

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	33,718	3,052	4,686	41,456	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,718	3,052	4,686	41,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.13%

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

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 05/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 140 and days of care provided 3,940

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	204,273	23,073	4,895	232,241		232,241	10,489	242,730		1
2	Food Purchase		174,913		174,913		174,913	(144)	174,769		2
3	Housekeeping	135,718	22,021		157,739		157,739		157,739		3
4	Laundry	69,334	11,768		81,102		81,102		81,102		4
5	Heat and Other Utilities			115,045	115,045		115,045	(10,458)	104,587		5
6	Maintenance	77,522	9,813	38,613	125,948		125,948	26,463	152,411		6
7	Other (specify):*							1,883	1,883		7
8	TOTAL General Services	486,847	241,588	158,553	886,988		886,988	28,233	915,221		8
	B. Health Care and Programs										
9	Medical Director			58,000	58,000		58,000		58,000		9
10	Nursing and Medical Records	2,224,066	228,804	49,946	2,502,816		2,502,816	10,819	2,513,635		10
10a	Therapy	61,865			61,865		61,865		61,865		10a
11	Activities	76,742	3,105	5,275	85,122		85,122		85,122		11
12	Social Services	69,106		1,046	70,152		70,152		70,152		12
13	CNA Training										13
14	Program Transportation			7,498	7,498		7,498	2,491	9,989		14
15	Other (specify):*							5,628	5,628		15
16	TOTAL Health Care and Programs	2,431,779	231,909	121,765	2,785,453		2,785,453	18,938	2,804,391		16
	C. General Administration										
17	Administrative	111,132		21,000	132,132		132,132	24,846	156,978		17
18	Directors Fees										18
19	Professional Services			123,920	123,920		123,920	(29,862)	94,058		19
20	Dues, Fees, Subscriptions & Promotions			31,068	31,068		31,068	224	31,292		20
21	Clerical & General Office Expenses	62,251		190,792	253,043		253,043	(55,056)	197,987		21
22	Employee Benefits & Payroll Taxes			442,620	442,620		442,620		442,620		22
23	Inservice Training & Education										23
24	Travel and Seminar			610	610		610	837	1,447		24
25	Other Admin. Staff Transportation			21,819	21,819		21,819	4,691	26,510		25
26	Insurance-Prop.Liab.Malpractice			80,864	80,864		80,864	1,560	82,424		26
27	Other (specify):*							26,917	26,917		27
28	TOTAL General Administration	173,383		912,693	1,086,076		1,086,076	(25,843)	1,060,233		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,092,009	473,497	1,193,011	4,758,517		4,758,517	21,328	4,779,845		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 Rehabilitation Ctr

#0051482

Report Period Beginning:

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Ending:

12/31/13

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			85,355	85,355		85,355	(18,320)	67,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,390	51,390		51,390	(19,830)	31,560			32
33	Real Estate Taxes			54,709	54,709		54,709	3,890	58,599			33
34	Rent-Facility & Grounds			705,180	705,180		705,180		705,180			34
35	Rent-Equipment & Vehicles			9,162	9,162		9,162	4,041	13,203			35
36	Other (specify):*			8,731	8,731		8,731		8,731			36
37	TOTAL Ownership			914,527	914,527		914,527	(30,219)	884,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		168,643	420,834	589,477		589,477		589,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,998	245,998		245,998		245,998			42
43	Other (specify):*			46,517	46,517		46,517	(46,517)	(0)			43
44	TOTAL Special Cost Centers		168,643	713,349	881,992		881,992	(46,517)	835,475			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,092,009	642,140	2,820,887	6,555,036		6,555,036	(55,407)	6,499,629			45

*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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,442)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,194)	30		9
10	Interest and Other Investment Income	(24,215)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(86)	21		18
19	Entertainment	(3,022)	21		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,433)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(60,450)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (227,235)		\$	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)	171,828		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 171,828		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (55,407)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Lincoln Rehabilitation CtrID# 0051482Report Period Beginning: 01/01/13Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (13,272)	43	1
2	Promotional Products	(6,531)	43	2
3	Bank Charges	(37,319)	21	3
4	Theft & Damage Loss	(562)	21	4
5	Non-allowable Expense	(540)	21	5
6	Additional R&M	20,134	06	6
7	Non-Allowable Fees	(20,000)	43	7
8	COPE Dues	(2,360)	20	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	(60,450)	49

