,258	18
19	V	6 <u>Maintenance</u>		<u>kel-Tech Management Co.</u>	25.00%	4,185		4,185	19
20	V								20
21	V	19 <u>Professional Services</u>	24,000	<u>kel-Tech Management Co.</u>	25.00%			(24,000)	21
22	V	34 <u>Building Lease</u>	36,300	<u>Lincoln Square Land Trust</u>	100.00%			(36,300)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 60,300			\$ 17,288	\$ *	(43,012)	39

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

Facility Name & ID Number

Lincoln Square

#

0037044

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	Diana Alley	DON/Owner	DON	50.00	14,976	8	20.00	Nursing	\$ 20,816	10-1	1
2	Jacob L. Alley	Owner		50.00							2
3	Josh Alley	DSP	DSP	0.00	2,535	20	50.00	DSP	3,079	10-1	3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	973	10-1	8
9	Jacob Alley							Maintenance	4,185	6-1	9
10	James A. Keller							Administration	4,698	17-1	10
11	Ashley Alley							Clerical	748	21-1	11
12											12
13								TOTAL	\$ 34,499		13

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

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

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

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

Name of Related Organization

kel-Tech Management Co.

Street Address

158 E, Vienna Street

City / State / Zip Code

Anna, IL 62906

Phone Number

(618) 833-5070

Fax Number

(618) 833-4993

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	361,283	8	\$ 1,308	\$ 24,000	\$ 87	1
2	5	UTILITIES ELEC/GAS-G	Mgmt Fee Contribution	361,283	8	2,968	24,000	197	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	361,283	8	384	24,000	25	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	361,283	8	714	24,000	47	4
5	6	MAINT SUPPLIES-B	Mgmt Fee Contribution	361,283	8	209	24,000	14	5
6	6	MAINT VEHICLE	Mgmt Fee Contribution	361,283	8	354	24,000	24	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contribution	361,283	8	442	24,000	29	7
8	14	REPAIRS VEHICLES	Mgmt Fee Contribution	361,283	8	2,342	24,000	156	8
9	14	TRANSPORTATION	Mgmt Fee Contribution	361,283	8	5,405	24,000	359	9
10	18	DIRECTORS FEES	Mgmt Fee Contribution	361,283	8	1,200	24,000	80	10
11	19	LEGAL & ACCOUNTING	Mgmt Fee Contribution	361,283	8	1,340	24,000	89	11
12	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contribution	361,283	8	553	24,000	37	12
13	21	BANK CHARGES	Mgmt Fee Contribution	361,283	8	89	24,000	6	13
14	21	CONTRACT SERVICES	Mgmt Fee Contribution	361,283	8	654	24,000	43	14
15	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	361,283	8	218	24,000	14	15
16	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	361,283	8	462	24,000	31	16
17	21	G & A MISC-B	Mgmt Fee Contribution	361,283	8	326	24,000	22	17
18	21	G & A MISC-SUPPLIES STOCK	Mgmt Fee Contribution	361,283	8	268	24,000	18	18
19	21	G & A SUPPLIES	Mgmt Fee Contribution	361,283	8	6,309	24,000	419	19
20	21	POSTAGE	Mgmt Fee Contribution	361,283	8	2,265	24,000	150	20
21	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	361,283	8	1,765	24,000	117	21
22	21	TELEPHONE	Mgmt Fee Contribution	361,283	8	1,963	24,000	130	22
23	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	361,283	8	818	24,000	54	23
24	21	UTILITIES - INTERNET	Mgmt Fee Contribution	361,283	8	408	24,000	27	24
25	TOTALS					\$ 32,763	\$	\$ 2,175	25

