

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0037044</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>Lincoln Square</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> 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.																																
Address: <u>202 South Main Street</u> <u>Jonesboro</u> <u>62952</u> Number City Zip Code																																		
County: <u>Union</u>																																		
Telephone Number: <u>(618) 833-2063</u> Fax # <u>(618) 833-4993</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>08/08/1991</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Ashley Alley</u></td></tr><tr><td>(Title) <u>Asst. Comptroller</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name _____ and Title) _____</td></tr><tr><td>(Firm Name _____ & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Ashley Alley</u>	(Title) <u>Asst. Comptroller</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name _____ and Title) _____	(Firm Name _____ & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>	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																				
Officer or Administrator of Provider	(Signed) _____																																	
	(Type or Print Name) <u>Ashley Alley</u>																																	
	(Title) <u>Asst. Comptroller</u>																																	
	(Signed) _____																																	
Paid Preparer	(Date) _____																																	
	(Print Name _____ and Title) _____																																	
	(Firm Name _____ & Address) _____																																	
	(Telephone) <u>()</u> Fax # <u>()</u>																																	
	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																																	
Type of Ownership:																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☐</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☒</td><td>"Sub-S" Corp.</td></tr><tr><td>☐</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☒	"Sub-S" Corp.	☐	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
☐	VOLUNTARY, NON-PROFIT																																	
☐	Charitable Corp.																																	
☐	Trust																																	
IRS Exemption Code _____																																		
☐	PROPRIETARY																																	
☐	Individual																																	
☐	Partnership																																	
☐	Corporation																																	
☒	"Sub-S" Corp.																																	
☐	Limited Liability Co.																																	
☐	Trust																																	
☐	Other _____																																	
☐	GOVERNMENTAL																																	
☐	State																																	
☐	County																																	
☐	Other _____																																	
In the event there are further questions about this report, please contact:																																		
Name: <u>Ashley Alley</u> Telephone Number: <u>(618) 833-5070 x11</u>																																		
Email Address: _____																																		

Facility Name & ID Number Lincoln Square# 0037044 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	5,490	6
7	15	TOTALS	15	5,490	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,488			5,488	13
14	TOTALS	5,488			5,488	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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 01/01/1991NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	35,306	1,283	958	37,547		37,547		37,547		1
2	Food Purchase		48,337		48,337		48,337		48,337		2
3	Housekeeping		3,202		3,202		3,202	53	3,255		3
4	Laundry		226		226		226		226		4
5	Heat and Other Utilities			12,131	12,131		12,131	185	12,316		5
6	Maintenance		4,657	2,062	6,719		6,719	5,244	11,963		6
7	Other (specify):*										7
8	TOTAL General Services	35,306	57,705	15,151	108,162		108,162	5,482	113,644		8
	B. Health Care and Programs										
9	Medical Director		3,600		3,600		3,600		3,600		9
10	Nursing and Medical Records	190,777	2,480	1,251	194,508		194,508	1,039	195,547		10
10a	Therapy		535	2,516	3,051		3,051		3,051		10a
11	Activities	20,004	307		20,311		20,311		20,311		11
12	Social Services		1,603	1,590	3,193		3,193	(1,603)	1,590		12
13	CNA Training	4,611		890	5,501		5,501		5,501		13
14	Program Transportation		3,201	4,037	7,238		7,238	771	8,009		14
15	Other (specify):* Day Training			219,746	219,746		219,746	(219,746)			15
16	TOTAL Health Care and Programs	215,392	11,726	230,030	457,148		457,148	(219,539)	237,609		16
	C. General Administration										
17	Administrative			2,400	2,400		2,400	4,955	7,355		17
18	Directors Fees										18
19	Professional Services			29,147	29,147		29,147	(24,985)	4,162		19
20	Dues, Fees, Subscriptions & Promotions			1,762	1,762		1,762	(219)	1,543		20
21	Clerical & General Office Expenses	17,293	3,720	5,669	26,682		26,682	7,574	34,256		21
22	Employee Benefits & Payroll Taxes			34,191	34,191		34,191	2,118	36,309		22
23	Inservice Training & Education			108	108		108		108		23
24	Travel and Seminar							7	7		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,662	6,662		6,662	155	6,817		26
27	Other (specify):* Finance Charge			33	33		33	(33)			27
28	TOTAL General Administration	17,293	3,720	79,972	100,985		100,985	(10,428)	90,557		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	267,991	73,151	325,153	666,295		666,295	(224,485)	441,810		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			5,082	5,082		5,082	8,685	13,767			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,697	2,697		2,697	(34)	2,663			32
33	Real Estate Taxes			9,046	9,046		9,046	148	9,194			33
34	Rent-Facility & Grounds			42,300	42,300		42,300	(41,795)	505			34
35	Rent-Equipment & Vehicles			1,416	1,416		1,416	35	1,451			35
36	Other (specify):* State Income Tax			311	311		311	(311)				36
37	TOTAL Ownership			60,852	60,852		60,852	(33,272)	27,580			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							(1,270)	(1,270)			41
42	Provider Participation Fee			32,526	32,526		32,526		32,526			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,526	32,526		32,526	(1,270)	31,256			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	267,991	73,151	418,531	759,673		759,673	(259,027)	500,646			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(844)	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	8,455	30		9
10	Interest and Other Investment Income	(34)	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)	(1,055)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33)	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	(311)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(3,073)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,722)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,305)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (42,305)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (259,027)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lincoln Square