Lincoln Rehabilitation Ctr

ID# 0051482

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Rehabilitation Ctr# 0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

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				10,489								10,489	1
2	Food Purchase	(144)											(144)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,442)		984									(10,458)	5
6	Maintenance	20,134		1,726	4,603								26,463	6
7	Other (specify):*			147	1,736								1,883	7
8	TOTAL General Services	8,548		2,857	16,828								28,233	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				10,819								10,819	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				2,491								2,491	14
15	Other (specify):*				5,628								5,628	15
16	TOTAL Health Care and Programs				18,938								18,938	16
	C. General Administration													
17	Administrative			23,364	1,482								24,846	17
18	Directors Fees													18
19	Professional Services			(21,763)	(5,782)	292	(2,609)						(29,862)	19
20	Fees, Subscriptions & Promotions	(2,610)		655	2,163	16							224	20
21	Clerical & General Office Expenses	(145,962)		73,633	17,146	127							(55,056)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			271	566								837	24
25	Other Admin. Staff Transportation			2,520	2,171								4,691	25
26	Insurance-Prop.Liab.Malpractice			1,294	266								1,560	26
27	Other (specify):*			19,700	7,217								26,917	27
28	TOTAL General Administration	(148,572)		99,674	25,229	435	(2,609)						(25,843)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(140,024)		102,531	60,995	435	(2,609)						21,328	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(23,194)		1,579		3,295							(18,320) 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(24,215)		1,301		3,084							(19,830) 32
33	Real Estate Taxes					3,890							3,890 33
34	Rent-Facility & Grounds			11,409		(11,409)							34
35	Rent-Equipment & Vehicles			1,698	2,343								4,041 35
36	Other (specify):*												36
37	TOTAL Ownership	(47,409)		15,987	2,343	(1,140)							(30,219) 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												41
42	Provider Participation Fee												42
43	Other (specify):*	(39,803)			(6,714)								(46,517) 43
44	TOTAL Special Cost Centers	(39,803)			(6,714)								(46,517) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(227,235)		118,518	56,624	(705)	(2,609)						(55,407) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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							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

