FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0037044

Facility Name: Lincoln Square

Address: 202 South Main St (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: 08/08/1991

Type of Ownership:

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

IRS Exemption Code

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 01/01/2013 to 12/31/2013 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: 01/01/2013 Ending: 12/31/2013

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	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: 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	5,473			5,473	13
14	TOTALS	5,473			5,473	14

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

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	12,008	1,331	1,064	14,403		14,403		14,403			1
2	Food Purchase		47,106		47,106		47,106		47,106			2
3	Housekeeping		5,250	186	5,436		5,436	73	5,509			3
4	Laundry		470		470		470		470			4
5	Heat and Other Utilities			13,367	13,367		13,367	215	13,582			5
6	Maintenance		6,781	1,900	8,681		8,681	5,441	14,122			6
7	Other (specify):*											7
8	TOTAL General Services	12,008	60,938	16,517	89,463		89,463	5,729	95,192			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	220,274	3,208	1,235	224,717		224,717	1,065	225,782			10
10a	Therapy		446	2,096	2,542		2,542		2,542			10a
11	Activities	18,680		273	18,953		18,953		18,953			11
12	Social Services		1,231	1,650	2,881		2,881	(1,120)	1,761			12
13	CNA Training	14,114		2,115	16,229		16,229		16,229			13
14	Program Transportation		5,809	1,323	7,132		7,132	894	8,026			14
15	Other (specify):* Day Training Expense			190,447	190,447		190,447	(190,447)				15
16	TOTAL Health Care and Programs	253,068	10,694	202,439	466,201		466,201	(189,608)	276,593			16
	C. General Administration											
17	Administrative	6,009		2,400	8,409		8,409	5,037	13,446			17
18	Directors Fees			300	300		300		300			18
19	Professional Services			27,394	27,394		27,394	(25,232)	2,162			19
20	Dues, Fees, Subscriptions & Promotions			1,567	1,567		1,567	(651)	916			20
21	Clerical & General Office Expenses	18,045	3,099	6,036	27,180		27,180	8,552	35,732			21
22	Employee Benefits & Payroll Taxes			33,955	33,955		33,955	2,487	36,442			22
23	Inservice Training & Education			243	243		243		243			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,109	4,109		4,109	136	4,245			26
27	Other (specify):* Finance Charges			375	375		375	(375)				27
28	TOTAL General Administration	24,054	3,099	76,379	103,532		103,532	(10,046)	93,486			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	289,130	74,731	295,335	659,196		659,196	(193,925)	465,271			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:** 01/01/2013 **Ending:** 12/31/2013

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			6,975	6,975		6,975	8,416	15,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,091	1,091		1,091	(165)	926			32
33	Real Estate Taxes			10,486	10,486		10,486	(452)	10,034			33
34	Rent-Facility & Grounds			60,000	60,000		60,000	(59,485)	515			34
35	Rent-Equipment & Vehicles			1,251	1,251		1,251	30	1,281			35
36	Other (specify):*			142	142		142	(142)				36
37	**TOTAL Ownership**			79,945	79,945		79,945	(51,798)	28,147			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							(1,761)	(1,761)			41
42	Provider Participation Fee			32,529	32,529		32,529		32,529			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			32,529	32,529		32,529	(1,761)	30,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	289,130	74,731	407,809	771,670		771,670	(247,484)	524,186			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: 01/01/2013 Ending: 12/31/2013

