FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0035410

Facility Name: Lincoln Terrace

Address: 2324 N Kickapoo St (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: (217) 732-4422 **Fax #** (217) 732-6547

HFS ID Number:

Date of Initial License for Current Owners: 06/08/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Brian Burger **Telephone Number:** (309) 343-1550
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 10/1/2024 to 9/30/2025 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) Brian Burger
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	3,228							3,228	13
14	TOTALS	3,228							3,228	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 55.27%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 06/08/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/24/90 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/2025 Fiscal Year: 9/30/2025

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	37,300	2,035	2,459	41,794		41,794		41,794			1
2	Food Purchase		47,311		47,311		47,311		47,311			2
3	Housekeeping	21,500	4,752		26,252		26,252		26,252			3
4	Laundry		4,149		4,149		4,149		4,149			4
5	Heat and Other Utilities			23,230	23,230		23,230	60	23,290			5
6	Maintenance	11,238	4,502	15,890	31,630		31,630		31,630			6
7	Other (specify):*											7
8	**TOTAL General Services**	70,038	62,749	41,579	174,366		174,366	60	174,426			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	241,765	7,376	3,778	252,919		252,919		252,919			10
10a	Therapy											10a
11	Activities		681	1,949	2,630		2,630		2,630			11
12	Social Services											12
13	CNA Training	34,481			34,481		34,481		34,481			13
14	Program Transportation			6,439	6,439		6,439		6,439			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	276,246	8,057	16,566	300,869		300,869		300,869			16
	C. General Administration											
17	Administrative											17
18	Directors Fees							583	583			18
19	Professional Services			64,566	64,566		64,566	515	65,081			19
20	Dues, Fees, Subscriptions & Promotions			27,412	27,412		27,412	(412)	27,000			20
21	Clerical & General Office Expenses	25,458	3,349	7,872	36,679		36,679	2,364	39,043			21
22	Employee Benefits & Payroll Taxes			50,628	50,628		50,628	4	50,632			22
23	Inservice Training & Education			6,398	6,398		6,398	4	6,402			23
24	Travel and Seminar			195	195		195		195			24
25	Other Admin. Staff Transportation			2,710	2,710		2,710	19	2,729			25
26	Insurance-Prop.Liab.Malpractice			6,561	6,561		6,561	1,086	7,647			26
27	Other (specify):*											27
28	**TOTAL General Administration**	25,458	3,349	166,342	195,149		195,149	4,163	199,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	371,742	74,155	224,487	670,384		670,384	4,223	674,607			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lincoln Terrace #0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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			14,361	14,361		14,361	6,448	20,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			14,361	14,361		14,361	6,448	20,809			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											41
42	Provider Participation Fee			32,278	32,278		32,278		32,278			42
43	Other (specify):* **Disallowed Costs**			714	714		714	(714)				43
44	**TOTAL Special Cost Centers**			32,992	32,992		32,992	(714)	32,278			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	371,742	74,155	271,840	717,737		717,737	9,957	727,694			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,448	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(714)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	1,875			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 7,609		$	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)	2,348		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,348		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 9,957		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Lincoln Terrace

ID# 0035410

Report Period Beginning: 10/1/2024

Ending: 9/30/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (462)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Expense Equipment under $2500	2,337	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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48				48
49	**Total**	1,875		49

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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
None	N/A	Community Living Options, Inc. (CLO)		See Page 6 Supplemental		
		Unlimited Development, Inc. (CLO is sole member)				
		See Page 6 Supplemental for specific homes				

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	5	Utilities	$	Community Living Options, Inc.	100.00%	$ 60	$ 60	1
2	V	18	Director Fees		Community Living Options, Inc.	100.00%	583	583	2
3	V	19	Professional Fees		Community Living Options, Inc.	100.00%	515	515	3
4	V	20	Dues, Licenses and Subs		Community Living Options, Inc.	100.00%	50	50	4
5	V	21	Clerical & General Office		Community Living Options, Inc.	100.00%	27	27	5
6	V	22	Employee Benefits		Community Living Options, Inc.	100.00%	4	4	6
7	V	23	Inservice Training		Community Living Options, Inc.	100.00%	4	4	7
8	V	25	Vehicle Expense		Community Living Options, Inc.	100.00%	19	19	8
9	V	26	Property/ Liability Insurance		Community Living Options, Inc.	100.00%	1,086	1,086	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 2,348	$ * 2,348	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS **Ownership Listing-1**