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	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 984	\$	984	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,726		1,726	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	147		147	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	23,364		23,364	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	4,218		4,218	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	655		655	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	73,633		73,633	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	271		271	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	2,520		2,520	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,294		1,294	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	19,700		19,700	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,579		1,579	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	1,301		1,301	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	11,409		11,409	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,698		1,698	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	13,646	YAM MANAGEMENT, LLC	100.00%			(13,646)	35
36	V	19 ACCOUNTING	2,000	YAM MANAGEMENT, LLC	100.00%			(2,000)	36
37	V	19 PROFESSIONAL FEES	10,335	YAM MANAGEMENT, LLC	100.00%			(10,335)	37
38	V								38
39	Total		\$ 25,981			\$ 144,499	\$ *	118,518	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1	DIETARY		100.00%	\$ 10,489	\$	10,489	15
16	V	7	EMP. BEN. GEN. SERV.		100.00%	1,736		1,736	16
17	V	10	NURSING SALARY		100.00%	40,519		40,519	17
18	V	14	PROGRAM TRANSPORTATION		100.00%	2,491		2,491	18
19	V	15	EMP. BEN. HEALTHCARE		100.00%	5,628		5,628	19
20	V	17	ADMINISTRATIVE		100.00%	22,482		22,482	20
21	V	19	PROFESSIONAL FEES		100.00%	1,218		1,218	21
22	V	20	FEES, SUBSCRIPTIONS		100.00%	2,163		2,163	22
23	V	21	CLERICAL & GENERAL		100.00%	17,146		17,146	23
24	V	24	SEMINARS		100.00%	566		566	24
25	V	25	AUTO AND TRAVEL		100.00%	2,171		2,171	25
26	V	27	EMP. BEN.-GEN. ADMIN.		100.00%	7,217		7,217	26
27	V	26	INSURANCE		100.00%	266		266	27
28	V	35	AUTO RENTAL		100.00%	2,343		2,343	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		100.00%	4,603		4,603	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	10	NURSE CONSULTING	29,700	100.00%			(29,700)	34
35	V	17	DIR. OF OPERATIONS CONSULT	21,000	100.00%			(21,000)	35
36	V	19	DATA PROCESSING FEES	7,000	100.00%			(7,000)	36
37	V	43	MARKETING	6,714	100.00%			(6,714)	37
38	V								38
39	Total		\$ 64,414			\$ 121,038	\$ *	56,624	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 292	\$	292	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		16		16	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		127		127	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		3,295		3,295	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,084		3,084	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,890		3,890	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	11,409	8131 N. MONTICELLO, LLC				(11,409)	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		\$ 11,409			\$ 10,704	\$ *	(705)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	19 Payroll Services	\$ 20,066	ProPay HR LLC	66.67%	\$ 17,457	\$ (2,609)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,066			\$ 17,457	\$ * (2,609)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Declaration of Trust Yosef Meystel	24.75%	BERKSHIRE NURSING & REHAB CENTER, LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO	1
2	David Berkowitz Revocable Trust	28.75%	CONCORD NURSING AND REHABILITATION CENTER, LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO	2
3	Jay Meystel Trust	10.00%	DOLTON NURSING & REHAB, LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE	3
4	Steven Turofsky	1.00%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	PROPAY HR, LLC	EVANSTON	PAYROLL SERVICES	4
5	Frederick S. Frankel	1.00%	EXCEPTIONAL CARE, LLC	BURBANK	ROOSEVELT RISK MANAGEME	SKOKIE	CAPTIVE INSURANCE	5
6	Christina Inofre	0.50%	HIGHLAND PARK NURSING AND REHAB CENTER	HIGHWOOD				6
7	257 Ltd. Partnership	17.00%	LITCHFIELD CARE CENTER, LLC	LITCHFIELD				7
8	42170 Limited Partnership	8.50%	NORTH CHURCH NURSING & REHAB, LLC	JACKSONVILLE				8
9	1219 Limited Partnership	8.50%	PLAZA NURSING AND REHAB CENTER, LLC	MIDLOTHIAN				9
10			PLUM GROVE NURSING AND REHAB, LLC	PALATINE				10
11			RIVIERA CARE CENTER, LLC	CHICAGO HEIGHTS				11
12			SPRINGFIELD CARE CENTER, LLC	SPRINGFIELD				12
13			THE ARBORS AT MICHIGAN CITY	MICHIGAN, IN				13
14			THE COPPERAS HOLLOW	CALDWELL, TX				14
15			INTERNATIONAL NURSING AND REHAB CENTER , LLC	CHICAGO				15
16			ISLAND CITY REHAB CENTER	WILMINGTON				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr # 0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Jay Meystel	Owner	Administrative		See Attached	1.3	3.25%	Alloc. Salary	\$ 3,825	17-7	1
2	Joel Meystel	Relative	Administrative		See Attached	1.3	7%	Alloc. Salary	1,571	17-7	2
3	Cynthia Meystel	Relative	Clerical		See Attached	0.2	6%	Alloc. Salary	1,152	21-7	3
4	Fred Frankel	Owner	Administrative	1.00%	See Attached	2.5	6%	Alloc. Salary	9,597	17-7	4
5	Steve Turofsky	Owner	Administrative	1.00%	See Attached	2.5	6%	Alloc. Salary	8,371	17-7	5
6	Christina Inofre	Owner	Nursing	0.50%	See Attached	2.5	6%	Alloc. Salary	6,974	10-7	6
7	Shimon Meystel	Relative	Clerical		See Attached	2.5	6%	Alloc. Salary	543	21-7	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 32,033		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 Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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					\$	\$		\$	1
2									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 Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 YAM MANAGEMENT, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

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	5	UTILITIES	AVAIL. BED DAYS	806,222	20	\$ 15,532	\$ 51,100	\$ 984	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	51,100	1,726	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325	51,100	147	3	
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	51,100	23,364	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554	51,100	4,218	5	
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341	51,100	655	6	
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	51,100	73,633	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271	51,100	271	8	
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751	51,100	2,520	9	
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417	51,100	1,294	10	
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817	51,100	19,700	11	
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916	51,100	1,579	12	
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530	51,100	1,301	13	
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-	51,100		14	
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000	51,100	11,409	15	
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797	51,100	1,698	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,279,844	\$ 1,442,113	\$ 144,499	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 YAM CONSULTING, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

