FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0034678

Facility Name: THE LINCOLN HOME

Address: 150 NORTH 27TH STREET (Number) BELLEVILLE (City) 62226 (Zip Code)

County: SINCLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

HFS ID Number:

Date of Initial License for Current Owners: 09/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARTIN WEISS
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,755	4,755	8
9	SNF/PED					9
10	ICF	37,055	4,300	1,515	42,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,055	4,300	6,270	47,625	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.84%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 4,755

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	249,860	21,137	8,596	279,593		279,593		279,593			1
2	Food Purchase		253,108		253,108		253,108	(960)	252,148			2
3	Housekeeping	154,610	37,192		191,802		191,802		191,802			3
4	Laundry	116,245	22,440	5,118	143,803		143,803		143,803			4
5	Heat and Other Utilities			158,880	158,880		158,880		158,880			5
6	Maintenance	68,771	51,144	21,527	141,442		141,442		141,442			6
7	Other (specify):*			23,027	23,027		23,027		23,027			7
8	**TOTAL General Services**	589,486	385,021	217,148	1,191,655		1,191,655	(960)	1,190,695			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,033,156	249,551	156,010	2,438,717		2,438,717	(18,956)	2,419,761			10
10a	Therapy			1,019	1,019		1,019		1,019			10a
11	Activities	130,337	7,050	1,345	138,732		138,732		138,732			11
12	Social Services	62,400	263	1,345	64,008		64,008		64,008			12
13	CNA Training											13
14	Program Transportation			24	24		24		24			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,225,893	256,864	186,743	2,669,500		2,669,500	(18,956)	2,650,544			16
	C. General Administration											
17	Administrative	70,227		328,000	398,227		398,227	88,983	487,210			17
18	Directors Fees											18
19	Professional Services			449,116	449,116		449,116	(299,432)	149,684			19
20	Dues, Fees, Subscriptions & Promotions			77,934	77,934		77,934	(46,280)	31,654			20
21	Clerical & General Office Expenses	169,446	19,735	48,369	237,550		237,550	33,273	270,823			21
22	Employee Benefits & Payroll Taxes			521,342	521,342		521,342		521,342			22
23	Inservice Training & Education			5,180	5,180		5,180	2,023	7,203			23
24	Travel and Seminar			20,143	20,143		20,143		20,143			24
25	Other Admin. Staff Transportation							2,131	2,131			25
26	Insurance-Prop.Liab.Malpractice			152,248	152,248		152,248	18,429	170,677			26
27	Other (specify):*			465,500	465,500		465,500	(441,735)	23,765			27
28	**TOTAL General Administration**	239,673	19,735	2,067,832	2,327,240		2,327,240	(642,608)	1,684,632			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,055,052	661,620	2,471,723	6,188,395		6,188,395	(662,524)	5,525,871			29

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

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

Facility Name & ID#: THE LINCOLN HOME **#0034678** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,924	
	REPAIRS & MAINTENANCE		672	
			0	8,596
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,118	
			0	5,118
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,559	
	ELECTRICITY		76,869	
	WATER		54,614	
	CABLE TV - LOBBY		1,838	
			0	158,880
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,606	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		601	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		9,320	
			0	
			0	
			0	
			0	21,527
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVI		23,027	
	SECURITY SERVICE		0	
			0	
			0	23,027
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	27,000	27,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,213	
	PHARMACY CONSULTANT	XVIII B 39-2	1,573	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	152,224	
			0	
			0	156,010
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	184	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	499	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	336	
				1,019
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,345	
			0	1,345
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,345	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,345
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE LINCOLN HOME **#0034678** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		24	24
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	328,000	328,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,112	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	118,004	
	BOOKKEEPING/ADMINISTRATIVE FEES		300,000	449,116
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	38,773	
	EMPLOYEE WANT ADS	XIX F	15,614	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8,960	
	LICENSES & PERMITS	XIX F	2,283	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,824	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,920	
	PATIENT BACKGROUND CHECKS	XIX F	2,560	
				77,934
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,819	
	EQUIPMENT REPAIR & MAINTENANCE		11,052	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,992	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27,515	
	MESSENGER SERVICE		2,991	
			0	48,369