ID#

0037044

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Vending Expense offsett by Vending Income	\$ (1,270)	41	1
2	Personal Items/Gifts/Floral	(1,603)	12	2
3	CILA Application Fee	(200)	20	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	(3,073)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	53	0	0	0	0	0	0	0	0	0	53	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	185	0	0	0	0	0	0	0	0	0	185	5
6	Maintenance	0	110	5,134	0	0	0	0	0	0	0	0	5,244	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	348	5,134	0	0	0	0	0	0	0	0	5,482	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	1,039	0	0	0	0	0	0	0	0	1,039	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	(1,603)	0	0	0	0	0	0	0	0	0	0	(1,603)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	771	0	0	0	0	0	0	0	0	0	771	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	(221,349)	771	1,039	0	0	0	0	0	0	0	0	(219,539)	16
	C. General Administration													
17	Administrative	0	0	4,955	0	0	0	0	0	0	0	0	4,955	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,055)	70	(24,000)	0	0	0	0	0	0	0	0	(24,985)	19
20	Fees, Subscriptions & Promotions	(281)	62	0	0	0	0	0	0	0	0	0	(219)	20
21	Clerical & General Office Expenses	0	906	6,668	0	0	0	0	0	0	0	0	7,574	21
22	Employee Benefits & Payroll Taxes	(844)	2,962	0	0	0	0	0	0	0	0	0	2,118	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7	0	0	0	0	0	0	0	0	0	7	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	155	0	0	0	0	0	0	0	0	0	155	26
27	Other (specify):*	(33)	0	0	0	0	0	0	0	0	0	0	(33)	27
28	TOTAL General Administration	(2,213)	4,162	(12,377)	0	0	0	0	0	0	0	0	(10,428)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(223,562)	5,281	(6,204)	0	0	0	0	0	0	0	0	(224,485)	29

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Square

0037044

Report Period Beginning:

01/01/2012 Ending:

Summary B
12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	8,455	230	0	0	0	0	0	0	0	0	0	8,685	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	0	0	0	0	0	0	0	0	0	0	(34)	32
33	Real Estate Taxes	0	148	0	0	0	0	0	0	0	0	0	148	33
34	Rent-Facility & Grounds	0	505	(42,300)	0	0	0	0	0	0	0	0	(41,795)	34
35	Rent-Equipment & Vehicles	0	0	35	0	0	0	0	0	0	0	0	35	35
36	Other (specify):*	(311)	0	0	0	0	0	0	0	0	0	0	(311)	36
37	TOTAL Ownership	8,110	883	(42,265)	0	0	0	0	0	0	0	0	(33,272)	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	(1,270)	0	0	0	0	0	0	0	0	0	0	(1,270)	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	(1,270)	0	0	0	0	0	0	0	0	0	0	(1,270)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(216,722)	6,164	(48,469)	0	0	0	0	0	0	0	0	(259,027)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacob L. Alley	40	Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
Diana Alley	40	Pilot House	Cairo	JR's Center	Anna	Workshop
Joshua Alley	10	Glen Brook	Vienna	ILS 1-3 & 5-6	Anna	CILA
Jacob L. Alley, II	10	Krypton	Metropolis	ILS 4	Metropolis	CILA
		New Way	Anna	ILS Land Trust	Anna	Land Trust
				CIL	Anna	CILA

