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: 0021501

Facility Name: Lincoln Manor

Address: 2650 North Monroe Street (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 875-1973 **Fax #** (217) 875-2172

HFS ID Number:

Date of Initial License for Current Owners: 04/21/75

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: Michael W. Martin **Telephone Number:** (217) 258-8888
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 1/1/2010 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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 N/A

	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	24	Skilled (SNF)	24	8,760	1
2		Skilled Pediatric (SNF/PED)			2
3	116	Intermediate (ICF)	116	42,340	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,270	4,270	8
9	SNF/PED					9
10	ICF	28,190	8,540		36,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,190	8,540	4,270	41,000	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.23%

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 04/01/1975

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,270

Medicare Intermediary Wisconsin Physician Services

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	282,962	16,945	9,059	308,966		308,966		308,966			1
2	Food Purchase		284,566		284,566		284,566	(11,052)	273,514			2
3	Housekeeping	178,115	12,245	29,893	220,253		220,253		220,253			3
4	Laundry	83,844	11,899	4,903	100,646		100,646		100,646			4
5	Heat and Other Utilities			114,982	114,982		114,982		114,982			5
6	Maintenance	56,535	3,288	56,763	116,586		116,586		116,586			6
7	Other (specify):*											7
8	**TOTAL General Services**	601,456	328,943	215,600	1,145,999		1,145,999	(11,052)	1,134,947			8
	B. Health Care and Programs											
9	Medical Director			30,250	30,250		30,250		30,250			9
10	Nursing and Medical Records	2,091,619	170,024	22,918	2,284,561		2,284,561		2,284,561			10
10a	Therapy			553,809	553,809		553,809		553,809			10a
11	Activities	58,387	68	6,337	64,792		64,792	(2,418)	62,374			11
12	Social Services			4,155	4,155		4,155	2,418	6,573			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,150,006	170,092	617,469	2,937,567		2,937,567		2,937,567			16
	C. General Administration											
17	Administrative	155,829			155,829		155,829		155,829			17
18	Directors Fees			30,000	30,000		30,000		30,000			18
19	Professional Services			152,947	152,947		152,947		152,947			19
20	Dues, Fees, Subscriptions & Promotions			26,532	26,532		26,532	(953)	25,579			20
21	Clerical & General Office Expenses	113,067	10,383	25,704	149,154		149,154	(2,354)	146,800			21
22	Employee Benefits & Payroll Taxes			363,270	363,270		363,270	10,950	374,220			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,904	1,904		1,904		1,904			24
25	Other Admin. Staff Transportation			16,124	16,124		16,124	(13,328)	2,796			25
26	Insurance-Prop.Liab.Malpractice			158,566	158,566		158,566		158,566			26
27	Other (specify):*											27
28	**TOTAL General Administration**	268,896	10,383	775,047	1,054,326		1,054,326	(5,685)	1,048,641			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,020,358	509,418	1,608,116	5,137,892		5,137,892	(16,737)	5,121,155			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor #0021501 Report Period Beginning: 1/1/2010 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			72,161	72,161		72,161	96,570	168,731			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,027	4,027		4,027	(981)	3,046			32
33	Real Estate Taxes			56,354	56,354		56,354		56,354			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,570	7,570		7,570		7,570			35
36	Other (specify):*											36
37	TOTAL Ownership			140,112	140,112		140,112	95,589	235,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,992	1,672	136,664		136,664		136,664			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,720	76,720		76,720		76,720			42
43	Other (specify):* Non-Allowable Cos	17,507		252,328	269,835		269,835	(269,835)				43
44	TOTAL Special Cost Centers	17,507	134,992	330,720	483,219		483,219	(269,835)	213,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,037,865	644,410	2,078,948	5,761,223		5,761,223	(190,983)	5,570,240			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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	(102)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,391)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	96,570	30		9
10	Interest and Other Investment Income	(981)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,660)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(187,363)	43		24
25	Fund Raising, Advertising and Promotional	(6,803)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,520)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(51,733)	Vari		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,983)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,983)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lincoln Manor

ID# 0021501

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Part A	$ (12,564)	43	1
2	X-Ray - Part A	(3,775)	43	2
3	IV Therpay - Part A	(39)	43	3
4	Transportation - Part A	(994)	43	4
5	Disallow Nonallowable Legal Expenses		19	5
6	Yellow Pages Advertising	(953)	21	6
7	Donations	(219)	43	7
8	Marketing Salary	(17,507)	43	8
9	Miscellaneous Income	(2,354)	21	9
10	Disallow Out of State Travel	(13,328)	25	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**	(51,733)		49