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	240,494	
	UNEMPLOYMENT COMPENSATION	XIX D	103,317	
	WORKERS COMPENSATION INSURANC	XIX D	91,994	
	HOSPITALIZATION INSURANCE	XIX D	78,197	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,340	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	521,342
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,180	
				5,180
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	20,143	
				20,143
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		152,248	
				152,248
27	**OTHER**			
	BAD DEBTS	VI 24	465,500	
				465,500

GRAND TOTAL COLUMN 3 OTHER **2,471,723**

THE LINCOLN HOME
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	253,108
LESS SALES TAX	(960)
NET FOOD	252,148
TOTAL PATIENT CENSUS	47,625
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	142,875
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	142,875
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	142,875
NET FOOD	252,148
DIVIDE TOTAL MEALS/YEAR	142,875
COST PER MEAL	1.76
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number THE LINCOLN HOME #0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			66,158	66,158		66,158	132,262	198,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,038	34,038		34,038	218,611	252,649			32
33	Real Estate Taxes			2,868	2,868		2,868	53,637	56,505			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(476,776)	3,224			34
35	Rent-Equipment & Vehicles			11,946	11,946		11,946	11,770	23,716			35
36	Other (specify):*							20,948	20,948			36
37	TOTAL Ownership			595,010	595,010		595,010	(39,548)	555,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		163,875	520,264	684,139		684,139		684,139			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,220	83,220		83,220		83,220			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		163,875	603,484	767,359		767,359		767,359			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,055,052	825,495	3,670,217	7,550,764		7,550,764	(702,072)	6,848,692			45

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,369)	30		9
10	Interest and Other Investment Income	(165)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(960)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,992)	21		18
19	Entertainment		20		19
20	Contributions	(7,824)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(465,500)	27		24
25	Fund Raising, Advertising and Promotional	(38,773)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(38,495)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (584,078)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(117,994)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (117,994)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (702,072)		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 Yes	2 No	3 Amount	4 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

THE LINCOLN HOME

ID# 0034678

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARIES	(38,495)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38,495)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(960)	0	0	0	0	0	0	0	0	0	0	(960)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(960)	0	0	0	0	0	0	0	0	0	0	(960)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(18,956)	0	0	0	0	0	0	0	0	(18,956)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(18,956)	0	0	0	0	0	0	0	0	(18,956)	16
	C. General Administration													
17	Administrative	0	0	88,983	0	0	0	0	0	0	0	0	88,983	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(299,432)	0	0	0	0	0	0	0	0	(299,432)	19
20	Fees, Subscriptions & Promotions	(46,597)	0	317	0	0	0	0	0	0	0	0	(46,280)	20
21	Clerical & General Office Expenses	(43,487)	0	76,760	0	0	0	0	0	0	0	0	33,273	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	2,023	0	0	0	0	0	0	0	0	2,023	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	2,131	0	0	0	0	0	0	0	0	2,131	25
26	Insurance-Prop.Liab.Malpractice	0	15,096	3,333	0	0	0	0	0	0	0	0	18,429	26
27	Other (specify):*	(465,500)	0	23,765	0	0	0	0	0	0	0	0	(441,735)	27
28	**TOTAL General Administration**	(555,584)	15,096	(102,120)	0	0	0	0	0	0	0	0	(642,608)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(556,544)	15,096	(121,076)	0	0	0	0	0	0	0	0	(662,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(27,369)	159,631	0	0	0	0	0	0	0	0	0	132,262	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(165)	218,776	0	0	0	0	0	0	0	0	0	218,611	32
33	Real Estate Taxes	0	53,637	0	0	0	0	0	0	0	0	0	53,637	33
34	Rent-Facility & Grounds	0	(480,000)	3,224	0	0	0	0	0	0	0	0	(476,776)	34
35	Rent-Equipment & Vehicles	0	0	11,770	0	0	0	0	0	0	0	0	11,770	35
36	Other (specify):*	0	20,948	0	0	0	0	0	0	0	0	0	20,948	36
37	**TOTAL Ownership**	(27,534)	(27,008)	14,994	0	0	0	0	0	0	0	0	(39,548)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(584,078)	(11,912)	(106,082)	0	0	0	0	0	0	0	0	(702,072)	45