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	$ (190,447)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(611)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,266	30		9
10	Interest and Other Investment Income	(165)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,312)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(375)	27		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(81)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(142)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg 5A	(4,035)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (189,002)		$	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)	(58,482)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,482)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (247,484)		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Expense off set by Vending Income	$ (1,761)	41	1
2	Personal Items/Gifts/Floral	(1,120)	12	2
3	Future CILA Site Real Estate Taxes	(634)	33	3
4	CILA App Completion	(350)	20	4
5	CILA Site Gas Hookup Fee	(170)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,035)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square # 0037044 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	215	0	0	0	0	0	0	0	0	0	215	5
6	Maintenance	0	156	5,285	0	0	0	0	0	0	0	0	5,441	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	444	5,285	0	0	0	0	0	0	0	0	5,729	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	1,065	0	0	0	0	0	0	0	0	1,065	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	(1,120)	0	0	0	0	0	0	0	0	0	0	(1,120)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	894	0	0	0	0	0	0	0	0	0	894	14
15	Other (specify):*	(190,447)	0	0	0	0	0	0	0	0	0	0	(190,447)	15
16	**TOTAL Health Care and Programs**	(191,567)	894	1,065	0	0	0	0	0	0	0	0	(189,608)	16
	C. General Administration													
17	Administrative	0	0	5,037	0	0	0	0	0	0	0	0	5,037	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,312)	80	(24,000)	0	0	0	0	0	0	0	0	(25,232)	19
20	Fees, Subscriptions & Promotions	(701)	50	0	0	0	0	0	0	0	0	0	(651)	20
21	Clerical & General Office Expenses	0	1,049	7,503	0	0	0	0	0	0	0	0	8,552	21
22	Employee Benefits & Payroll Taxes	(611)	3,098	0	0	0	0	0	0	0	0	0	2,487	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	136	0	0	0	0	0	0	0	0	0	136	26
27	Other (specify):*	(375)	0	0	0	0	0	0	0	0	0	0	(375)	27
28	**TOTAL General Administration**	(2,999)	4,413	(11,460)	0	0	0	0	0	0	0	0	(10,046)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(194,566)	5,751	(5,110)	0	0	0	0	0	0	0	0	(193,925)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lincoln Square # 0037044 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	8,266	150	0	0	0	0	0	0	0	0	0	8,416	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(165)	0	0	0	0	0	0	0	0	0	0	(165)	32
33	Real Estate Taxes	(634)	182	0	0	0	0	0	0	0	0	0	(452)	33
34	Rent-Facility & Grounds	0	515	(60,000)	0	0	0	0	0	0	0	0	(59,485)	34
35	Rent-Equipment & Vehicles	0	30	0	0	0	0	0	0	0	0	0	30	35
36	Other (specify):*	(142)	0	0	0	0	0	0	0	0	0	0	(142)	36
37	**TOTAL Ownership**	7,325	877	(60,000)	0	0	0	0	0	0	0	0	(51,798)	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	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	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**	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(189,002)	6,628	(65,110)	0	0	0	0	0	0	0	0	(247,484)	45

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacob L. Alley	30	Mulberry Manor	Anna	Pilot House of Cairo	Cairo	CILA
Diana Alley	30	Glen Brook of Vienna	Vienna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
Joshua Alley	20	Krypton ICF-DD	Metropolis	ILS 2, 5-8	Anna	CILA
Jacob L. Alley, II	20			ILS 4	Metropolis	CILA
				Krypton CILA	CILA	Metropolis

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%	$ 73	$ 73	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	215	215	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	156	156	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	894	894	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	80	80	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	50	50	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	1,049	1,049	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	3,098	3,098	8
9	V	26	Insurance		kel-Tech Management Co.	25.00%	136	136	9
10	V	30	Depreciation		kel-Tech Management Co.	25.00%	150	150	10
11	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	182	182	11
12	V	34	Rent- Facility		kel-Tech Management Co.	25.00%	515	515	12
13	V	35	Rent - Equipment		kel-Tech Management Co.	25.00%	30	30	13
14	Total			$			$ 6,628	$ * 6,628	14