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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
See attached Schedule 6A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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			$			$	$	1
2	V		N/A						2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Lincoln Manor
Facility ID: 0021501
01/01/10 - 12/31/10

Owners **Schedule 6A**
As of 12/31/10

Name of Owner	Ownership %
Seymour Chazin Trust	10.00%
Gabriel Wolff	10.00%
Carlyle Weinberger	11.00%
Francy Melnik Starr	7.25%
David Cohn	10.00%
Vicki Pollard	10.00%
Seymour & Ann Melnik	12.50%
Arlene Rubin	10.00%
Morton Melaik	10.00%
Judith Nack	3.00%
Gayle Rovnick	3.00%
Kenneth Weinberger	3.00%
	100.00%

See Accountants' Compilation Report

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	Vicki Pollard Evans	Director	Administrative	10.00	None	0.46	1.15	Director Fee	$ 2,000	18(3)	1
2	William Glickauf	Director	Administrative	0.00	None	0.46	1.15	Director Fee	1,000	18(3)	2
3	Richard Rovnick	Director	Administrative	8.00	None	0.5	1.25	Director Fee	3,000	18(3)	3
4	Pam Ferris	Director	Administrative	0.00	None	0.23	0.58	Director Fee	2,000	18(3)	4
5	Kenneth Weinberger	Director	Administrative	3.00	None	0.53	1.35	Director Fee	4,000	18(3)	5
6	Mort Melnik	Director	Administrative	10.00	None	0.38	0.96	Director Fee	4,000	18(3)	6
7	Dr. Seymour Melnik	Director	Administrative	12.50	None	0.57	1.44	Director Fee	6,000	18(3)	7
8	Gayle Rovnick	Director	Administrative	3.00	None	0.23	0.58	Director Fee	2,000	18(3)	8
9	David Cohn	Director	Administrative	10.00	None	2.3	5.77	Director Fee	4,000	18(3)	9
10	Arlene Rubin	Director	Administrative	10.00	None	0.42	1.06	Director Fee	2,000	18(3)	10
11											11
12											12
13								TOTAL	$ 30,000		13

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

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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 [ ] NO [X]

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 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		N/A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	Busey Bank		X	Facilities Improvement	$7,419.00	5/23/08	$ 376,000	$ 80,274	5/2023	0.0675	$ 4,027	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$7,419.00		$ 376,000	$ 80,274			$ 4,027	9
	B. Non-Facility Related*											
10								Interest Income Offset			(981)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (981)	14
15	TOTALS (line 9+line14)						$ 376,000	$ 80,274			$ 3,046	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor # 0021501 **Report Period Beginning:** 1/1/2010 **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.**		$ 54,000	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.)	2009	$ 55,154	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,154	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,200	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.		$ 56,354	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	49,603	8
	2006	50,462	9
	2007	52,355	10
	2008	54,096	11
	2009	55,154	12

2010 Accrual is based on the 2009 Real Estate Tax

	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 Lincoln Manor COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0021501

CONTACT PERSON REGARDING THIS REPORT Mary Buffington

TELEPHONE (217) 875-1973 FAX #: (217) 875-2172

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.	04-12-03-251-002	Long Term Care Property	$ 55,154.00	$ 55,154.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,154.00	$ 55,154.00