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

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

1 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	Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 53	\$ 53	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	185	185	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	110	110	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	771	771	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	70	70	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	62	62	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	906	906	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	2,962	2,962	8
9	V	24	Inservice Trn'g & Education		kel-Tech Management Co.	25.00%	7	7	9
10	V	26	Insurance		kel-Tech Management Co.	25.00%	155	155	10
11	V	30	Depreciation		kel-Tech Management Co.	25.00%	230	230	11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	148	148	12
13	V	34	Rent- Facility		kel-Tech Management Co.	25.00%	505	505	13
14	Total			\$			\$ 6,164	\$ * 6,164	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent - Equipment	\$	kel-Tech Management Co.		\$ 35	\$ 35	15
16	V	10	Nursing		kel-Tech Management Co.		1,039	1,039	16
17	V	17	Administration		kel-Tech Management Co.		4,955	4,955	17
18	V	21	Clerical		kel-Tech Management Co.		6,668	6,668	18
19	V	6	Maintenance		kel-Tech Management Co.		5,134	5,134	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/Office Lease	42,300	Lincoln Square Land Trust	100.00%		(42,300)	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			\$ 66,300			\$ 17,831	\$ * (48,469)	39

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

Facility Name & ID Number

Lincoln Square

0037044

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Diana Alley	DON/Owner	DON	40.00	1,152	8	20.00	Nursing	\$ 21,085	10-1	1
2	Jacob Alley	Owner		40.00				Clerical	242	21-1	2
3	Ashley Alley	Clerical	Clerical	0.00	14,380			Clerical	55	21-1	3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	1,039	19-3	8
9	Jacob Alley							Maintenance	3,977	19-3	9
10	James A. Keller							Administration	4,955	19-3	10
11	Ashley Alley							Clerical	2,601	19-3	11
12											12
13								TOTAL	\$ 33,954		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:

01/01/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

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	342,496	8	\$ 756	\$	24,000	\$ 53	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	342,496	8	2,254		24,000	158	2
3	5	Utilities Water	Mgmt Fee Contribution	342,496	8	380		24,000	27	3
4	6	Maint. Building	Mgmt Fee Contribution	342,496	8	93		24,000	7	4
5	6	Maint. Supplies	Mgmt Fee Contribution	342,496	8	293		24,000	21	5
6	6	Repairs Furn/Equip	Mgmt Fee Contribution	342,496	8	181		24,000	13	6
7	6	Grounds Maint.	Mgmt Fee Contribution	342,496	8	50		24,000	4	7
8	6	Contract Services	Mgmt Fee Contribution	342,496	8	950		24,000	67	8
9	14	Repairs Vehicle	Mgmt Fee Contribution	342,496	8	420		24,000	29	9
10	14	Transportation	Mgmt Fee Contribution	342,496	8	6,808		24,000	477	10
11	14	Insurance Vehicles	Mgmt Fee Contribution	342,496	8	1,613		24,000	113	11
12	14	Maint. Vehicle	Mgmt Fee Contribution	342,496	8	2,166		24,000	152	12
13	19	Legal & Accounting	Mgmt Fee Contribution	342,496	8	995		24,000	70	13
14	20	Dues Fees Subscriptions	Mgmt Fee Contribution	342,496	8	889		24,000	62	14
15	21	G & A Misc.	Mgmt Fee Contribution	342,496	8	1,044		24,000	73	15
16	21	G & A Misc. Stock	Mgmt Fee Contribution	342,496	8	272		24,000	19	16
17	21	G & A Supplies	Mgmt Fee Contribution	342,496	8	6,570		24,000	460	17
18	21	Postage	Mgmt Fee Contribution	342,496	8	1,996		24,000	140	18
19	21	Bank Charges	Mgmt Fee Contribution	342,496	8	61		24,000	4	19
20	21	Telephone	Mgmt Fee Contribution	342,496	8	1,621		24,000	114	20
21	21	Cell Phone	Mgmt Fee Contribution	342,496	8	964		24,000	68	21
22	21	Utilities Internet	Mgmt Fee Contribution	342,496	8	408		24,000	29	22
23	22	Ins Emp Group	Mgmt Fee Contribution	342,496	8	20,144		24,000	1,412	23
24	22	Insurance W/C	Mgmt Fee Contribution	342,496	8	3,115		24,000	218	24
25	TOTALS					\$ 54,043	\$		\$ 3,790	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Capaha Bank		X	Line of Credit		6/10/2012			6/10/2013	6.0000	2,697	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 2,697	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 2,697	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	8,990	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.)				\$	9,018	2
3. Under or (over) accrual (line 2 minus line 1).				\$	28	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	9,018	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.				\$	9,046	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	7,668	8
2008	8,136	9
2009	8,379	10
2010	8,813	11
2011	9,018	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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	9046
kel-Tech Allocation	148
Sch V, Line 33, Col. 8	9194

