		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: 0037044

Facility Name: Lincoln Square

Address: 202 South Main Street (Number) Jonesboro (City) 62952 (Zip Code)

County: Union

Telephone Number: (618) 833-2063 **Fax #** (618) 833-4993

HFS ID Number:

Date of Initial License for Current Owners: 8/8/1991

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: Ashley Alley **Telephone Number:** (618) 833-5070 x11
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) Ashley Alley
(Title) Asst. Comptroller

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Lincoln Square # 0037044 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 5475

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less	15	5,475	6
7		TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,464			5,464	13
14	TOTALS	5,464			5,464	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.80%

D. How many bed-hold days during this year were paid by the Department?
11 (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 01/01/1991

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

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

Medicare Intermediary _____

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 Lincoln Square # 0037044 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	25,934	1,543	969	28,446		28,446		28,446			1
2	Food Purchase		45,355		45,355		45,355		45,355			2
3	Housekeeping		4,437	380	4,817		4,817	85	4,902			3
4	Laundry		441	13	454		454		454			4
5	Heat and Other Utilities			14,314	14,314		14,314	239	14,553			5
6	Maintenance		4,755	1,945	6,700		6,700	4,728	11,428			6
7	Other (specify):*											7
8	**TOTAL General Services**	25,934	56,531	17,621	100,086		100,086	5,052	105,138			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	187,501	1,749	2,286	191,536		191,536	1,079	192,615			10
10a	Therapy		531	2,448	2,979		2,979		2,979			10a
11	Activities	15,945		295	16,240		16,240		16,240			11
12	Social Services		1,733	2,164	3,897		3,897	(1,589)	2,308			12
13	CNA Training	7,826		490	8,316		8,316		8,316			13
14	Program Transportation		2,519	4,269	6,788		6,788	391	7,179			14
15	Other (specify):* Day Training			219,746	219,746		219,746	(219,746)				15
16	**TOTAL Health Care and Programs**	211,272	6,532	235,298	453,102		453,102	(219,865)	233,237			16
	C. General Administration											
17	Administrative			2,400	2,400		2,400	5,107	7,507			17
18	Directors Fees											18
19	Professional Services			27,715	27,715		27,715	(24,794)	2,921			19
20	Dues, Fees, Subscriptions & Promotions			969	969		969	(27)	942			20
21	Clerical & General Office Expenses	15,856	2,741	5,663	24,260		24,260	8,055	32,315			21
22	Employee Benefits & Payroll Taxes			34,924	34,924		34,924	1,753	36,677			22
23	Inservice Training & Education			455	455		455	50	505			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,010	4,010		4,010	198	4,208			26
27	Other (specify):* Finance Charge			37	37		37	(37)				27
28	**TOTAL General Administration**	15,856	2,741	76,173	94,770		94,770	(9,695)	85,075			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	253,062	65,804	329,092	647,958		647,958	(224,508)	423,450			29

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

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

Facility Name & ID Number Lincoln Square #0037044 **Report Period Beginning:** 1/1/2010 **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			9,102	9,102		9,102	4,643	13,745			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			463	463		463		463			32
33	Real Estate Taxes			8,301	8,301		8,301	143	8,444			33
34	Rent-Facility & Grounds			36,300	36,300		36,300	(35,782)	518			34
35	Rent-Equipment & Vehicles			1,306	1,306		1,306	93	1,399			35
36	Other (specify):* State Inc. Tax			991	991		991	(991)				36
37	**TOTAL Ownership**			56,463	56,463		56,463	(31,894)	24,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		1,766		1,766		1,766	(4,233)	(2,467)			41
42	Provider Participation Fee			29,535	29,535		29,535		29,535			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,766	29,535	31,301		31,301	(4,233)	27,068			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	253,062	67,570	415,090	735,722		735,722	(260,635)	475,087			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 Lincoln Square # 0037044 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 Reference	3 BHF USE ONLY	
1	Day Care	$ (219,746)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,306)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,204	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(975)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(37)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(81)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(991)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg. 5A	(5,822)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (224,754)		$	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)	(35,881)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,881)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (260,635)		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