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 Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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? [X] (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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Facility		1965	$ 55,770	1
2	Demolished House		1995	13,200	2
3	TOTALS			$ 68,970	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	140		1975	1975	$ 745,047	$	35	$	$	$ 745,047	4
5			1981	1981	369,094		35			369,094	5
6			1984	1984	368,408		35			368,408	6
7			1985	1985	5,143		35			5,143	7
8			1993	1993	47,097		35	1,177	1,177	20,258	8
	Improvement Type**										
9	Various			1975	9,508		20			7,010	9
10	Various			1981	3,615		20			3,615	10
11	Various			1982	25,660		20			24,773	11
12	Various			1984	2,107		20			2,107	12
13	Various			1985	13,371		20			13,371	13
14	Various			1986	12,384		20	300	300	9,861	14
15	Various			1987	59,842		20	1,360	1,360	36,525	15
16	Various			1988	16,800		20	841	841	12,609	16
17	Various			1989	24,981		20	259	259	23,690	17
18	Various			1990	26,245		20	68	68	24,951	18
19	Various			1991	9,545		20			9,545	19
20	Various			1992	24,119		20	211	211	19,953	20
21	Various			1993	9,429		20	391	391	7,475	21
22	Various			1994	31,724		20	(347)	(347)	31,724	22
23	Various			1995	89,487		20	3,796	3,796	58,399	23
24	Various			1996	96,885		20	4,846	4,846	63,671	24
25	Various			1997	75,339		20	3,768	3,768	52,283	25
26	Various			1998	126,326		20	6,315	6,315	78,588	26
27	Various			1999	46,295		20	2,314	2,314	26,147	27
28	Various			2000	172,355		20	7,412	7,412	78,862	28
29	Various			2001	129,251		20	6,462	6,462	61,448	29
30	Various			2002	38,912		20	3,921	3,921	33,313	30
31	Various			2003	61,774		20	3,089	3,089	4,989	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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	Window Treatment, Wall Covering	2004	$ 3,416	$	20	$ 171	$ 171	$ 1,025	37
38	Painting (Dining Room)	2004	1,960		20	98	98	678	38
39	Drywall repairs	2004	8,381		20	419	419	2,549	39
40	Flooring	2004	1,064		20	53	53	107	40
41	Plumbing	2004	183		20	9	9	63	41
42	Wall Covering	2004	3,701		20	185	185	1,295	42
43	Code Alert System	2004	1,613		20	81	81	512	43
44	Storage Room	2004	4,889		20	244	244	1,486	44
45	Faucets	2004	510		20	26	26	180	45
46	Painting - Labor	2005	7,100		20	355	355	1,923	46
47	Electrical Work	2005	623		20	31	31	168	47
48	Paint	2005	4,547		20	227	227	1,155	48
49	Storage Shed & Slab	2005	8,630		20	432	432	2,375	49
50	New Sidewalk	2005	6,066		20	303	303	1,617	50
51	Fencing	2005	775		20	39	39	207	51
52	Electrical - Lighting	2005	910		20	45	45	241	52
53	Carpet, Vinyl Flooring	2005	5,853		20	293	293	1,489	53
54	Carpet Installation	2005	675		20	34	34	172	54
55	Roof Top Heating Cooling Unit	2005	7,233		20	362	362	1,809	55
56	Roof Top Heating Cooling Parts	2005	7,812		20	391	391	2,215	56
57	Replace Heating Cooling Roof Top Units	2005	9,044		20	452	452	2,373	57
58	Flooring	2006	7,330		20	366	366	1,831	58
59	Windows	2006	3,678		20	184	184	843	59
60	Paint, Molding	2006	5,249		20	262	262	1,180	60
61	Tile	2006	9,085		20	454	454	2,043	61
62	Electrical / Fire Protection	2006	5,020		20	251	251	1,130	62
63	Remodeling / Redecorating	2006	14,333		20	717	717	3,226	63
64	Front Entrance	2006	2,333		20	117	117	516	64
65	Two Water Heaters	2006	15,475		20	774	774	3,870	65
66	Vanities, Marble Tops	2006	8,964		20	448	448	2,016	66
67	Faucets / Lavatories	2006	4,002		20	200	200	850	67
68	Blinds	2006	4,407		20	220	220	935	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,805,604	$		$ 54,426	$ 54,426	$ 2,234,938	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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		$ 2,805,604	$		$ 54,426	$ 54,426	$ 2,234,938	1