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	1	DIETARY	AVAIL. BED DAYS	806,222	20	\$ 165,484	\$ 152,992	51,100	\$ 10,489	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		51,100	1,736	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	51,100	40,519	3
4	14	PROGRAM TRANSPORTATION	AVAIL. BED DAYS	806,222	20	39,307		51,100	2,491	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		51,100	5,628	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	51,100	22,482	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		51,100	1,218	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		51,100	2,163	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	51,100	17,146	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		51,100	566	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		51,100	2,171	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		51,100	7,217	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		51,100	266	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		51,100	2,343	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	51,100	4,603	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,909,677	\$ 1,478,385		\$ 121,038	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 8131 N. MONTICELLO, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	\$ 4,605	\$ 37,960	\$ 292	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250	37,960	16	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000	37,960	127	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991	37,960	3,295	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653	37,960	3,084	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377	37,960	3,890	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					\$ 168,876	\$	\$ 10,704	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 ProPay HR LLC
 Street Address 2201 W. MAIN ST
 City / State / Zip Code EVANSON, IL 60202
 Phone Number (847) 905-3268
 Fax Number ()

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	19	Payroll Services	Direct		\$	\$		\$ 17,457	1
2									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				\$	\$		\$ 17,457	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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									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 Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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									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 Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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					\$	\$		\$	1
2									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 Rehabilitation Ctr

0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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					\$	\$		\$	1
2									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 Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>54,541</u>	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.)		\$	<u>58,515</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>3,974</u>	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>54,625</u>	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.		\$	<u>58,599</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY	
	2009	_____	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13
	2010	<u>55,326</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2011	<u>54,541</u>	11	15	LESS REFUND FROM LINE 6 \$ _____ 15
	2012	<u>54,625</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
<u>2013 Accrual = 2012 Tax</u>					
<u>8131 N. Monticello Allocation = \$3,890</u>					

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

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>		<u>2010</u>	<u>\$ 5,641</u>	1
2					2
3	TOTALS			\$ 5,641	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					\$	\$		\$	\$	4	
5										5	
6										6	
7										7	
8										8	
	Improvement Type**										
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	

*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

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			70,519	3,605	2,588	(1,017)	8,361	68
69				85,355		(85,355)		69
70			\$ 70,519	\$ 88,960		\$ 2,588	\$ (86,372)	\$ 8,361 70

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 and Improvement Costs-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		\$ 70,519	\$ 88,960		\$ 2,588	\$ (86,372)	\$ 8,361	1
2	Framing & Dry Wall	2011	5,500		20	550	550	1,375	2
3	Mag Locks, Plates & Key Pads	2011	10,476		20	2,095	2,095	5,064	3
4	Heating & Cooling (Rooftop)	2011	4,500		20	450	450	1,125	4
5	Heating & Cooling (Rooftop)	2011	4,455		20	446	446	1,077	5
6	Toilets	2011	8,467		20	423	423	882	6
7	Tpo Roofing System On Flat Roof	2012	98,800		20	9,880	9,880	19,760	7
8	Stainless Steel Fire Shutter Door	2012	3,865		20	387	387	580	8
9	Digital Watchdog/ Camera	2012	12,560		20	2,498	2,498	3,955	9
10	Therapy Room Flooring & Painting	2012	14,526		20	726	726	1,271	10
11	Lobby Flooring & Wallcovering	2012	12,753		20	638	638	1,116	11
12	Medicare Corridor Wallcovering	2012	60,266		20	3,013	3,013	5,273	12
13	Activity Room Floor & Blinds	2012	7,195		20	360	360	630	13
14	Dining Room Flooring, Railings, Wallcovering & Fans	2012	37,514		20	1,876	1,876	3,282	14
15	Light Fixtures In Lobby, Reception, Smoke Lounge, Medicare Corridor	2012	21,188		20	1,059	1,059	1,854	15
16	Wallpaper In Lobby, Corridors, Large Dining Room	2012	61,394		20	3,070	3,070	5,372	16
17	Signage	2012	13,012		20	651	651	1,139	17
18	Installed Wiring In Dialysis Room	2013	2,740		20	69	69	69	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)		\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183		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 Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183		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 Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12D, Carried Forward		\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 449,731	\$ 88,960		\$ 30,777	\$ (58,183)	\$ 62,183	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 and Improvement Costs-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	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$	\$		\$	\$	\$	34