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 480,000	LINCOLN ASSOCIATES, L.P.		$	$ (480,000)	1
2	V	30	DEPRECIATION				159,631	159,631	2
3	V	32	INTEREST EXPENSE				215,392	215,392	3
4	V	32	AMORT LOAN COST				3,384	3,384	4
5	V	33	REAL ESTATE TAXES				53,637	53,637	5
6	V	36	MIP INSURANCE				20,948	20,948	6
7	V	26	INSURANCE				15,096	15,096	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 468,088	$ * (11,912)	14

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING CONSULTANT	$ 57,000	WEISS MANAGEMENT GROUP, INC.		$	$ (57,000)	15
16	V	17	MANAGEMENT FEES	328,000				(328,000)	16
17	V	19	ADMIN./BKKP. FEES	300,000				(300,000)	17
18	V								18
19	V								19
20	V								20
21	V	10	NURSING SALARIES				38,044	38,044	21
22	V	17	ADMINISTRATIVE SALARIES				416,983	416,983	22
23	V	19	PROFESSIONAL FEES				568	568	23
24	V	20	ADVERTISING, LICENSES				317	317	24
25	V	21	OFFICE EXPENSES				76,760	76,760	25
26	V	25	TRANSPORTATION				2,131	2,131	26
27	V	26	INSURANCE				3,333	3,333	27
28	V	27	EMPLOYEE BENEFITS				23,765	23,765	28
29	V	34	OFFICE RENT				3,224	3,224	29
30	V	35	AUTO LEASE				11,770	11,770	30
31	V	23	SEMINARS				2,023	2,023	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 685,000			$ 578,918	$ * (106,082)	39

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARTIN WEISS	PRESIDENT	ADMINISTRATO	45.10		20		SALARY	$ 118,993	17-7	1
2					SEE						2
3	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	ATTACHED	10		SALARY	157,768	17-7	3
4					SCHEDULE						4
5	NATAN WEISS	CONTROLLER	BOOKKEEPING	8.39		16		SALARY	140,222	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 416,983		13

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

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 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	10	NURSING SALARIES	PATIENT CENSUS	118,181	3	$ 94,406	$ 94,406	47,625	$ 38,044	1
2	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	118,181	3	1,034,740	1,034,740	47,625	416,983	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	118,181	3	1,410		47,625	568	3
4	20	ADVERTISING, LICENSES	PATIENT CENSUS	118,181	3	786		47,625	317	4
5	21	OFFICE EXPENSES	PATIENT CENSUS	118,181	3	190,480	153,167	47,625	76,760	5
6	25	TRANSPORTATION	PATIENT CENSUS	118,181	3	5,289		47,625	2,131	6
7	26	INSURANCE	PATIENT CENSUS	118,181	3	8,270		47,625	3,333	7
8	27	EMPLOYEE BENEFITS	PATIENT CENSUS	118,181	3	58,973		47,625	23,765	8
9	34	OFFICE RENT	PATIENT CENSUS	118,181	3	8,000		47,625	3,224	9
10	35	AUTO LEASE	PATIENT CENSUS	118,181	3	29,208		47,625	11,770	10
11	23	SEMINARS	PATIENT CENSUS	118,181	3	5,021		47,625	2,023	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,436,583	$ 1,282,313		$ 578,918	25

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$31,065.72	04/04	4,528,900	4,161,144	04/39	5.1400	215,392	2
3	AMORT LOAN COST		X	AMORT OVER LIFE			118,455	95,613			3,384	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND					PRIME+	30,109	6
7			X	INSURANCE FINANCING							3,929	7
8												8
9	TOTAL Facility Related				$31,065.72		$ 4,647,355	$ 4,256,757			$ 252,814	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,647,355	$ 4,256,757			$ 252,814	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,948 Line # 36

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

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,917	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.)		$ 53,890	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,973	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,532	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.		$ 56,505	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	44,310	8
	2006	47,114	9
	2007	48,929	10
	2008	51,185	11
	2009	53,890	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE LINCOLN HOME COUNTY SINCLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-204-015	NURSING HOME	$ 2,868.38	$ 2,868.38
2.	08-20.0-210-029	NURSING HOME	$ 49,799.42	$ 49,799.42
3.	08-20.0-207-025	NURSING HOME	$ 913.56	$ 913.56
4.	08-20.0-210-028	NURSING HOME	$ 308.74	$ 308.74
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,890.10	$ 53,890.10