Lincoln Square

ID# 0037044

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Expense offset by Vending Revenue	$ (4,233)	41	1
2	Personal Items	(1,589)	12	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**	(5,822)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square # 0037044 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	85	0	0	0	0	0	0	0	0	0	85	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	239	0	0	0	0	0	0	0	0	0	239	5
6	Maintenance	0	66	4,662	0	0	0	0	0	0	0	0	4,728	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	390	4,662	0	0	0	0	0	0	0	0	5,052	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	1,079	0	0	0	0	0	0	0	0	1,079	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,589)	0	0	0	0	0	0	0	0	0	0	(1,589)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	391	0	0	0	0	0	0	0	0	0	391	14
15	Other (specify):*	(219,746)	0	0	0	0	0	0	0	0	0	0	(219,746)	15
16	**TOTAL Health Care and Programs**	(221,335)	391	1,079	0	0	0	0	0	0	0	0	(219,865)	16
	C. General Administration													
17	Administrative	0	0	5,107	0	0	0	0	0	0	0	0	5,107	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(975)	181	(24,000)	0	0	0	0	0	0	0	0	(24,794)	19
20	Fees, Subscriptions & Promotions	(81)	54	0	0	0	0	0	0	0	0	0	(27)	20
21	Clerical & General Office Expenses	0	1,166	6,889	0	0	0	0	0	0	0	0	8,055	21
22	Employee Benefits & Payroll Taxes	(1,306)	3,059	0	0	0	0	0	0	0	0	0	1,753	22
23	Inservice Training & Education	0	50	0	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	198	0	0	0	0	0	0	0	0	0	198	26
27	Other (specify):*	(37)	0	0	0	0	0	0	0	0	0	0	(37)	27
28	**TOTAL General Administration**	(2,399)	4,708	(12,004)	0	0	0	0	0	0	0	0	(9,695)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(223,734)	5,489	(6,263)	0	0	0	0	0	0	0	0	(224,508)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lincoln Square** **#** **0037044** **Report Period Beginning:** **1/1/2010** **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	4,204	439	0	0	0	0	0	0	0	0	0	4,643	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	143	0	0	0	0	0	0	0	0	0	143	33
34	Rent-Facility & Grounds	0	518	(36,300)	0	0	0	0	0	0	0	0	(35,782)	34
35	Rent-Equipment & Vehicles	0	0	93	0	0	0	0	0	0	0	0	93	35
36	Other (specify):*	(991)	0	0	0	0	0	0	0	0	0	0	(991)	36
37	**TOTAL Ownership**	3,213	1,100	(36,207)	0	0	0	0	0	0	0	0	(31,894)	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	(4,233)	0	0	0	0	0	0	0	0	0	0	(4,233)	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**	(4,233)	0	0	0	0	0	0	0	0	0	0	(4,233)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(224,754)	6,589	(42,470)	0	0	0	0	0	0	0	0	(260,635)	45

Facility Name & ID Number Lincoln Square # 0037044 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
Jacob L. Alley	50	Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
Diana Alley	50	Holly Hill	Anna	JR's Centre	Anna	Workshop
		Pilot House	Cairo	ILS 1-3 & 5-6	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis	ILS Land Trust	Anna	Land Trust
		New Way	Anna	LS Land Trust	Anna	Land Trust

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	3	Housekeeping	$	kel-Tech Management Co.	25.00%	$ 85	$ 85	1
2	V	5	Heat and Other Utilities		kel-Tech Management Co.	25.00%	239	239	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	66	66	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	391	391	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	181	181	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	54	54	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	1,166	1,166	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	3,059	3,059	8
9	V	23	Inservice Trn'g & Education		kel-Tech Management Co.	25.00%	50	50	9
10	V	26	Insurance		kel-Tech Management Co.	25.00%	198	198	10
11	V	30	Depreciation		kel-Tech Management Co.	25.00%	439	439	11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	143	143	12
13	V	34	Rent-Facility		kel-Tech Management Co.	25.00%	518	518	13
14	Total			$			$ 6,589	$ * 6,589	14

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/2010 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	35	Rent- Equipment	$	kel-Tech Management Co.	25.00%	$ 93	$ 93	15
16	V	10	Nursing		kel-Tech Management Co.	25.00%	1,079	1,079	16
17	V	17	Administration		kel-Tech Management Co.	25.00%	5,107	5,107	17
18	V	21	Clerical		kel-Tech Management Co.	25.00%	6,889	6,889	18
19	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,662	4,662	19
20	V								20
21	V								21
22	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	22
23	V	34	Building Lease	36,300	Lincoln Square Land Trust	100.00%		(36,300)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,300			$ 17,830	$ * (42,470)	39

