

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0039305 Facility Name: Linden Estate Address: 1000 Linden Street Morton 61550 County: Tazewell Telephone Number: 3092669781 Fax # 3092669468 HFS ID Number: Date of Initial License for Current Owners: 09/17/1994 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501 (C) (3) ☐ 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: Matthew D. Steffen

Telephone Number: (309) 266-9781

Email Address:

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 08/06/2010

	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	16	Intermediate/DD	16	5,840	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	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	5,648			5,648	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,648			5,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.71%

D. How many bed-hold days during this year were paid by the Department? 162 (Do not include bed-hold days in Section B.)

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

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

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

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 09/17/1994

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

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

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	31,634	2,228	720	34,582	(234)	34,348	0	34,348			1
2	Food Purchase		36,263		36,263		36,263	0	36,263			2
3	Housekeeping		562	33	595		595	0	595			3
4	Laundry		2,805		2,805		2,805	0	2,805			4
5	Heat and Other Utilities			17,791	17,791		17,791	0	17,791			5
6	Maintenance	16,286	1,405	4,811	22,502	(263)	22,239	0	22,239			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	47,920	43,263	23,355	114,538	(497)	114,041	0	114,041			8
	B. Health Care and Programs											
9	Medical Director			1,078	1,078		1,078	0	1,078			9
10	Nursing and Medical Records	43,109	9,456		52,565	(38,425)	14,140	0	14,140			10
10a	Therapy	218,646		1,031	219,677	(2,789)	216,888	0	216,888			10a
11	Activities		1,037		1,037	(64)	973	0	973			11
12	Social Services	42,746		2,699	45,445	(1,507)	43,938	0	43,938			12
13	CNA Training				0	40,932	40,932	0	40,932			13
14	Program Transportation		3,043		3,043		3,043	0	3,043			14
15	Other (specify):*				0	(19)	(19)	0	(19)			15
16	TOTAL Health Care and Programs	304,501	13,536	4,808	322,845	(1,872)	320,973	0	320,973			16
	C. General Administration											
17	Administrative	14,751			14,751		14,751	0	14,751			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			3,841	3,841		3,841	0	3,841			19
20	Dues, Fees, Subscriptions & Promotions			1,283	1,283		1,283	(303)	980			20
21	Clerical & General Office Expenses	34,613	2,935		37,548		37,548	0	37,548			21
22	Employee Benefits & Payroll Taxes			102,045	102,045	2,369	104,414	0	104,414			22
23	Inservice Training & Education			634	634		634	0	634			23
24	Travel and Seminar			992	992		992	(411)	581			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			9,587	9,587		9,587	0	9,587			26
27	Other (specify):*			3,740	3,740	(3,727)	13	0	13			27
28	TOTAL General Administration	49,364	2,935	122,122	174,421	(1,358)	173,063	(714)	172,349			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	401,785	59,734	150,285	611,804	(3,727)	608,077	(714)	607,363			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			26,015	26,015		26,015	0	26,015			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):* Asset Management Fees				0		0	0	0			36
37	TOTAL Ownership			26,015	26,015	0	26,015	0	26,015			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0	3,727	3,727	0	3,727			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			32,724	32,724		32,724	0	32,724			42
43	Other (specify):* Facility Bulletin				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	32,724	32,724	3,727	36,451	0	36,451			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	401,785	59,734	209,024	670,543	0	670,543	(714)	669,829			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				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	(303)	20		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	(411)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (714)		\$ 0	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (714)		37

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

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

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

Linden Estate

ID# 0039305

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Out-of-state Travel (In-service Training & Education)	\$	24	1
2	Out-of-state Travel (Board of Directors)	(411)	24	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(411)		49

Summary A

06/30/2011

[illegible]

Summary B

06/30/2011

[illegible]