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	3+ACRES	1987	$ 148,649	1
2	PARKING LOT	2+ACRES	2005	50,000	2
3	TOTALS	#VALUE!		$ 198,649	3

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	152		1988		$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 1,397,837	4
5			2003		1,249,221	45,426	27.5	45,426		338,802	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		7,174	9
10	VARIOUS			1993	6,676	171	39	171		3,779	10
11	VARIOUS			1994	7,797	200	39	200		4,258	11
12	VARIOUS			1995	13,072	335	39	335		6,257	12
13	CARPET			1996	907	23	39	23		374	13
14	BILLBOARD			1996	900	23	39	23		377	14
15	SMOKE DETECTORS			1996	602	15	39	15		250	15
16	PARKING LOT			1996	8,006	205	39	205		3,460	16
17	AWNING			1996	905	23	39	23		392	17
18	CARPETING			1996	1,512	39	39	39		677	18
19	DOOR LOCKS			1997	2,100	54	39	54		814	19
20	WALL PAPER			1997	2,012	52	39	52		794	20
21	HANDRAIL			1997	3,217	83	39	83		1,191	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		3,867	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		3,069	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		999	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		363	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		1,506	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		13,732	27
28	WALLPAPER			2000	14,896	382	39	382		4,565	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		3,154	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		2,378	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		726	31
32	NEW NURSES STATION			2000	20,379	522	39	522		5,491	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		494	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		2,054	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		14,594	35
36	REMODELING OF BATHROOMS			2000	18,490	474	39	474		4,975	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	$ 13,369	$ 726	20	$ 668	$ (58)	$ 9,338	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		12,408	38
39	ROOF	2001	47,500	1,727	27.5	1,727		16,407	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		3,172	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		4,218	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		3,923	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		18,838	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		12,978	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159	2,346	20	1,558	(788)	14,022	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		2,169	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		5,391	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		2,290	48
49	LANDSCAPING	2004	7,759		15	517	517	3,296	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	11,501	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	2,198	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	36,841	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		633	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		502	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		6,038	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		1,877	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		1,670	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		7,838	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		3,706	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906	3,581	5	3,581		16,115	60
61	AIR CONDITIONERS	2007	7,968	918	5	918		6,592	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		7,207	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		1,111	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		491	64
65	PAINTING	2007	9,986	1,150	5	1,150		8,260	65
66	GARDEN	2007	60,172	2,249	15	2,249		11,944	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		498	67
68	PAINTING - 30 ROOMS	2008	2,550	490	5	490		1,816	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		293	69
70	TOTAL (lines 4 thru 69)		$ 4,265,246	$ 143,720		$ 150,611	$ 6,891	$ 2,063,984	70

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Totals from Page 12A, Carried Forward		$ 4,265,246	$ 143,720		$ 150,611	$ 6,891	$ 2,063,984	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		270	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		446	3
4	INSTALL 2 HOLLOW METAL DOORS	2009	1,599	58	27.5	58		99	4
5	WALL AIR CONDITIONS	2009	5,187	1,660	5	1,660		2,697	5
6	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		189	6
7	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		452	7
8	INSTALL TON 1,1/2 ROCK ON PARKING LOT	2009	1,865	124	15	1,865	1,741	1,927	8
9	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		6,758	9
10	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344	9,390	5	9,390		15,259	10
11	WALL AIR CONDITIONS	2010	4,581	2,749	5	2,749		2,749	11
12	INSTALL STEEL DOOR	2010	10,694	146	27.5	146		146	12
13	FIRE PROTECTION WORK	2010	97,653	444	27.5	444		444	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)		$ 4,547,933	$ 163,127		$ 171,759	$ 8,632	$ 2,095,420	34

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 130,157	$ 17,163	$ 14,157	$ (3,006)	3-10 YRS	$ 54,981	71
72	Current Year Purchases	69,529	37,640	7,035	(30,605)	3-10 YRS	7,035	72
73	Fully Depreciated Assets	94,530					94,530	73
74	RELATED PARTY DEPRECIATION		5,469	5,469				74
75	TOTALS	$ 294,216	$ 60,272	$ 26,661	$ (33,611)		$ 156,546	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2005 FORD ECONOCARE	2005	$ 41,500	$ 2,390	$	$ (2,390)	5	$ 41,500	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$ 2,390	$	$ (2,390)		$ 41,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,082,298	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 225,789	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,420	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,369)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,293,466	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: $ 11,946 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number THE LINCOLN HOME