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$	kel-Tech Management Co.	25.00%	$ 1,065	$ 1,065	15
16	V	17	Administration		kel-Tech Management Co.	25.00%	5,037	5,037	16
17	V	21	Clerical		kel-Tech Management Co.	25.00%	7,503	7,503	17
18	V	6	Maintenance		kel-Tech Management Co.	25.00%	5,285	5,285	18
19	V								19
20	V								20
21	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	21
22	V	34	Building Lease	60,000	Lincoln Square Land Trust	100.00%		(60,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 84,000			$ 18,890	$ * (65,110)	39

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James A. Keller	50	Glen Brook of Vienna	Vienna				1
2	Norine Keller	50	Glen Brook of Vienna	Vienna				2
3	Jacob L. Alley	30	Krypton	Metropolis				3
4	Diana Alley	30	Krypton	Metropolis				4
5	James K. Keller Family Trust	50	Pilot House	Cairo				5
6	JoAnn Keller	50	Pilot House	Cairo				6
7	JoAnn Keller	50	Mulberry Manor	Anna				7
8	James K. Keller Family Trust	50	Mulberry Manor	Anna				8
9	Don Pippins	50			CIL	Anna	CILA	9
10	Denise Pippins	50			CIL	Anna	CILA	10
11	Don Pippins	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	11
12	Jacob L. Alley	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	12
13	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	13
14	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	14
15	Don Pippins	25			Independent Living Se	Anna	CILA	15
16	Jacob L. Alley	25			Independent Living Se	Anna	CILA	16
17	James A. Keller	25			Independent Living Se	Anna	CILA	17
18	James K. Keller Family Trust	25			Independent Living Se	Anna	CILA	18
19	Don Pippins	25			ILS Land Trust	Anna	Land Trust	19
20	Jacob L. Alley	25			ILS Land Trust	Anna	Land Trust	20
21	James A. Keller	25			ILS Land Trust	Anna	Land Trust	21
22	James K. Keller Family Trust	25			ILS Land Trust	Anna	Land Trust	22
23	JoAnn Keller	25			JR Center	Anna	Workshop	23
24	Don Pippins	12.5			JR Center	Anna	Workshop	24
25	JoAnn Keller	25			ILS Land Trust	Anna	Land Trust	25
26	Jacob L. Alley, II	20			Krypton	Metropolis	CILA	26
27	Josh Alley	20			Krypton	Metropolis	CILA	27
28	Jacob L. Alley	30			Krypton	Metropolis	CILA	28
29	Diana Alley	30			Krypton	Metropolis	CILA	29
30								30

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	30.00		8	20.00	Nursing	$ 21,056	10-1	1
2	Jacob Alley	Owner	Director	30.00				Admin.	247	21-1	2
3	Jacob Alley, II	Owner	Director/Admin.	20.00		4	10.00	Admin.	6,009	17-1	3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	1,065	19-3	8
9	Jacob Alley							Maintenance	4,069	19-3	9
10	James A. Keller							Administration	5,037	19-3	10
11	Ashley Alley							Clerical	2,776	19-3	11
12											12
13								TOTAL	$ 40,259		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: 01/01/2013 Ending: 2/31/2013