2	Hand Rails	2006	3,220		20	161	161	684	2
3	Fabric, Rods, Brackets	2006	1,121		20	56	56	229	3
4	A/C Repair	2006	6,748		20	337	337	1,517	4
5	Code Alert - Smoking Room Door	2006	3,963		20	198	198	957	5
6	Bath Room Vanities	2006	7,572		20	379	379	1,673	6
7	Circulating Pump	2006	3,249		20	162	162	662	7
8	Decorating & Painting	2006	3,581		20	179	179	731	8
9	Lanscaping	2007	7,345		20	326	326	1,304	9
10	Lanscaping	2007	1,288		20	57	57	228	10
11	Interior Painting	2007	34,817		20	2,611	2,611	10,444	11
12	Decorating Valance	2007	650		20	65	65	260	12
13	Corner Guard	2007	3,477		20	348	348	1,392	13
14	Wallcoverings	2007	3,264		20	272	272	1,088	14
15	Privacy Curtains	2007	8,267		20	689	689	2,756	15
16	Sanding & Patching Walls	2007	3,200		20	240	240	960	16
17	Crowns In Foyer & Hallway	2007	6,739		20	618	618	2,472	17
18	Wallpaper	2007	22,540		20	1,503	1,503	6,012	18
19	Carpeting	2007	3,239		20	216	216	864	19
20	Flooring	2007	1,820		20	121	121	484	20
21	Wall Base & Cove Base	2007	12,904		20	860	860	3,440	21
22	Paneling & Wallpaper	2007	3,299		20	275	275	1,100	22
23	Paneling & Crown Molding	2007	3,699		20	308	308	1,232	23
24	Install & Caulk Cove Base	2007	3,598		20	300	300	1,200	24
25	Base & Crown	2007	5,772		20	433	433	1,732	25
26	Base & Crown	2007	7,320		20	488	488	1,952	26
27	Bases, Crowns & Drywall Repair	2007	7,203		20	480	480	1,920	27
28	Base, Drywall, Chair Rails, Crowns	2007	9,222		20	615	615	2,460	28
29	Flooring, Wall Fixtures, Signs, Tiling, Bathroom Vanities, Faucets	2007	103,555		20	5,178	5,178	20,712	29
30	Beauty Shop Remodel (Carpeting, Wallcoverings, Cove Base)	2008	6,279		20	314	314	942	30
31	Paint & Repair Resident Closets	2008	3,523		20	176	176	528	31
32	Five Ton Furnace	2009	5,000		20	250	250	500	32
33	Carpeting	2009	570		20	29	29	355	33
34	TOTAL (lines 1 thru 33)		$ 3,103,648	$		$ 72,670	$ 72,670	$ 2,307,728	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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 12B, Carried Forward		$ 3,103,648	$		$ 72,670	$ 72,670	$ 2,307,728	1
2	Parking Lot Repair & Speed Bump	2009	9,008		20	450	450	900	2
3	A/C 5 Ton (Hall 3)	2009	8,000		20	400	400	800	3
4	Generator	2009	3,444		20	172	172	344	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	Financial Statement Depreciation			72,161			(72,161)		33
34	TOTAL (lines 1 thru 33)		$ 3,124,100	$ 72,161		$ 73,692	$ 1,531	$ 2,309,772	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	$ 778,984	$	$ 82,748	$ 82,748	7-10	$ 574,605	71
72	Current Year Purchases	29,321		2,137	2,137	5-7	2,137	72
73	Fully Depreciated Assets	435,329				10	435,329	73
74								74
75	TOTALS	$ 1,243,634	$	$ 84,885	$ 84,885		$ 1,012,071	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Chevy Van	1993	$ 17,701	$	$	$		$ 17,701	76
77		2006 Southern Bus	2006	50,771		10,154	10,154		49,924	77
78										78
79										79
80	TOTALS			$ 68,472	$	$ 10,154	$ 10,154		$ 67,625	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,505,176	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,161	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,731	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 96,570	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,389,468	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 7,570 Description: Postage Meter-$2,105; Copier-$3,845; Ice Machine-$1,620
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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