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

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)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Virgil Metzger	Director	Director	0.00	533	0.5		Travel	\$ 94	line 24; col.3	1
2	Roger Aberle	Director	Director	0.00	1,222	0.5		Travel	215	line 24; col.3	2
3	Bryan Stoller	Director	Director	0.00	37	0.5		Travel	7	line 24; col.3	3
4	Dennis Mott	Director	Director	0.00	144	0.5		Travel	26	line 24; col.3	4
5	Ron Hodel	Vice-Chairman	Director	0.00		0.5					5
6	Roger Beutel	Director	Director	0.00		0.5					6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	697	0.5		Travel	123	line 24; col.3	7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Stan Virkler	Chairman	Director	0.00	429	0.5		Travel	76	line 24; col.3	9
10	Tim Steffen	Director	Director	0.00	683	0.5		Travel	120	line 24; col.3	10
11											11
12											12
13								TOTAL	\$ 660		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 Linden Estate # 0039305 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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													6	
7													7	
8													8	
9	TOTAL Facility Related						\$	0	\$	0		\$	0	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	0	14
15	TOTALS (line 9+line14)						\$	0	\$	0		\$	0	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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).				\$	0 3
4. Real Estate Tax accrual used for 2011 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.				\$	0 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Linden Estate</u>	COUNTY	<u>Tazewell</u>
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FACILITY IDPH LICENSE NUMBER 0039305

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 2010 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 2010.

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.				\$		\$	
2.				\$		\$	
3.				\$		\$	
4.				\$		\$	
5.				\$		\$	
6.				\$		\$	
7.				\$		\$	
8.				\$		\$	
9.				\$		\$	
10.				\$		\$	
TOTALS				\$	0.00	\$	0.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 6,848

B. General Construction Type: Exterior Brick Veneer Frame Wood Frame Number of Stories 1

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>87,120</u>	<u>1993</u>	<u>\$ 52,959</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	87,120		\$ 52,959	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	16			1994	\$ 244,343	\$ 8,145	30	\$ 8,145	\$	144,347	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	403--Mirrors			1994	330		10			330	9
10	429--Landscaping			1994	11,829		10			11,829	10
11	435--Organizational Costs			1994	11,887		5			11,887	11
12	436--Light Fixtures			1994	2,445		10			2,445	12
13	434--Concrete for Water Spillway			1995	393	20	20	20		334	13
14	401--Painting /Dumpster			1994	405	14	30	14		231	14
15	402--Generator Wing			1999	527	18	30	18		219	15
16	598--Livingroom carpet			2003	710	71	10	71		603	16
17	625--Bathroom remodel			2004	899	60	15	60		449	17
18	520--Lobby Carpet			2001	1,256	84	15	84		879	18
19	437--Cabinetry/Countertops/Vanities			1994	8,191		15			8,191	19
20	430--Lawn Sprinkler System			1994	4,083	163	25	163		2,792	20
21	432--Lighting & Down Spout Trenches			1994	5,315	266	20	266		4,626	21
22	433--Sod for Lawn			1994	5,259	263	20	263		4,491	22
23	431--Concrete for Porches			1994	7,365	368	20	368		6,379	23
24	399--Shelter			1996	8,900	445	20	445		7,120	24
25	441--Heating & Air Conditioning			1994	19,683		15			19,683	25
26	428--Asphalt			1994	25,150		15			25,150	26
27	438--Fire Prevention System			1994	14,174	567	25	567		10,056	27
28	398--Garage			1994	25,346	1,014	25	1,014		18,250	28
29	440--Electrical			1994	30,570	1,529	20	1,529		26,668	29
30	439--Plumbing			1994	32,699	1,635	20	1,635		28,231	30
31	427--Sewer System			1994	33,335	1,111	30	1,111		22,916	31
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		1,780	32
33	747--Flooring-Men's bathroom			2006	496	33	15	33		182	33
34	772--Fiber Optic Cable			2006	1,250	83	15	83		458	34
35	860--Interior Painting			2008	5,097	340	15	340		1,359	35
36	861--Telephone System			2008	610	41	15	41		163	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 Linden Estate

0039305

Report Period Beginning:

07/01/2010 Ending: 06/30/2011

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	862--Landscape upgrade	2008	\$ 553	\$ 37	15	\$ 37	\$	\$ 148	37
38	863--Exit Ramps	2008	3,430	229	15	229		915	38
39	884--Bathroom Floors	2009	4,091	584	7	584		1,753	39
40	885--Lighting Project	2009	2,500	167	15	167		500	40
41	886--Hot water heater	2009	2,899	414	7	414		1,242	41
42	930--Landscaping	2008	185	12	15	12		37	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)		\$ 521,059	\$ 18,037		\$ 18,037	\$ 0	\$ 366,643	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	\$46,731	\$6,926	\$6,926	\$0	9	\$28,081	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	101,781	1,054	1,054	0	9	101,781	73
74	Disposed Assets				0	#REF!		74
75	TOTALS	\$148,512	\$7,980	\$7,980	\$0		\$129,862	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$0	\$0	\$0	0		\$0	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$722,530	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$26,017	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$26,017	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$496,505	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

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

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

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

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

15. Is Movable equipment rental included in building rental?
- YES
- XNO
16. Rental Amount for movable equipment: \$
- 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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 CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies		250		250
3	Classroom Wages (a)		1,241		1,241
4	Clinical Wages (b)		2,482		2,482
5	In-House Trainer Wages (c)		4,548		4,548
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 8,521	\$ 0	\$ 8,521
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,521			

COMPLETED	
1. From this facility	3
2. From other facilities (f)	29
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	6
TOTAL TRAINED	38

(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	\$ 300	\$ 319,123	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	136,526	1,949,708	3
4	Supply Inventory (priced at)	3,289	24,700	4
5	Short-Term Investments		3,189,650	5
6	Prepaid Insurance	3,168	30,892	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		529,387	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 143,283	\$ 6,043,460	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	52,959	452,033	13
14	Buildings, at Historical Cost	303,473	5,179,531	14
15	Leasehold Improvements, at Historical Cost	96,897	580,495	15
16	Equipment, at Historical Cost	257,314	2,667,832	16
17	Accumulated Depreciation (book methods)	(484,620)	(5,395,534)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,887	46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,887)	(46,121)	20
21	Restricted Funds		8,942,076	21
22	Other Long-Term Assets (spe <u>Cash Value of Life Insurance</u>)		36,270	22
23	Other(specify): <u>Investment in other facilities</u>		6,229,646	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 226,023	\$ 18,692,349	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 369,306	\$ 24,735,809	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,284	\$ 1,307,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,636	329,313	30
31	Accrued Taxes Payable (excluding real estate taxes)		59,430	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	18,372	229,956	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Rounding</u>	2	1	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 43,294	\$ 1,926,662	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	<u>Capital Lease</u>		42,360	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 42,360	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 43,294	\$ 1,969,022	46
47	TOTAL EQUITY(page 18, line 24)	\$ 326,012	\$ 22,766,787	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 369,306	\$ 24,735,809	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 315,714	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 315,714	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,298	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)	\$ 10,298	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 326,012	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 680,447	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 680,447	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)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions	394	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 394	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule		28
28a	Cost to Market Gain on Investments		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 680,841	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	114,538	31
32	Health Care	322,845	32
33	General Administration	174,421	33
	B. Capital Expense		
34	Ownership	26,015	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,724	36
	D. Other Expenses (specify):		
37	Rounding Errors		37
38	Cost to Market Loss on Investments		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 670,543	40
41	Income before Income Taxes (line 30 minus line 40)**	10,298	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,298	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	310	310	\$ 11,024	\$ 35.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,419	1,419	32,577	22.96	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					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	375	375	7,088	18.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,306	3,295	40,081	12.16	15
16	Dishwashers					16
17	Maintenance Workers	933	933	16,491	17.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	505	505	14,751	29.21	20
21	Assistant Administrator					21
22	Other Administrative	213	213	8,694	40.82	22
23	Office Manager					23
24	Clerical	1,335	1,335	26,313	19.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,811	1,864	37,356	20.04	29
30	Habilitation Aides (DD Homes)	17,906	19,197	207,103	10.79	30
31	Medical Records					31
32	Other Health Care: OT/PT & Speech Therapy	15	15	307	20.47	32
33	Other(specify) Day Program					33
34	TOTAL (lines 1 - 33)	27,128	29,461	\$ 401,785 *	\$ 13.64	34

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	24	\$ 720	1-3	35
36	Medical Director	Flat Fee	360	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	681	10-3	39
40	Physical Therapy Consultant	5	295	10-3	40
41	Occupational Therapy Consultant	11	665	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	28	1,979	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist Consultant	9	720	12-3	46
47				10-3	47
48				10-3	48
49	TOTAL (lines 35 - 48)	77	\$ 5,419		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10a-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