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	Houskeeping	Mgmt Fee Contribution	335,796	8	$ 1,016	$	24,000	$ 73	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	335,796	8	2,633		24,000	188	2
3	5	Utilities Water	Mgmt Fee Contribution	335,796	8	380		24,000	27	3
4	6	Maint. Building	Mgmt Fee Contribution	335,796	8	220		24,000	16	4
5	6	Maint. Supplies	Mgmt Fee Contribution	335,796	8	916		24,000	65	5
6	6	Grounds Maint.	Mgmt Fee Contribution	335,796	8	1,046		24,000	75	6
7	14	Maint. Vehicle	Mgmt Fee Contribution	335,796	8	1,133		24,000	81	7
8	14	Repairs Vehicle	Mgmt Fee Contribution	335,796	8	3,326		24,000	238	8
9	14	Transportation	Mgmt Fee Contribution	335,796	8	7,026		24,000	502	9
10	14	Insurance Vehicles	Mgmt Fee Contribution	335,796	8	1,028		24,000	73	10
11	19	Legal & Accounting	Mgmt Fee Contribution	335,796	8	1,115		24,000	80	11
12	20	Dues Fees Subscriptions	Mgmt Fee Contribution	335,796	8	699		24,000	50	12
13	21	G & A Supplies	Mgmt Fee Contribution	335,796	8	6,651		24,000	475	13
14	21	Postage	Mgmt Fee Contribution	335,796	8	2,122		24,000	152	14
15	21	Bank Charges	Mgmt Fee Contribution	335,796	8	131		24,000	9	15
16	21	IT Services	Mgmt Fee Contribution	335,796	8	1,580		24,000	113	16
17	21	Copier Expense Service Calls	Mgmt Fee Contribution	335,796	8	72		24,000	5	17
18	21	G&A Misc.	Mgmt Fee Contribution	335,796	8	195		24,000	14	18
19	21	Software Expense	Mgmt Fee Contribution	335,796	8	796		24,000	57	19
20	21	Telephone	Mgmt Fee Contribution	335,796	8	1,514		24,000	108	20
21	21	Cell Phone Expense	Mgmt Fee Contribution	335,796	8	1,246		24,000	89	21
22	21	Utilities - Internet	Mgmt Fee Contribution	335,796	8	369		24,000	26	22
23	22	Ins. Emp. Group	Mgmt Fee Contribution	335,796	8	19,832		24,000	1,417	23
24	22	Insurance W/C	Mgmt Fee Contribution	335,796	8	3,124		24,000	223	24
25	TOTALS					$ 58,170	$		$ 4,156	25

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	22	Payroll Tax Expense	Mgmt Fee Contribution	335,796	8	$ 20,383	$	24,000	$ 1,457	1
2	22	Misc. Emp Benefits	Mgmt Fee Contribution	335,796	8	(7)		24,000	(1)	2
3	26	Insurance Bldg & Liab	Mgmt Fee Contribution	335,796	8	1,898		24,000	136	3
4	30	Depreciation	Mgmt Fee Contribution	335,796	8	2,100		24,000	150	4
5	33	Real Estate Taxes	Mgmt Fee Contribution	335,796	8	2,553		24,000	182	5
6	34	Lease Bldg	Mgmt Fee Contribution	335,796	8	7,200		24,000	515	6
7	35	Lease Equip	Mgmt Fee Contribution	335,796	8	425		24,000	30	7
8	10	Nursing	Mgmt Fee Contribution	335,796	8	14,896	14,898	24,000	1,065	8
9	17	Administration	Mgmt Fee Contribution	335,796	8	70,444	70,454	24,000	5,035	9
10	21	Clerical	Mgmt Fee Contribution	335,796	8	104,923	104,937	24,000	7,499	10
11	6	Maintenance	Mgmt Fee Contribution	335,796	8	73,909	73,919	24,000	5,282	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					$ 298,724	$ 264,208		$ 21,350	25

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Citizens Bank		X	Vehicle Loan	$312.23	7/17/13	$ 17,501	$ 16,452	7/17/18	2.7000	$ 200	1
2	Yard Card		X	Lawn Mower	$131.48	4/11/13	6,574		4/11/17			2
3												3
4												4
5												5
	Working Capital											
6	Capaha Bank		X	Line of Credit		6/10/13	100,000	42,000	6/10/14	6.0000	891	6
7												7
8												8
9	TOTAL Facility Related				$443.71		$ 124,075	$ 58,452			$ 1,091	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 124,075	$ 58,452			$ 1,091	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:** 01/01/2013 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 9,018	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.)		$ 10,004	2
3. Under or (over) accrual (line 2 minus line 1).		$ 986	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,500	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.		$ 10,486	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	8,136	8
	2009	8,379	9
	2010	8,813	10
	2011	9,018	11
	2012	10,004	12