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/2010 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	Diana Alley	DON/Owner	DON	50.00	14,976	8	20.00	Nursing	$ 21,024	10-1	1
2	Jacob L. Alley	Owner		50.00	224			Clerical	224	21-1	2
3	Josh Alley	DSP	DSP	0.00	5,395	4	10.00	DSP	4,622	10-1	3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	1,079	19-3	8
9	Jacob Alley							Maintenance	4,662	19-3	9
10	James A. Keller							Administration	5,107	19-3	10
11	Ashley Alley							Clerical	2,411	19-3	11
12											12
13								TOTAL	$ 39,129		13

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

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/2010 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: kel-Tech Management Co.
Street Address: 158 E. Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618) 833-5070
Fax Number: (618) 833-4993

	1 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	3	Housekeeping	Mgmt Fee Contribution	333,596	8	$ 1,100	$	24,000	$ 79	1
2	3	Office Décor	Mgmt Fee Contribution	333,596	8	76		24,000	5	2
3	5	Utilities Elec/Gas	Mgmt Fee Contribution	333,596	8	2,942		24,000	212	3
4	5	Utilities Water	Mgmt Fee Contribution	333,596	8	377		24,000	27	4
5	6	Grounds Maintenance	Mgmt Fee Contribution	333,596	8	315		24,000	23	5
6	6	Maint. Supplies	Mgmt Fee Contribution	333,596	8	204		24,000	15	6
7	6	Maint. Vehicle	Mgmt Fee Contribution	333,596	8	393		24,000	28	7
8	14	Repairs Vehicles	Mgmt Fee Contribution	333,596	8	1,176		24,000	85	8
9	14	Transportation	Mgmt Fee Contribution	333,596	8	4,257		24,000	306	9
10	19	Legal & Accounting	Mgmt Fee Contribution	333,596	8	2,515		24,000	181	10
11	20	Dues Fees Subscriptions	Mgmt Fee Contribution	333,596	8	757		24,000	54	11
12	21	Bank Charges	Mgmt Fee Contribution	333,596	8	(45)		24,000	(3)	12
13	21	Contract Services	Mgmt Fee Contribution	333,596	8	1,740		24,000	125	13
14	21	Copier Expense Service Calls	Mgmt Fee Contribution	333,596	8	286		24,000	21	14
15	21	G & A Misc	Mgmt Fee Contribution	333,596	8	1,292		24,000	93	15
16	21	G & A Supplies	Mgmt Fee Contribution	333,596	8	6,821		24,000	491	16
17	21	Postage	Mgmt Fee Contribution	333,596	8	2,687		24,000	193	17
18	21	Telephone	Mgmt Fee Contribution	333,596	8	1,789		24,000	129	18
19	21	Cell Phone Expense	Mgmt Fee Contribution	333,596	8	1,223		24,000	88	19
20	21	Utilities - Internet	Mgmt Fee Contribution	333,596	8	408		24,000	29	20
21	22	Ins. Emp. Group	Mgmt Fee Contribution	333,596	8	20,343		24,000	1,464	21
22	22	Ins. W/C	Mgmt Fee Contribution	333,596	8	2,971		24,000	214	22
23	22	Payroll Tax Exp.	Mgmt Fee Contribution	333,596	8	19,211		24,000	1,382	23
24	23	Travel & Entertainment	Mgmt Fee Contribution	333,596	8	237		24,000	17	24
25	TOTALS					$ 73,075	$		$ 5,258	25

Facility Name & ID Number Lincoln Square # 0037044 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 [X] NO [ ]

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

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

	1 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	23	Adm. Staff Trn'g	Mgmt Fee Contribution	333,596	8	$ 455	$	24,000	$ 33	1
2	26	Ins. Bldg. & Liab.	Mgmt Fee Contribution	333,596	8	1,240		24,000	89	2
3	26	Ins. Vehicles	Mgmt Fee Contribution	333,596	8	1,516		24,000	109	3
4	30	Depreciation	Mgmt Fee Contribution	333,596	8	6,103		24,000	439	4
5	33	Real Estate Taxes	Mgmt Fee Contribution	333,596	8	1,990		24,000	143	5
6	34	Lease Bldg	Mgmt Fee Contribution	333,596	8	7,200		24,000	518	6
7	35	Lease Equip	Mgmt Fee Contribution	333,596	8	1,291		24,000	93	7
8	10	Nursing	Mgmt Fee Contribution	333,596	8	15,001	15,001	24,000	1,079	8
9	17	Administration	Mgmt Fee Contribution	333,596	8	70,992	70,992	24,000	5,107	9
10	21	Clerical	Mgmt Fee Contribution	333,596	8	95,761	95,761	24,000	6,889	10
11	6	Maintenance	Mgmt Fee Contribution	333,596	8	64,802	64,802	24,000	4,662	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					$ 266,351	$ 246,556		$ 19,161	25