Lincoln Terrace

ID# **0035410**

Report Period Beginning: **10/1/2024**

Ending: **9/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Board of Directors:								1
2	John		Crock						2
3	John		Thompson						3
4	Gene		Frioli						4
5	Forrest		Langenfled						5
6	Marilyn		Holt						6
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Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryvillle				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Manor Court of Carbondale	Carbondale				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				20
21	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	21
22	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	22
23	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				23
24	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	24
25	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				25
26	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				26
27	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	27
28	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				28
29								29
30								30

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCor	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle,	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	See Attached Schedule 7A								$ 583	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 583		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 Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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: Community Living Options, Inc.
Street Address: 285 S Farnham
City / State / Zip Code: Galesburg, IL 61401
Phone Number: (309) 343-1550
Fax Number: (309) 343-2857

	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	5	Utilities	Bed Days Available	192,720	35	$ 1,986	$	5,840	$ 60	1
2	18	Director Fees	Bed Days Available	192,720	35	19,248		5,840	583	2
3	19	Professional Fees	Bed Days Available	192,720	35	16,983		5,840	515	3
4	20	Dues, Licenses and Subs	Bed Days Available	192,720	35	1,650		5,840	50	4
5	21	Clerical & General Office	Bed Days Available	192,720	35	881		5,840	27	5
6	22	Employee Benefits	Bed Days Available	192,720	35	134		5,840	4	6
7	23	Inservice Training	Bed Days Available	192,720	35	130		5,840	4	7
8	25	Vehicle Expense	Bed Days Available	192,720	35	624		5,840	19	8
9	26	Property/ Liability Insurance	Bed Days Available	192,720	35	35,835		5,840	1,086	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 77,471	$		$ 2,348	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Assessed Value from Real Estate Tax Bill:	2024	N/A	8
Real Estate Tax Bill for Calendar Year:	2020	N/A	9
	2021	N/A	10
	2022	N/A	11
	2023	N/A	12
	2024	N/A	13

The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.**

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lincoln Terrace COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0035410

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

None

F. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease. N/A

I. Are you presently operating under a sublease agreement? No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES NO X If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over.

N/A

K. 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	Facility	52,300	1990	$ 22,692	1
2					2
3	TOTALS	52,300		$ 22,692	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	16		1990	1989	$ 442,308	$	30	$	$	$ 442,308	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1997			7				9
10	2 A/C Units, Shower			2004			7-10yrs				10
11	Shower, Carpet/Vinyl, Water Heaters			2005			7-10yrs				11
12	Kitchen Cabinets/Bathroom Cabinets/Sinks/Faucets/Mirrors			2007	9,720		15			9,720	12
13	Cabinets			2009	6,844		15			6,844	13
14	Roof Repair			2009	16,304		10			16,304	14
15	Bathroom Remodel-Vanity/Cabinets/Toilet/Floor/Drains			2011	32,738		12			32,738	15
16	Handrails, Corner Guards, Wall Guards			2011	3,964		5			3,964	16
17	Bathroom 1 - New Toilet/Cement Board/Tile/Cabinets/Paint/Fixtures			2016	25,308	2,109	12	2,109		19,332	17
18	Convert Sprinkler System to a Wet System			2018	15,500	1,550	10	1,550		10,850	18
19	New Wet Sprinkler System			2021	4,800	320	15	320		1,520	19
20	New Carrier Furnace/Coil/Condensing Unit			2022	10,265	685	15	685		2,282	20
21	Install New Flooring/Paint Walls & Ceilings - 8 Resident Rooms			2023	26,625	2,219	12	2,219		6,102	21
22	New Furnace			2023	3,450	230	15	230		575	22
23	New Generator Switches/Wiring/Grounding			2024	3,543	709	5	709		1,063	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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)		$ 601,369	$ 7,822		$ 7,822	$	$ 553,602	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	$ 72,471	$ 5,214	$ 5,026	$ (188)	5-15 yrs	$ 31,565	71
72	Current Year Purchases	4,513	485	251	(234)	15 yrs	251	72
73	Fully Depreciated Assets	4,541					4,541	73
74								74
75	TOTALS	$ 81,525	$ 5,699	$ 5,277	$ (422)		$ 36,357	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	Patient Care	2001 Ford E350 Van	2002	$ 18,301	$	$	$	4	$ 18,301	76
77		Capitalized Repair	2021	7,669		1,918	1,918	4	7,669	77
78		Capitalized Repair	2023	19,806		4,952	4,952	4	14,856	78
79		Capitalized Repair	2025	5,752	840	840		4	840	79
80	TOTALS			$ 51,528	$ 840	$ 7,710	$ 6,870		$ 41,666	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)	$ 757,114	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,361	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,809	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,448	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 631,625	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned

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. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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 138

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

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)		34,481		34,481
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 34,481	$	$ 34,481
10	SUM OF line 9, col. 1 and 2 (e)	$ 34,481			

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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace STATE OF ILLINOIS # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	N/A	# 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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2025 (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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(6,035)	(6,035)	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)			8
9	Other(specify): Interdivision Receivable	918,691	918,691	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 912,656	$ 912,656	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	643,531	601,369	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	107,915	133,053	16
17	Accumulated Depreciation (book methods)	(651,499)	(631,625)	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)**	$ 109,947	$ 125,489	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,022,603	$ 1,038,145	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 439	$ 439	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,242	10,242	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,681	$ 10,681	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,681	$ 10,681	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,011,922	$ 1,027,464	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,022,603	$ 1,038,145	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,103,896	1
2	Restatements (describe):		2
3	**Prior Period Adjustment - Miscellaneous**	(160)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,103,736	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(91,814)	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)**	$ (91,814)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,011,922	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	$ 591,430	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 591,430	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	34,481	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,481	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Gain on Sale**	12	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 625,923	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	174,366	31
32	Health Care	300,869	32
33	General Administration	195,149	33
	B. Capital Expense		
34	Ownership	14,361	34
	C. Ancillary Expense		
35	Special Cost Centers	714	35
36	Provider Participation Fee	32,278	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 717,737	40
41	**Income before Income Taxes (line 30 minus line 40)****	(91,814)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (91,814)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 591,430.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 591,430	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	12,358	12,913	253,450	19.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,542	1,641	37,300	22.73	15
16	Dishwashers					16
17	Maintenance Workers	405	439	11,238	25.60	17
18	Housekeepers	1,310	1,351	21,500	15.91	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	925	1,041	25,458	24.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	888	982	22,796	23.21	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,428	18,367	$ 371,742 *	$ 20.24	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	Monthly	$ 2,459	L1, C3	35
36	Medical Director	Monthly	4,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	603	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	2,366	L10, C3	46
47	Psychological Consultant	Monthly	809	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 10,637		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Courtney Hanlin	Administrator	None	$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 35,688
LTC Support Services, LLC	Support Services	25,500
RSM US LLP	Accounting Services	1,948
Templin Healthcare Accounting	Accounting Services	1,430
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 64,566

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,313
Unemployment Compensation Insurance	
FICA Taxes	27,326
Employee Health Insurance	16,122
Employee Meals	1,386
Illinois Municipal Retirement Fund (IMRF)*	
401k	182
Other Employee Benefits	1,299
Indirect costs	4
TOTAL (agree to Schedule V, line 22, col.8)	$ 50,632

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,901
Health Care Worker Background Check	
(Indicate # of checks performed 16)	394
Patient Background Checks	
Association Dues (total from pg 22, #4)	1,302
Subscriptions	815
Indirect costs	50
Less: Public Relations Expense	( )
PAC and Lobbying payments	(462)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	195
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 195

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lincoln Terrace # 0035410 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
THE CENTER FOR DEVELOPMENTAL DISABILITIES	840
	840 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

THE CENTER FOR DEVELOPMENTAL DISABILITIES	462
	462 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

THE CENTER FOR DEVELOPMENTAL DISABILITIES	1,302
	1,302 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 1,555 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 32,278
This amount is to be recorded on line 42 of Schedule V.

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

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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 1,386 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(12) 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. $ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14

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. $ N/A

(13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP

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

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.