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	
Jodi Fehr	Administrator		\$ 14,751	Workers' Compensation Insurance		\$ 12,742	IDPH License Fee	\$	
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		
				FICA Taxes		30,839	Health Care Worker Background Check	6	
				Employee Health Insurance		21,943	(Indicate # of checks performed 8)		
				Employee Meals		11,230	Patient Background Checks	1	
				Illinois Municipal Retirement Fund (IMRF)*			Participation Fees & Certificates	99	
				Employee Physicals		474	Dues (Employers Assn, IHCA)	839	
				Employee Promotional		1,180	Subscriptions (journals, news, etc.)		
				Defined Contribution Pension Plan		8,716	Driving Records Verification	36	
				Benefits Allocated to Day Program			Secretary of State		
				Employee Shirts			Less: Public Relations Expense	()	
				Benefits for Transferred wages		14,171	Non-allowable advertising	()	
				Employee Scholarships		750	Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 102,045	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 980	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
\$ 14,751									
B. Administrative - Other									
Description				Amount					
				\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$					
C. Professional Services							G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Koch Consulting	Acctg. & Consulting		\$ 1,750			\$	Out-of-State Travel	\$	
Heinold-Banwart, LTD	Acctg. & Consulting		1,173				Board of Directors travel	411	
Quantum	Computer Consulting		918				Administrative travel		
							In-State Travel		
							Board of Directors travel	249	
							Administrative travel	332	
							Seminar Expense		
							Less out of state travel	(411)	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$			TOTAL (agree to Sch. V, line 24, col. 8)		
\$ 3,841							\$ 581		

*** Attach copy of IMRF notifications**

****See instructions.**

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?

Yes

If YES, give association name and amount.

Illinois Healthcare Association - \$839
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

N/A
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 287

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.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 32,724

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?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

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.

\$

No

Has any meal income been offset against related costs?

Indicate the amount.

\$ N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No, they have been adjusted out.

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 0

c. What percent of all travel expense relates to transportation of nurses and patients?

95%

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.

\$ 0
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Koch Consultants, LTD
- (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?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

Linden Estate
FYE 06/30/2011 #0039305
Sub schedules

Schedule V - Costs Center Expenses		
Lines	Description	Amount
43	Facility Bulletin / Newsletter	-
36	04 Investment Management Fees	-
36	04 Interest Expense	-
27	04 Dental costs	3,727
27	04 Dental costs - Emergency	-
27	04 Charitable Contributions	-
27	04 Fines & Penalties	-
27	04 Miscellaneous	7
	Other Expenses	3,734

Schedule V - Reclassifications				Amount
Lines	Description	Increase	Decrease	
6	04 Communication equipment rental	-		
35	Communication equipment rental		-	
11	Donated labor	-		
1	Donated labor	-		
4	Donated labor	-		
6	Donated labor	-		
21	Donated labor	-		
10	Donated labor	-		
10a	Donated labor	-		
12	Donated labor	-		
27	Donated labor		-	
38	Medically necessary transportation	-		
14	Medically necessary transportation		-	
10a	04 Disability Pay to Benefits		2,369	
22	Disability Pay to Benefits	2,369		
13	Nurse aid trainer wages	40,932		
1	Nurse aid trainer wages		234	
6	Nurse aid trainer wages		263	
10	Nurse aid trainer wages		38,425	
10a	Nurse aid trainer wages		420	
11	Nurse aid trainer wages		64	
12	Nurse aid trainer wages		1,507	
15	Nurse aid trainer wages		19	
17	Nurse aid trainer wages		-	
39	Dental costs	3,727		
27	Dental costs		3,727	
		47,028	47,028	

Schedule V, Line 39 - Ancillary Service Centers		
	Dental costs for 29 visits	\$ 3,727

Schedule VI B - Non-paid workers			
Lines	Description	Amount	
31	Donated Labor	\$	-
Department	Time in Hours	Time in Dollars	
0 Activities	-	-	
0 Kitchen	-	-	
0 Laundry	-	-	
0 Maintenance	-	-	
0 Nursing	-	-	
0 PT/OT	-	-	
0 Social Service Programs	-	-	
0 Office	-	-	
Totals	-	\$	-