Facility Name & ID Number Lincoln Square # 0037044 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	Capaha Bank		X	Vehichle Loan	$449.00	5/6/10	$ 10,000	$	5/6/12	6.5000	$ 38	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capaha Bank		X	Working Capital - LOC		8/20/10			8/20/11	5.5000	425	6
7												7
8												8
9	TOTAL Facility Related				$449.00		$ 10,000	$			$ 463	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,000	$			$ 463	15

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

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

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

Facility Name & ID Number Lincoln Square **#** 0037044 **Report Period Beginning:** 1/1/2010 **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.**	$ 8,624	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.)		$ 8,379	2
3. Under or (over) accrual (line 2 minus line 1).		$ (245)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 8,546	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.		$ 8,301	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	6,516	8
	2006	7,661	9
	2007	7,668	10
	2008	8,136	11
	2009	8,379	12

	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

Sch IX, Line 7 8301
kel-Tech Allocation 143
Sch V, Line 33, Col. 8 8444

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 Square COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037044

CONTACT PERSON REGARDING THIS REPORT Ashley Alley

TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

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.	14-00-07-353	Lot 69 Grammer's Addition	$ 6,959.50	$ 6,959.50
2.	14-00-07-418	W 1/2 Lot 120 Grammer's Addition	$ 1,347.04	$ 1,347.04
3.	14-00-07-408	Lot 111 Grammer's Addition	$ 72.00	$ 72.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,378.54	$ 8,378.54

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 Square # 0037044 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Healthcare	8,000	1987	$ 7,800	1
2	Healthcare	7,056	2006	2,200	2
3	TOTALS	15,056		$ 10,000	3

Facility Name & ID Number Lincoln Square # 0037044 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	15		2005	1987	$ 231,909	$	30	$ 7,730	$ 7,730	$ 177,145	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1997	4,056		7	271	271	3,658	9
10	Living Room Carpet			1998	571		7			571	10
11	Carpet			2001	3,640		7			3,640	11
12	Tile Floor			2002	3,922	162	15	261	99	2,284	12
13	Fire Alarm Panel			2005	1,835	106	5	105	(1)	1,835	13
14	Wood Decking			2005	2,100	131	15	140	9	1,000	14
15	Tile Floor-Living Room			2006	2,177	153	15	145	(8)	634	15
16	Tile Floor - Hall			2006	2,804	202	15	187	(15)	771	16
17	Carpet			2008	1,309		7	187	187	467	17
18	Stairway/Hall Flooring			2009	4,998	237	15	333	96	416	18
19	Sprinkler			2010	1,313	66	15	66		66	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lincoln Square # 0037044 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 260,634	$ 1,057		$ 9,425	$ 8,368	$ 192,487	70

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/2010 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	$ 18,022	$ 388	$ 552	$ 164		$ 14,037	71
72	Current Year Purchases	3,737	3,737	318	(3,419)		318	72
73	Fully Depreciated Assets	18,275		2,126	2,126		18,222	73
74								74
75	TOTALS	$ 40,034	$ 4,125	$ 2,996	$ (1,129)		$ 32,577	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	2001 Ford Van	2000	$ 26,232	$	$	$	5	$ 26,232	76
77	Healthcare	2004 Ford Focus	2004	14,909	860		(860)	5	14,909	77
78	Healthcare	2003 Jeep Wrangler	2010	6,637	3,060	885	(2,175)	5	885	78
79										79
80	TOTALS			$ 47,778	$ 3,920	$ 885	$ (3,035)		$ 42,026	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)	$ 358,446	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,102	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,306	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,204	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 267,090	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 Lincoln Square # 0037044 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: 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.	/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: $ 1,306 Description: Copier Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Lincoln Square # 0037044 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? [X] YES [ ] NO

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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		1,031		1,031
4	Clinical Wages (b)		2,010		2,010
5	In-House Trainer Wages (c)		4,785		4,785
6	Transportation				
7	Contractual Payments		490		490
8	CNA Competency Tests				
9	TOTALS	$	$ 8,316	$	$ 8,316
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,316			

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(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 Lincoln Square # 0037044 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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Square # 0037044 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	$ 130,468	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	432		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	99,075		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 229,975	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	28,725		15
16	Equipment, at Historical Cost	87,812		16
17	Accumulated Depreciation (book methods)	(103,660)		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)**	$ 12,877	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 242,852	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,714	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,132		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,541		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,546		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Deductions	113		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 23,046	$	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)**	$ 23,046	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 219,806	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 242,852	$	48

*(See instructions.)