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.**

2011 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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-00-07-353	Lot 69 Grammer's Addition	\$ 7,490.56	\$ 7,490.56
2.	14-00-07-418	W 1/2 Lot 120 Grammer's Addition	\$ 1,449.54	\$ 1,449.54
3.	14-00-07-408	Lot 111 Grammer's Addition	\$ 77.56	\$ 77.56
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 9,017.66	\$ 9,017.66

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,200

B. General Construction Type: Exterior WoodFrame Wood

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (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

☒ 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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	15		2005	1987	\$ 231,909	\$	30	\$ 7,730	\$ 7,730	\$ 192,605
5										
6										
7										
8										
	Improvement Type**									
9	Carpeting		1997		4,056		7	127	127	4,056
10	Living Room Carpet		1998		571		7			571
11	Carpet		2001		3,640		7			3,640
12	Tile Floor		2002		3,922	162	15	261	99	2,806
13	Fire Alarm Panel		2005		1,835		5			1,835
14	Wood Decking		2005		2,100	124	15	140	16	1,280
15	Tile Floor-Living Room		2006		2,177	128	15	145	17	924
16	Tile Floor - Hall		2006		2,804	165	15	187	22	1,145
17	Carpet		2008		1,309		7	187	187	841
18	Stairway/Hall Flooring		2009		4,998	192	15	333	141	1,082
19	Sprinkler		2010		1,313	112	15	88	(24)	242
20	Roof		2011		1,000	95	15	67	(28)	117
21	Bedroom Flooring		2011		1,541		15	103	103	163
22	Bedroom Linoleum		2011		2,375		7	339	339	509
23	Flooring		2012		2,667	2,667	7	95	(2,572)	95
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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)		\$ 268,217	\$ 3,645		\$ 9,802	\$ 6,157	\$ 211,911	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$16,257	\$166	\$2,398	\$2,232		\$10,527	71
72	Current Year Purchases	584	584	10	(574)		10	72
73	Fully Depreciated Assets	27,227					27,227	73
74								74
75	TOTALS	\$44,068	\$750	\$2,408	\$1,658		\$37,764	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	2004 Ford Focus	2004	14,909				5	14,909	77
78	Healthcare	2003 Jeep Wrangler	2010	6,637	687	1,327	640	5	3,539	78
79										79
80	TOTALS			\$47,778	\$687	\$1,327	\$640		\$44,680	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)	\$370,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$5,082	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$13,537	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,455	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$294,355	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.