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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3	Year Constructed	4	Cost	5	Current Book Depreciation	6	Life in Years	7	Straight Line Depreciation	8	Adjustments	9	Accumulated Depreciation	
1	Related Party Information			\$		\$				\$		\$		\$		1
2	Buildings:															2
3	Allocated from 8131 N. Monticello	2010			43,830		1,303		20		1,124		(179)		3,887	3
4																4
5																5
6																6
7																7
8	Leasehold Information															8
9	Allocated from YAM Management	2010			2,088		209		20		209				683	9
10	Allocated from YAM Management	2012			1,318		88		20		88				133	10
11	Allocated from YAM Management	2013			234		14		20		14				14	11
12	Allocated from 8131 N. Monticello	2010			19,634		1,963		20		982		(981)		3,473	12
13	Allocated from 8131 N. Monticello	2013			3,415		28		20		171		143		171	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 70,519	\$ 3,605		\$ 2,588	\$ (1,017)	\$ 8,361	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 Costs-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	\$ 159,312	\$ 663	\$ 33,515	\$ 32,852	10	\$ 70,338	71
72	Current Year Purchases	28,350	147	2,284	2,137	10	2,284	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 187,663	\$ 810	\$ 35,799	\$ 34,989		\$ 72,622	75

D. Vehicle Costs. (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		Allocated from YAM Managemen		\$ 2,155	\$ 459	\$ 459		5	\$ 1,083	76
77										77
78										78
79										79
80	TOTALS			\$ 2,155	\$ 459	\$ 459			\$ 1,083	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)	\$ 645,190	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 90,229	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,035	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,194)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 135,888	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr

0051482

Report Period Beginning:

01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FNR Decatur, LLC

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:	<u>1975</u>	<u>140</u>	<u>05/01/2011</u>	\$ <u>705,180</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>140</u>		\$ <u>705,180</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 9,162

Description: See Attached Schedule

(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	<u>Allocated from YAM Consulting</u>		\$ _____	\$ <u>2,343</u>	17
18	<u>Allocated from YAM Management</u>			<u>1,698</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,041</u>	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr # 0051482 Report Period Beginning: 01/01/13 Ending: 12/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	141,057	\$		\$	141,057	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				78,441				78,441	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				173,384				173,384	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					168,643			168,643	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						27,952				27,952	13
14	TOTAL			\$		\$	420,834	\$	168,643	\$	589,477	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 Rehabilitation Ctr# 0051482Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 486	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,325,276		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,579		6
7	Other Prepaid Expenses	7,911		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	203,199		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,602,451	\$	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	347,194		15
16	Equipment, at Historical Cost	254,796		16
17	Accumulated Depreciation (book methods)	(162,616)		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): <u>See Attached Schedule</u>	222,280		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 661,654	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,264,105	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 723,108	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	293,293		29
30	Accrued Salaries Payable	170,367		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,142		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,625		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,175,808		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,425,343	\$	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)	\$ 2,425,343	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (161,238)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,264,105	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (195,161)	1
2	Restatements (describe):		2
3	Late Entry	(81,994)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (277,155)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(866,083)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	982,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	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)	\$ 115,917	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)	\$ (161,238)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,056,348	1
2	Discounts and Allowances for all Levels	(2,828,599)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,227,749	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,213,414	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,213,414	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	15	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	176,785	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,904	19
20	Radiology and X-Ray	1,545	20
21	Other Medical Services	38,327	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 223,576	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24,214	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,214	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)	\$ 5,688,953	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	886,988	31
32	Health Care	2,785,453	32
33	General Administration	1,086,076	33
B. Capital Expense			
34	Ownership	914,527	34
C. Ancillary Expense			
35	Special Cost Centers	635,994	35
36	Provider Participation Fee	245,998	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,555,036	40
41	Income before Income Taxes (line 30 minus line 40)**	(866,083)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (866,083)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,371,872	44
45	Private Pay - Net Inpatient Revenue	468,751	45
46	Medicare - Net Inpatient Revenue	315,152	46
47	Other-(specify) <u>Insurance</u>	71,974	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,227,749	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Rehabilitation Ctr
 XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
 (This schedule must cover the entire reporting period.)