Schedule VII - Compensation Received From Other Nursing Homes	
Virgil Metzger - \$533.12 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Roger Aberle - \$1,221.89 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Stan Virkler - \$429.17 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Dennis Mott - \$144.48 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Keith Pflum - \$697.24 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Tim Steffen - \$683.11 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	
Bryan Stoller - \$36.72 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge Estate & Oakwood Estate	

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets	
Investment in Related Entities	-

Sch. XVII - Income Statement, Line 28; Other Revenue	
--	--

o Developmental training	
o Farm Income	
o Gain on Sale of Assets	-
o Increase in Cash Value of Life Insurance	
o Miscellaneous	
o Cost to Market Adjustment on Investments	
o	-
o	
o Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	10,298
Income from related parties	2,868,061
Estimated excess for year, Form 990, p.1, line 18	2,878,359

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Column 1, Row 45	401,785
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(401,785)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	401,785
Prior Year PTO Accrual at 06/30/10	11,341
Current Year PTO Accrual at 06/30/11	(11,012)
Prior Year Wage Accrual at 06/30/10	3,425
Current Year Wage Accrual at 06/30/11	(4,264)
Section 125 Wages not applicable to FICA taxes	(10,005)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilities	6,491
Add: ACCS Wages	
Add: wages included in employee meal calculation	5,363
Cash basis salaries	403,124
FICA rate	7.650%
Calculated FICA	30,839
FICA per Sch XIX	30,839
Variance	0

Sch. XX - General Information		
12. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	420
	Activities Director	64
	Day Program	19
	Head Cook	234
	Maintenance	263
	Nursing	38,425
	Soc. Serv. / QMRP	1,507
		40,932

14. A portion of office space is allocated to related entities based on number of beds.

16. Out of State Travel	
Administration	
Administrator	-
	-
Board of Directors	
Virgil Metzger (Not out of State)	
Stan Virkler	76
Roger Aberle	215
Keith Pflum (Not out of State)	
Dennis Mott (Not out of State)	
Bryan Stoller (Not out of State)	
Tim Steffen	120
	411
Nursing	
None	-
	-

LINDEN ESTATE, MORTON, ILLINOIS #0039305

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, Illinois, #0016220

Oakwood Estate, Morton, Illinois #0033712

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Stan Virkler, Chairman

Ron Hodel, Vice Chairman

Keith Pflum, Secretary/ Treasurer (term ended 05/17/2011)

Roger Aberle, Director

Roger Beutel, Director / (Secretary/Treasurer after 05/17/2011)

Cleve Klopfenstein, Director

Virgil Metzger, Director

Dennis Mott, Director

Timothy Steffen, Director

Bryan Stoller, Director (term began 05/17/2011)

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

AIDE CLASSES

LINDEN ESTATE, MORTON, ILLINOIS #0039305

From: 07/01/2010 to 06/30/2011

CLASS DATE	TR						OE						LE						CILA					
	# of Students	CLASS		OJT		# of Students	CLASS		OJT		# of Students	CLASS		OJT		# of Students	CLASS		OJT					
		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages				
completed	32	17	680	\$	5,780.00	1360	\$	80	\$	680.00	160	\$	120	\$	1,020.00	240	\$	400	\$	3,400.00				
still enrolled, not complete	18	10	174	\$	1,479.00	348	\$	1	29	\$	58	\$	26	\$	221.00	52	\$	16	\$	136.00				
dropouts	6	3	22	\$	187.00	44	\$	0	\$	-	0	\$	3	\$	-	0	\$	4	\$	34.00				
				\$	-	0	\$			-	0	\$			-	0	\$			-				
Total	1551	30	876	\$	7,446.00	1752	\$	3	109	\$	218	\$	4	146	\$	1,241.00	292	\$	19	420	\$	3,570.00		