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

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. /2013\$
13. /2014\$
14. /2015\$

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO

16. Rental Amount for movable equipment: \$1,416
- 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ 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☒

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER CNA86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		672		672
4	Clinical Wages (b)		1,311		1,311
5	In-House Trainer Wages (c)		3,028		3,028
6	Transportation				
7	Contractual Payments		490		490
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,501	\$	\$ 5,501
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,501		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 81,439	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	72,085		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)	99,575		8
9	Other(specify): DSP Training Reimbursable	2,113		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 255,212	\$	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	36,308		15
16	Equipment, at Historical Cost	91,846		16
17	Accumulated Depreciation (book methods)	(118,556)		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)	\$ 9,598	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 264,810	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,231	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,041		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,522		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,018		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessments	8,159		36
37	Payroll Deductions Payable	154		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 40,125	\$	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	Lincoln Square Land Trust Loan	22,600		43
44	Lease Payment Due to Land Trust	6,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 28,600	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 68,725	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 196,084	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 264,809	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 197,075	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 197,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	9,449	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	(10,440)	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)	\$ (991)	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)	\$ 196,084	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/2012Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 541,823	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 541,823	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	4,469	11
12	Gift and Coffee Shop	3,001	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)	\$ 7,470	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	49	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 49	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 769,122	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	108,162	31
32	Health Care	457,148	32
33	General Administration	100,985	33
	B. Capital Expense		
34	Ownership	60,852	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,526	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 759,673	40
41	Income before Income Taxes (line 30 minus line 40)**	9,449	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 9,449	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	417	417	\$ 21,085	\$ 50.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	60	60	1,805	30.08	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,051	2,108	20,004	9.49	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,172	3,349	35,306	10.54	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					22
23	Office Manager					23
24	Clerical	1,553	1,554	17,348	11.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,253	1,253	24,251	19.35	28
29	Resident Services Coordinator	836	836	16,168	19.34	29
30	Habilitation Aides (DD Homes)	13,119	13,497	132,024	9.78	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,461	23,074	\$ 267,991 *	\$ 11.61	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	26	\$ 958	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	240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	750	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Social Work Consult.	28	1,590	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	\$ 11,038		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

0037044

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Lincoln Square

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
				\$	Workers' Compensation Insurance		\$ 4,486	IDPH License Fee		\$	
					Unemployment Compensation Insurance		6,561	Advertising: Employee Recruitment		180	
					FICA Taxes		20,110	Health Care Worker Background Check			
					Employee Health Insurance		2,070	(Indicate # of checks performed 1)		16	
					Employee Meals		844	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Pg. 24		1,285	
					Staff Vaccinations		120				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	kel-Tech Management Allocation		2,962	kel-Tech Allocation		62	
B. Administrative - Other											
Description				Amount	Less: Employee Meals		(844)	Less: Public Relations Expense		()	
Cheryl Sherrill - Administrative Consultant				\$ 2,400				Non-allowable advertising		()	
								Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 36,309	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,543	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 2,400	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services					Description			Line #	Amount	Description	Amount
Vendor/Payee		Type		Amount						Out-of-State Travel	\$
Barnett & Levine		CPA		\$ 4,530							
FMGR		Legal		617						In-State Travel	
kel-Tech Management 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.)				\$ 29,147	TOTAL			\$		Entertainment Expense	()
										(agree to Sch. V, line 24, col. 8)	
										TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 481 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. \$ 32,526
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. \$ 844 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 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.
2012

P.O. Box Rental	44
Advertising	81
Fingerprinting	292
Top Dollar Subscription	30
Hosting Fee	144
Annual Insurance Fee	588
Food Sanitation Certificate	35
CILA Application Fee	200
Sec. Of State	22
Corporate Annual Report	130

Less:	
CILA Application Fee	(200)
Advertising	(81)

Total	<u>\$ 1,285</u>
-------	-----------------

Lincoln Square
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2012

Sch IX	\$ 13,537
kel-Tech Mgmt. Co. Alloc.	<u>230</u>

Total on Sch V	<u>\$ 13,906</u>
----------------	------------------

Lincoln Square
Allocation of Cost for Employee
Schedule XX, Question 12
2012

Anita Beatty, RSD/QMRP

RSD	40%	16,168
QMRP	60%	24,251
Total	100%	40,419