Sch IX, Line 7	10,486	
kel-Tech Allocation	182	
Non-Allowable	(634)	
Sch V, Line 33, Col 8.	10,034	

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-00-07-353	Lot 69 Grammers Addition	$ 7,783.46	$ 7,783.46
2.	14-00-07-418	W 1/2 Lot 120 Grammers Addition	$ 1,506.24	$ 1,506.24
3.	14-00-07-408	Lot 111 Grammer's Addition	$ 80.60	$ 80.60
4.	06-25-04-755	S25T13R1W PT SW NE E 1/2 NW P	$ 633.68	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,003.98	$ 9,370.30

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? X YES _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 200,335	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1997	4,056		7			4,056	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	3,067	12
13	Fire Alarm Panel			2005	1,835		5			1,835	13
14	Wood Decking			2005	2,100	124	15	140	16	1,420	14
15	Tile Floor-Living Room			2006	2,177	128	15	145	17	1,069	15
16	Tile Floor - Hall			2006	2,804	165	15	187	22	1,332	16
17	Carpet			2008	1,309		7	187	187	1,028	17
18	Stairway/Hall Flooring			2009	4,998	173	15	333	160	1,415	18
19	Sprinkler			2010	1,313	101	15	88	(13)	330	19
20	Roof			2011	1,000	86	15	67	(19)	184	20
21	Bedroom Flooring			2011	1,541		15	103	103	266	21
22	Bedroom Linoleum			2011	2,375		7	339	339	848	22
23	Flooring			2012	2,667		7	381	381	476	23
24	Laminate Flooring			2013	2,667	381	7	190	(191)	190	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: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 270,884	$ 1,320		$ 10,151	$ 8,831	$ 222,062	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: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 13,696	$ 72	$ 2,001	$ 1,929		$ 9,393	71
72	Current Year Purchases	8,639	1,343	672	(671)		672	72
73	Fully Depreciated Assets	30,372					30,372	73
74		8,782	1,648		(1,648)		825	74
75	TOTALS	$ 61,489	$ 3,063	$ 2,673	$ (390)		$ 41,262	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	2001 Ford Van	2000	$ 26,232	$	$	$	5	$ 26,232	76
77	Healthcare	2003 Jeep Wrangler	2010	6,637	412	1,327	915	5	4,866	77
78	Healthcare	2013 Ford Focus	2013	10,901	2,180	1,090	(1,090)	5	1,090	78
79										79
80	TOTALS			$ 43,770	$ 2,592	$ 2,417	$ (175)		$ 32,188	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)	$	386,143	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	6,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	15,241	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	8,266	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	295,512	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	Appliances & Furnishings for CILA	$ 8,782	$ 1,648	$ 1,648	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 8,782	$ 1,648	$ 1,648	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: 01/01/2013 Ending: 12/31/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 1,251 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: 01/01/2013 Ending: 12/31/2013

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)		1,947		1,947
4	Clinical Wages (b)		3,797		3,797
5	In-House Trainer Wages (c)		8,770		8,770
6	Transportation				
7	Contractual Payments		1,715		1,715
8	CNA Competency Tests				
9	TOTALS	$	$ 16,229	$	$ 16,229
10	SUM OF line 9, col. 1 and 2 (e)	$ 16,229			

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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.

Facility Name & ID Number Lincoln Square **#** 0037044 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2013 **(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	$ 25,061	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	71,833		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)	79,071		8
9	Other(specify): DSP Trn'g Reimbursable	2,324		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 178,289	$	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	38,975		15
16	Equipment, at Historical Cost	105,259		16
17	Accumulated Depreciation (book methods)	(110,622)		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)**	$ 33,612	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 211,901	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,008	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,863		30
31	Accrued Taxes Payable (excluding real estate taxes)	945		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Credit Card Payable	1,339		36
37	Payroll Deductions Payable	(2,127)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 32,528	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,974		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capaha Bank- Line of Credit	42,000		43
44	Pilot House of Cairo	433		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 64,407	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 96,935	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 114,965	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 211,900	$	48