WAGES				Hours				WAGES				Hours			
Classification	Hours	Hourly Rate	Wages	TR	OE	LE	CILA	TR	OE	LE	CILA	TR	OE	LE	CILA
Anna Liza Raboza	10		\$ -	-	-	-	-	-	-	-	-	-	-	-	8
Cheryl Hays	10s	30.00	\$ 450.00	254.16	31.62	42.36	121.86	16.94	2.11	2.82	8.12				7.25
Don Bowers	12q	36.00	\$ 655.20	370.05	46.05	61.68	177.42	20.33	2.53	3.39	9.75				
Evie Mogler	12r	1.00	\$ 21.95	12.40	1.54	2.07	5.94	0.56	0.07	0.09	0.27				22.936
Gary Folkerts	6	18.00	\$ 465.48	262.90	32.71	43.82	126.05	10.17	1.26	1.69	4.87				
Jodi Fehr	17	-	\$ -	-	-	-	-	-	-	-	-				-
Jenny Smith	10ot	14.00	\$ 294.00	166.05	20.66	27.68	79.61	7.91	0.98	1.32	3.79				20
Kathy Kelch	10	78.00	\$ 1,989.00	1,123.38	139.78	187.23	538.61	44.05	5.48	7.34	21.12				5.734
Leigh Wamsley	12q	-	\$ -	-	-	-	-	-	-	-	-				-
Lori Brittain	1	18.00	\$ 414.00	233.83	29.09	38.97	112.11	10.17	1.26	1.69	4.87				
Marcella Chapman	10	-	\$ -	-	-	-	-	-	-	-	-				-
Mary Beth Garza	11	4.00	\$ 76.92	43.44	5.41	7.24	20.83	2.26	0.28	0.38	1.08				
Randy Mogler	12r	54.00	\$ 1,388.88	784.44	97.61	130.74	376.10	30.50	3.79	5.08	14.62				
Rob Mooney	12r	8.50	\$ 190.74	107.73	13.40	17.95	51.65	4.80	0.60	0.80	2.30				
Sherrie Parnham	12r	2.00	\$ 38.00	21.46	2.67	3.58	10.29	1.13	0.14	0.19	0.54				
Tina Leman	12m	11.00	\$ 227.81	128.67	16.01	21.44	61.69	6.21	0.77	1.04	2.98				
Mark Baker	12q	8.00	\$ 145.60	82.23	10.23	13.71	39.43	4.52	0.56	0.75	2.17				
Isaac Aberle	11	2.00	\$ 37.00	20.90	2.60	3.48	10.02	1.13	0.14	0.19	0.54				
Gayle Fidler	10	4.00	\$ 88.44	49.95	6.22	8.33	23.95	2.26	0.28	0.38	1.08				
Vikki Steele	15	2.00	\$ 33.10	18.69	2.33	3.12	8.96	1.13	0.14	0.19	0.54				
Kathy Kelch	10	1,583.05	\$ 40,367.78	22,799.59	2,836.94	3,799.93	10,931.31	894.10	111.25	149.02	428.68				
Gayle Fidler	10	1,157.28	\$ 25,587.46	14,451.72	1,798.22	2,408.62	6,928.91	653.63	81.33	108.94	313.38				
OE				-	-	-	-	-	-	-	-				-
Jodi Fehr	17		\$ -	-	-	-	-	-	-	-	-				-
Evie Mogler	12r		\$ -	-	-	-	-	-	-	-	-				-
LE				-	-	-	-	-	-	-	-				-
Rob Mooney	12r		\$ -	-	-	-	-	-	-	-	-				-
			\$ -	-	-	-	-	-	-	-	-				-
CILA				-	-	-	-	-	-	-	-				-
Sherrie Parnham	12r		\$ -	-	-	-	-	-	-	-	-				-
Leigh Wamsley	12q		\$ -	-	-	-	-	-	-	-	-				-
				40,931.60	5,093.09	6,821.93	19,624.74	1,711.80	213.00	285.30	820.73				