Facility Name & ID Number Lincoln Square

0037044

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

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	22	INS EMP GROUP-B	Mgmt Fee Contribution	361,283	8	\$ 24,010	\$ 24,000	\$ 1,595	1
2	22	INSURANCE W/C-B	Mgmt Fee Contribution	361,283	8	5,940	24,000	395	2
3	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	361,283	8	19,953	24,000	1,325	3
4	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	361,283	8	1,787	24,000	119	4
5	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	361,283	8	2,757	24,000	183	5
6	30	DEPRECIATION-B	Mgmt Fee Contribution	361,283	8	3,326	24,000	221	6
7	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	361,283	8	2,037	24,000	135	7
8	34	LEASE BLDG-B	Mgmt Fee Contribution	361,283	8	7,200	24,000	478	8
9	35	LEASE EQUIP-B	Mgmt Fee Contribution	361,283	8	2,613	24,000	174	9
10	10	NURSING	Mgmt Fee Contribution	361,283	8	14,653	24,000	973	10
11	17	ADMINISTRATION	Mgmt Fee Contribution	361,283	8	70,720	24,000	4,698	11
12	21	CLERICAL	Mgmt Fee Contribution	361,283	8	109,259	24,000	7,258	12
13	6	MAINTENANCE	Mgmt Fee Contribution	361,283	8	63,000	24,000	4,185	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					\$ 327,254	\$ 257,632	\$ 21,739	25

Facility Name & ID Number

Lincoln Square

0037044

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Capaha Bank		X	Working Capital - LOC		8/20/09			8/20/10	5.5000	641	6						
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	641	9						
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$		14						
15	TOTALS (line 9+line14)					\$	\$			\$	641	15						

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

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

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

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,200 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 2

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	8,000	1987	\$ 7,800	1
2	Healthcare	7,056	2006	2,200	2
3	TOTALS	15,056		\$ 10,000	3

Facility Name & ID Number Lincoln Square

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	15	2005	1987	\$ 231,909	\$	27.5	\$ 7,730	\$ 7,730	\$
5									
6									
7									
8									
Improvement Type**									
9	Carpeting		1997	4,056		7	271	271	4,056
10	Living Room Carpwt		1998	571		7			571
11	Carpeting		2001	3,640		7			3,640
12	Tile Floor		2002	3,922	162	15	261	99	2,706
13	Fire Alarm Panel		2005	1,835	211	5	367	156	1,623
14	Wood Deck		2005	2,100	146	15	140	(6)	988
15	Tile Floor - Living Room		2006	2,177	170	15	145	(25)	651
16	Tile Floor - Hall		2006	2,804	224	15	187	(37)	785
17	Carpeting		2008	1,309		7	187	187	1,309
18	Stairway/Hall Flooring		2009	4,998	2,624	15	83	(2,541)	2,624
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 259,321	\$ 3,537		\$ 9,371	\$ 5,834	\$ 18,953	70

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

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

1/1/2009

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	\$ 2,113	\$ 189	\$ 302	\$ 113		\$ 1,642	71
72	Current Year Purchases	1,249	750	125	(625)		750	72
73	Fully Depreciated Assets	32,935		2,446	2,446		32,935	73
74								74
75	TOTALS	\$ 36,297	\$ 939	\$ 2,873	\$ 1,934		\$ 35,327	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	2001 Ford Van	2000	\$ 26,232	\$	\$			\$ 26,232	76
77	Healthcare	2004 Ford Focus	2004	14,909	248	993	745		14,049	77
78										78
79										79
80	TOTALS			\$ 41,141	\$ 248	\$ 993	\$ 745		\$ 40,281	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)	\$ 346,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,724	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,237	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,513	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 94,561	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 1,447

Description: Copier Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		582		582
4	Clinical Wages (b)		1,135		1,135
5	In-House Trainer Wages (c)		2,542		2,542
6	Transportation				
7	Contractual Payments		980		980
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,239	\$	\$ 5,239
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,239		