It is the policy of this facility to only hire certified nurses aides.

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor STATE OF ILLINOIS # 0021501 Report Period Beginning: 1/1/2010 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	10A(3)	hrs	$	2,578	$ 193,387	$	2,578	$ 193,387	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,606	120,431		1,606	120,431	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,200	239,991		3,200	239,991	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				134,992		134,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Physician Services	39(3)				1,672			1,672	12
13	Other (specify):									13
14	TOTAL			$	7,384	$ 555,481	$ 134,992	7,384	$ 690,473	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

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	$ 261,543	$ 261,543	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance - 0 -)	783,300	783,300	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,305	15,305	6
7	Other Prepaid Expenses	2,406	2,406	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Payroll Advances	610	610	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,063,164	$ 1,063,164	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	84,560	68,970	13
14	Buildings, at Historical Cost	2,093,029	1,534,789	14
15	Leasehold Improvements, at Historical Cost	43,895	1,589,311	15
16	Equipment, at Historical Cost	2,007,926	1,312,106	16
17	Accumulated Depreciation (book methods)	(3,659,907)	(3,389,468)	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)**	$ 569,503	$ 1,115,708	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,632,667	$ 2,178,872	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 116,348	$ 116,348	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	80,274	80,274	29
30	Accrued Salaries Payable	72,244	72,244	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,533	6,533	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,200	55,200	32
33	Accrued Interest Payable	320	320	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Tax Withholding	8,662	8,662	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 339,581	$ 339,581	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)**	$ 339,581	$ 339,581	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,293,086	$ 1,839,291	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,632,667	$ 2,178,872	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lincoln Manor **#** 0021501 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 996,361	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 996,361	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	296,726	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) **Rounding**	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 296,725	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)**	$ 1,293,086	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	$ 6,050,336	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,050,336	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	102	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)**	$ 102	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	981	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 981	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,530	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,530	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,057,949	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,145,999	31
32	Health Care	2,937,567	32
33	General Administration	1,054,326	33
	B. Capital Expense		
34	Ownership	140,112	34
	C. Ancillary Expense		
35	Special Cost Centers	406,499	35
36	Provider Participation Fee	76,720	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,761,223	40
41	**Income before Income Taxes (line 30 minus line 40)****	296,726	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 296,726	43

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

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

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

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

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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	1,783	1,854	$ 63,337	$ 34.16	1
2	Assistant Director of Nursing	1,915	1,991	53,700	26.97	2
3	Registered Nurses	13,185	13,706	333,170	24.31	3
4	Licensed Practical Nurses	20,325	21,128	440,885	20.87	4
5	CNAs & Orderlies	85,738	89,125	1,081,388	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,668	1,734	23,320	13.45	9
10	Activity Assistants	3,189	3,315	35,067	10.58	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,830	1,902	31,901	16.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,832	23,734	251,061	10.58	15
16	Dishwashers					16
17	Maintenance Workers	3,894	4,048	56,535	13.97	17
18	Housekeepers	18,382	19,108	178,115	9.32	18
19	Laundry	8,429	8,762	83,844	9.57	19
20	Administrator	2,413	2,509	111,289	44.36	20
21	Assistant Administrator	1,622	1,687	44,540	26.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,370	9,740	113,067	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,369	1,423	29,412	20.67	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,949	7,223	89,727	12.42	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Coord.	1,544	1,605	17,507	10.91	33
34	TOTAL (lines 1 - 33)	206,437	214,594	$ 3,037,865 *	$ 14.16	34

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	199	$ 9,059	1(3)	35
36	Medical Director	Monthly	30,250	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	44	3,938	10(3)	38
39	Pharmacist Consultant	Monthly	6,180	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	317	2,417	11(3)	44
45	Social Service Consultant	317	2,418	12(3)	45
46	Other(specify) QA Coordinator	Monthly	800	10(3)	46
47	Medical Advisor	Monthly	12,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	877	$ 67,062		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell	Administrator	0	$ 58,558
Pam Rosenkranz	Administrator	0	50,728
Mary Buffington	Administrator	0	2,003
Jan Pasier	Asst. Administrator	0	44,540
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 155,829

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 152,947
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 152,947

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,076
Unemployment Compensation Insurance	
FICA Taxes	208,856
Employee Health Insurance	64,152
Employee Meals	10,950
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	6,479
Employee Drug Screening	3,781
Employee Appreciation	4,979
Employee Physicals	52
Retirement Expense	5,895
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,220

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	19,444
Health Care Worker Background Check	1,288
(Indicate # of checks performed 68)	
Patient Background Checks 48	912
Miscellaneous Licenses & Fees	1,082
Miscellaneous Dues & Subscriptions	863
Yellow Page Advertising	953
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(953)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,904
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,904

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lincoln Manor
Provider #: 0021501
1/1/2010 to 12/31/2010 **Schedule 21A**

XIX. Support Schedule
C. Professional Services

Vendor/Payee	Type	Amount
Winters, Fetherstun, Gaumer, Postlewait, Stocks & Flynn	Legal	12,922
Duane Morris, LLP	Legal	56,756
Barry E. Morge	Legal	150
McGuire, Yuhas, Huffman & Buckley, P.C.	Accounting	51,297
McGladrey	Accounting	29,222
Pam Ferris	Professional Services	2,500
Beth McCoy	Professional Services	100
Total (agree to Schedule V, Line 19, Column 3)		152,947
Less Non allowable legal		(6,064)
Total (agree to Schedule V, Line 19, Column 8)		146,883

SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Lincoln Manor # 0021501 Report Period Beginning: 1/1/2010 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								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lincoln Manor **#** 0021501 **Report Period Beginning:** 1/1/2010 **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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,212** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,720**
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. $ **10,950** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **102**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
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? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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.