Facility Name & ID Number Lincoln Square # 0037044 **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**	$ 193,498	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 193,498	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,248	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	(12,940)	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)**	$ 26,308	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)**	$ 219,806	24 *

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

Facility Name & ID Number Lincoln Square # 0037044 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	$ 540,223	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 540,223	3
	B. Ancillary Revenue		
4	Day Care	219,746	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 219,746	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	10,768	11
12	Gift and Coffee Shop	4,233	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)**	$ 15,001	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 774,970	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	100,086	31
32	Health Care	453,326	32
33	General Administration	94,546	33
	B. Capital Expense		
34	Ownership	56,463	34
	C. Ancillary Expense		
35	Special Cost Centers	1,766	35
36	Provider Participation Fee	29,535	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 735,722	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,248	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,248	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 Lincoln Square # 0037044 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	416	416	$ 21,040	$ 50.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	60	60	1,133	18.88	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,816	1,824	15,945	8.74	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	2,095	2,207	25,934	11.75	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative			224		22
23	Office Manager					23
24	Clerical	1,489	1,489	15,632	10.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,250	1,250	23,390	18.71	28
29	Resident Services Coordinator	834	834	15,594	18.70	29
30	Habilitation Aides (DD Homes)	13,500	13,830	134,170	9.70	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,460	21,910	$ 253,062 *	$ 11.55	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	26	$ 969	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	220	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	800	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	30	1,500	10a-3	46
47	Administrator Consultant	133	2,400	17-3	47
48	Social Work Consultant	40	2,164	12-3	48
49	TOTAL (lines 35 - 48)	302	$ 11,653		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Cheryl Sherrill - Administrative Consultant	$ 2,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Barnett & Levine	CPA	$ 3,700
FMGR	Legal	15
kel-Tech Management Co.	Acct'g/Mgmt. Services	24,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,715

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,051
Unemployment Compensation Insurance	5,319
FICA Taxes	17,560
Employee Health Insurance	3,433
Employee Meals	1,306
Illinois Municipal Retirement Fund (IMRF)*	
Staff Physicals	255
kel-Tech Mgmt Allocation	3,059
Less:	
Employee Meals	(1,306)
TOTAL (agree to Schedule V, line 22, col.8)	$ 36,677

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	120
Health Care Worker Background Check	
(Indicate # of checks performed 12)	192
Patient Background Checks	
See Pg. 25	576
kel-Tech Allocation	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 942

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lincoln Square # 0037044 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													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lincoln Square # 0037044 **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.

(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?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Lincoln Square #0032469 01/01/1991

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **29,535**
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? **Yes** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,306** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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

Related Parties Schedule VII
Owners Compensation
Jan.1 2010 - Dec. 31 2010

	Totals / Entity	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook
Diana Alley	$ 51,225	14,976	-	21,024	15,001	224	-
Jo Ann Keller	$ 129,923	105,923	24,000	-		-	-
James K. Keller	$ 14,400	14,400	-	-		-	-
Jacob Alley	$ 57,420	-	-	224	56,972	224	-
Ashley Alley	$ 33,639				33,639		
Josh Alley	$ 10,017	-	-	4,622		5,395	-
James A. Keller	$ 89,216	-	-	-	70,992	-	18,224
	$ 385,840	$ 135,299	$ 24,000	$ 25,870	$ 176,604	$ 5,843	$ 18,224

Lincoln Square
Analysis of Sch XIX, Section F.
2010

Resident Acct Bond Renewal/Increase	$ 260
Hotmail Annual Fee	20
P.O. Box Rental	40
IL Corp Ann Report	130
Advertising	81
Fingerprinting	33
Dietary Sanitation Class & Certificate	80
Top Health Subscription	13
Less:	
Advertising	(81)
Total	$ 576

Lincoln Square
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2010

Sch IX	$ 13,306
kel-Tech Mgmt. Co. Alloc.	439
Total on Sch V	$ 13,745

Lincoln Square
Detail of Sch. V , Line 36, Col. 3
2010

State Income Tax	991
Total	$ 991

Lincoln Square
Detail of Sch. V , Line 27, Col. 3
2010

Late Fee/Finance Charge	37
Total	$ 37

Lincoln Square
Allocation of Cost for Employee
Schedule XX, Question 12
2010

Anita Beatty, RSD/QMRP

Salary			$ 38,984
	RSD	40%	15,594
	QMRP	60%	23,390
Total		100%	38,984