***(See instructions.)**

Facility Name & ID Number Lincoln Square **#** 0037044 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 196,084	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 196,084	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(23,379)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (23,379)	17
	B. Transfers (Itemize):		
18	**Reclass Stock @ time of Change From S to C-Corp**	(57,740)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (57,740)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 114,965	24 *

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 540,311	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 540,311	3
	B. Ancillary Revenue		
4	Day Care	190,447	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 190,447	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,565	11
12	Gift and Coffee Shop	2,802	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)**	$ 17,367	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	165	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 165	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 748,290	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	89,463	31
32	Health Care	466,201	32
33	General Administration	103,532	33
	B. Capital Expense		
34	Ownership	79,945	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,529	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 771,670	40
41	**Income before Income Taxes (line 30 minus line 40)****	(23,380)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (23,380)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	417	417	$ 21,087	$ 50.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	111	111	2,047	18.44	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,814	1,918	18,680	9.74	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,264	1,344	12,008	8.93	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	208	208	6,009	28.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,605	1,606	18,045	11.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	722	722	24,209	33.53	28
29	Resident Services Coordinator	481	481	16,140	33.56	29
30	Habilitation Aides (DD Homes)	17,897	18,363	170,905	9.31	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,519	25,170	$ 289,130 *	$ 11.49	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	30	$ 1,064	1-3	35
36	Medical Director	48	3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	300	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Social Work Cons.	33	1,650	12-3	46
47	Psychologist Consultant	30	1,500	10a-3	47
48	Administrator Consultant	133	2,400	17-3	48
49	TOTAL (lines 35 - 48)	289	$ 10,454		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: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacob Alley, II	Exec. Director	20	$ 6,009
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 6,009

B. Administrative - Other

Description	Amount
Cheryl Sherrill - Admin. 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	$ 2,815
FMGR	Legal	579
kel-Tech Mgmt. Co.	Mgmt Services	24,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,394

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,474
Unemployment Compensation Insurance	2,543
FICA Taxes	21,757
Employee Health Insurance	2,172
Employee Meals	611
Illinois Municipal Retirement Fund (IMRF)*	
Employee Vacinations & Physicals	1,398
kel-Tech Management Allocation	3,098
Less: Employee Meals	(611)
TOTAL (agree to Schedule V, line 22, col.8)	$ 36,442

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	137
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Pg. 24	729
kel-Tech Allocation	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 916

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)	$

**See instructions.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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:** 01/01/2013 **Ending:** 12/31/2013

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. $ **1,212** 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. $ **32,529**
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. $ **611** 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? **!00%**
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? **No**
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 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.

Lincoln Square
Analysis of Sch XIX, Section F.
2013

P.O. Box Rental	44
Advertising	81
Contributions	100
Fingerprinting	160
Resident Surety Bond	230
Personal Advisor	31
Food Sanitation Certificate	35
CILA App Completion Fee	350
Go To My PC Annual Fee	99
CILA Gas Hookup Fee	170
Corporate Annual Report	130
Less:	
CILA App Completion Fee	(350)
CILA Gas Hookup Fee	(170)
Contribution	(100)
Advertising	(81)
Total	$ 729

Lincoln Square
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2013

Sch IX	$ 15,241
CILA Depreciation Expenses	$ 1,648
kel-Tech Mgmt. Co. Alloc.	150
Total on Sch V	$ 17,039

Lincoln Square
Allocation of Cost for Employee

Schedule XX, Question 12
2013

Anita Beatty, RSD/QMRP

RSD	40%	16,140
QMRP	60%	24,209
Total	100%	40,349

Lincoln Square, Inc.
Allocation of Real Estate to Nursing Home
Schedule IX
2013

Lincoln Square ICF-DD	9,370
Future Site Lincoln Square CILA	634
Total R/E Tax Expense	10,004