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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 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	\$ 12,135	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	184,078		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,580		7
8	Accounts Receivable (owners or related parties)	99,075		8
9	Other(specify): <u>DSP Training Reimbursable</u>	239		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 297,108	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	27,412		15
16	Equipment, at Historical Cost	77,438		16
17	Accumulated Depreciation (book methods)	(94,558)		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)	\$ 10,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 307,400	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,762	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	77,000		29
30	Accrued Salaries Payable	3,282		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,234		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,624		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 113,902	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 113,902	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 193,498	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 307,400	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 201,131	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 201,131	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,702	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	(57,335)	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)	\$ (7,633)	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)	\$ 193,498	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lincoln Square# 0037044Report 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	\$ 540,174	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 540,174	3
B. Ancillary Revenue			
4	Day Care	117,198	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 117,198	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	239	11
12	Gift and Coffee Shop	3,250	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,489	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 660,861	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	99,599	31
32	Health Care	333,806	32
33	General Administration	90,890	33
B. Capital Expense			
34	Ownership	54,011	34
C. Ancillary Expense			
35	Special Cost Centers	3,493	35
36	Provider Participation Fee	29,360	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 611,159	40
41	Income before Income Taxes (line 30 minus line 40)**	49,702	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 49,702	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Lincoln Square**

0037044

Report Period Beginning:

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	416	416	\$ 20,816	\$ 50.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,614	1,710	16,761	9.80	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,063	2,208	26,065	11.80	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,347	1,347	13,607	10.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	802	834	15,453	18.53	28
29	Resident Services Coordinator	1,202	1,250	23,180	18.54	29
30	Habilitation Aides (DD Homes)	12,364	12,566	118,335	9.42	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,808	20,331	\$ 234,217 *	\$ 11.52	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	33	\$ 1,591	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	260	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	975	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	30	1,500	10a-3	46
47	<u>Administrator Consultant</u>	55	2,400	17-3	47
48	<u>Social Work Consultant</u>	40	2,190	12-3	48
49	TOTAL (lines 35 - 48)	236	\$ 12,516		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 1/1/2009Ending: 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. IL Healthcare Assoc. \$600
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Lincoln Square #0032469 1/6/1988
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 29,360
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 562 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
 Owners Compensation
 Jan.1 2009 - Dec. 31 2009

	Totals / Entity	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook
Don Pippins	\$ -	-	-	-	-	-	-
Denise Pippins	\$ -	-	-	-	-	-	-
Diana Alley	\$ 50,429	14,976	-	20,800	14,653	-	-
Jo Ann Keller	\$ 126,000	102,000	24,000	-	-	-	-
James K. Keller	\$ 14,400	14,400	-	-	-	-	-
Jacob Alley	\$ 56,424	-	-	-	56,424	-	-
Ashley Alley	\$ 11,246	-	-	-	11,246	-	-
James A. Keller	\$ 88,166	-	-	-	70,720	-	17,446
	\$ 346,665	\$ 131,376	\$ 24,000	\$ 20,800	\$ 153,043	\$ -	\$ 17,446

Lincoln Square				
Analysis of Sch XIX, Section F.				
2009				
Resident Acct Bond Renewal/Increase			\$ 260	
IL Health Care Assoc Dues			552	
P.O. Box Rental			39	
IL Corp Ann Report			130	
Help Wanted Advertising			78	
Advertising			177	
IHCA PAC Dues			48	
NFIB Annual Membership Fee			29	
Less:				
	Advertising		(177)	
	IHCA PAC Dues		(48)	
	NFIB Fee		(29)	
Total			<u>\$ 1,059</u>	
<hr/>				
Lincoln Square				
Reconciliation of Depreciation				
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2				
2009				
Sch IX			\$ 13,237	
kel-Tech Mgmt. Co. Alloc.			<u>221</u>	
Total on Sch V			<u>\$ 13,458</u>	
<hr/>				
Lincoln Square				
Detail of Sch. V , Line 36, Col. 3				
2009				
State Income Tax			<u>2,000</u>	
Total			<u>\$ 2,000</u>	
<hr/>				
Lincoln Square				
Detail of Sch. V , Line 27, Col. 3				
2009				
Late Fee/Finance Charge			<u>6</u>	
Total			<u>\$ 6</u>	
<hr/>				
<hr/>				

Lincoln Square				
Allocation of Cost for Employee				
Schedule XX, Question 12				
2009				
Anita Beatty, RSD/QMRP				
Salary			\$ 38,633	
	RSD	40%	15,453	
	QMRP	60%	23,180	
Total		100%	38,633	