STATE OF ILLINOIS
0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 232,707	$		$ 232,707	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			82,819			82,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			204,738			204,738	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				151,758		151,758	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY, LAB	39-2					12,117		12,117	13
14	TOTAL			$		$ 520,264	$ 163,875		$ 684,139	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.

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 108,712	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,130,050		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	113,619		6
7	Other Prepaid Expenses	20,664		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,373,045	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	84,852		15
16	Equipment, at Historical Cost	335,716		16
17	Accumulated Depreciation (book methods)	(307,310)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 237,284	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,610,329	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 545,592	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	505,607		29
30	Accrued Salaries Payable	142,626		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,100		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,215,925	$	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)**	$ 1,215,925	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 394,404	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,610,329	$	48

*(See instructions.)

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 683,531	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 683,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(289,127)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	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)**	$ (289,127)	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)**	$ 394,404	24 *

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,356,646	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,356,646	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	904,826	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 904,826	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	165	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 165	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)**	$ 7,261,637	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,191,655	31
32	Health Care	2,669,500	32
33	General Administration	2,327,240	33
	B. Capital Expense		
34	Ownership	595,010	34
	C. Ancillary Expense		
35	Special Cost Centers	684,139	35
36	Provider Participation Fee	83,220	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,550,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	(289,127)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (289,127)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 76,929	$ 36.99	1
2	Assistant Director of Nursing	3,968	4,144	104,507	25.22	2
3	Registered Nurses	9,470	9,783	235,406	24.06	3
4	Licensed Practical Nurses	27,186	28,018	556,021	19.85	4
5	CNAs & Orderlies	89,510	91,422	869,245	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,003	13,559	130,337	9.61	10
11	Social Service Workers	4,815	5,087	62,400	12.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,590	26,828	249,860	9.31	15
16	Dishwashers					16
17	Maintenance Workers	3,966	4,165	68,771	16.51	17
18	Housekeepers	15,959	16,473	154,610	9.39	18
19	Laundry	13,626	14,034	116,245	8.28	19
20	Administrator	2,016	2,080	70,227	33.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,241	12,542	169,446	13.51	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	4,186	4,568	60,276	13.20	31
32	Other Health C: Care Plan Coord	5,904	6,091	130,772	21.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,472	240,874	$ 3,055,052 *	$ 12.68	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,924	1-3	35
36	Medical Director	O	27,000	9-3	36
37	Medical Records Consultant	N	2,213	10-3	37
38	Nurse Consultant	T	152,224	10-3	38
39	Pharmacist Consultant	H	1,573	10-3	39
40	Physical Therapy Consultant	L	184	10a-3	40
41	Occupational Therapy Consultant	Y	499	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	336	10a-3	43
44	Activity Consultant	E	1,345	11-3	44
45	Social Service Consultant	E	1,345	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 194,643		49

C. CONTRACT NURSES

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

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRISTOPHER RAYBORN	ADMINISTRATOR	0	$ 70,227
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,227

B. Administrative - Other

Description		Amount
WEISS MANAGEMENT GROUP	MANAGEMENT FEES	$ 328,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 328,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		449,116
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 449,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,994
Unemployment Compensation Insurance	103,317
FICA Taxes	240,494
Employee Health Insurance	78,197
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,340
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 521,342

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	15,614
Health Care Worker Background Check	1,920
(Indicate # of checks performed 192)	
Patient Background Checks 256	2,560
TRUST/FRANCHISE/CONTRIB/ETC	7,824
MARKETING/ADV/PROMO	38,773
LICENSES/DUES/SUBSCRIPTIONS	10,248
MGMT CO ALLOC	317
TRUST/FRANCHISE/CONTRIB/ETC	(7,824)
Less: Public Relations Expense	(0)
Non-allowable advertising	(38,773)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,654

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	20,143
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,143

**See instructions.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $13,862**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **83,220**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.