0051482

Report Period Beginning: 01/01/13

Ending: 12/31/13

12/31/13

	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	2,024	2,120	\$ 81,670	\$ 38.52	1
2	Assistant Director of Nursing	1,659	1,794	52,421	29.22	2
3	Registered Nurses	14,852	15,624	501,194	32.08	3
4	Licensed Practical Nurses	24,359	25,774	529,574	20.55	4
5	CNAs & Orderlies	80,854	85,858	1,032,002	12.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,016	2,080	61,865	29.74	8
9	Activity Director	1,427	1,596	24,383	15.28	9
10	Activity Assistants	4,381	4,740	52,359	11.05	10
11	Social Service Workers	2,305	2,470	69,106	27.98	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	43,348	20.84	13
14	Head Cook	5,957	6,545	68,828	10.52	14
15	Cook Helpers/Assistants	7,016	7,515	92,097	12.26	15
16	Dishwashers					16
17	Maintenance Workers	7,271	7,710	77,522	10.05	17
18	Housekeepers	12,405	13,207	135,718	10.28	18
19	Laundry	5,499	5,892	69,334	11.77	19
20	Administrator	2,080	2,444	90,035	36.84	20
21	Assistant Administrator	688	880	21,097	23.97	21
22	Other Administrative					22
23	Office Manager	160	160	2,077	12.98	23
24	Clerical	4,410	4,633	60,174	12.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,238	2,348	27,205	11.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,577	195,470	\$ 3,092,009 *	\$ 15.82	34

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	89	\$ 4,895	01-03	35
36	Medical Director	Monthly	58,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	395	29,700	10-03	38
39	Pharmacist Consultant	165	8,246	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	106	5,275	11-03	44
45	Social Service Consultant	21	1,046	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	776	\$ 119,162		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tonya Blackman (1/1/13-2/6/13)	Admin	0	\$ 7,503	Workers' Compensation Insurance	\$ 59,068	IDPH License Fee	\$ 1,990	
Barbara Lowry (2/7/13 - 8/22/13)	Admin	0	48,770	Unemployment Compensation Insurance	131,549	Advertising: Employee Recruitment	16,613	
Jacqueline Liddell (8/23/13-12/31/13)	Admin	0	33,762	FICA Taxes	234,782	Health Care Worker Background Check		
Kristin Chaudoin	Asst. Admin	0	21,097	Employee Health Insurance	14,219	(Indicate # of checks performed <u>323.5</u>)	3,235	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,266	
				Employee Benefits Other	3,002	License & Permits	1,354	
						Allocated from YAM Consulting	2,163	
						Allocated from YAM Management	655	
						See Supplemental Schedule	16	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,132	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 442,619		\$ 31,292		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
YAM Consulting - Administrative Consulting	\$ 21,000						Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 21,000				Seminar Expense	610
							Allocated from YAM Consulting	566
							Allocated from YAM Management	271
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,447
C. Professional Services				TOTAL				
Vendor/Payee	Type	Amount						
YAM Management	Bookkeeping	\$ 15,646						
YAM Consulting	Data Processing	7,000						
ProPay HR, LLC	Payroll Services	20,066						
FR&R	Accounting	25,118						
Personnel Planners	Unemployment Consulting	961						
Yam Management	Professional	5,334						
Quintairos, Prieto, Wood & Boyer	Legal	132						
Holland & Knight	Legal	15,208						
YAM Management	Legal	109						
e-Health Data	MDS Software	1,800						
American Data	Electronic Charting System	8,288						
See Supplemental Schedule		24,258						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 123,919	\$				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
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 Rehabilitation Ctr# 0051482

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$7,151
- (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? 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. \$ 6,866 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. 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. \$ 245,998
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 15
- (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? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.