Total trainer wages 3030.83 \$ 72,471.36 \$ 2,800.00 Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	3	0	0	3
Clinical Wages	\$ 374.00	\$ -	\$ -	\$ 68.00
Classroom Wages	\$ 187.00	\$ -	\$ -	\$ 34.00
In-House Trainer Wages	\$ 343.00	\$ -	\$ -	\$ 62.00
Completed				
Number from this Facility	17	2	3	10
Clinical Wages	\$ 7,259.00	\$ 927.00	\$ 1,241.00	\$ 3,536.00
Classroom Wages	\$ 14,518.00	\$ 218.00	\$ 2,482.00	\$ 7,072.00
In-House Trainer Wages	\$ 26,602.00	\$ 970.00	\$ 4,548.00	\$12,959.00

Supplies 2671

Schedule V		TR	OE	LE	CILA
	Line	Change	Change	Change	Change
Dietary	1	(234.00)	(29.00)	(39.00)	(112.00)
Maintenance	6	(263.00)	(33.00)	(44.00)	(126.00)
Nursing	10	(38,425.00)	(4,781.00)	(6,404.00)	(18,423.00)
Therapy	10a	-	-	-	-
OT/PT	10ot	(166.00)	(21.00)	(28.00)	(80.00)
Activities	11	(64.00)	(8.00)	(11.00)	(31.00)
RSD	12r	(926.00)	(115.00)	(154.00)	(444.00)
QMRP's	12q	(452.00)	(56.00)	(75.00)	(217.00)
MSSD	12m	(129.00)	(16.00)	(21.00)	(62.00)
Training Wages	13	40,932.00	5,093.00	6,822.00	19,625.00
Day Program	15	(19.00)	(2.00)	(3.00)	(9.00)
Administrator	17	-	-	-	-
OJT	12ojt	-	-	-	-
Speech	10s	(254.00)	(32.00)	(42.00)	(122.00)
Adjustment	12	-	-	(1.00)	1.00
		-	-	-	-

LINDEN ESTATE, MORTON, ILLINOIS

#0039305

	Wages	Supplies	Other	Total	Reclass- ification	Total	Cost / Day Resident Days 5,648	Adjust- ments	Adjusted Total
A. General Services									
1 Dietary	31,634	2,228	720	34,582	(234)	34,348	\$6.08	-	34,348
2 Food Purchase	-	36,263	-	36,263	-	36,263	\$6.42	-	36,263
3 Housekeeping	-	562	33	595	-	595	\$0.11	-	595
4 Laundry	-	2,805	-	2,805	-	2,805	\$0.50	-	2,805
5 Heat and Other Utilities	-	-	17,791	17,791	-	17,791	\$3.15	-	17,791
6 Maintenance	16,286	1,405	4,811	22,502	(263)	22,239	\$3.94	-	22,239
7 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
8 TOTAL General Services	47,920	43,263	23,355	114,538	(497)	114,041	\$20.19	-	114,041
B. Health Care and Programs									
9 Medical Director	-	-	1,078	1,078	-	1,078	\$0.19	-	1,078
10 Nursing and Medical Records	43,109	9,456	-	52,565	(38,425)	14,140	\$2.50	-	14,140
10a Therapy	218,646	-	1,031	219,677	(2,789)	216,888	\$38.40	-	216,888
11 Activities	-	1,037	-	1,037	(64)	973	\$0.17	-	973
12 Social Services	42,746	-	2,699	45,445	(1,507)	43,938	\$7.78	-	43,938
13 CNA Training	-	-	-	-	40,932	40,932	\$7.25	-	40,932
14 Program Transportation	-	3,043	-	3,043	-	3,043	\$0.54	-	3,043
15 Other (specify):*	-	-	-	-	(19)	(19)	(\$0.00)	-	(19)
16 TOTAL Health Care and Programs	304,501	13,536	4,808	322,845	(1,872)	320,973	\$56.83	-	320,973
C. General Administration									
17 Administrative	14,751	-	-	14,751	-	14,751	\$2.61	-	14,751
18 Directors Fees	-	-	-	-	-	-	\$0.00	-	-
19 Professional Services	-	-	3,841	3,841	-	3,841	\$0.68	-	3,841
20 Dues, Fees, Subscriptions & Promotion	-	-	1,283	1,283	-	1,283	\$0.23	(303)	980
21 Clerical & General Office Expenses	34,613	2,935	-	37,548	-	37,548	\$6.65	-	37,548
22 Employee Benefits & Payroll Taxes	-	-	102,045	102,045	2,369	104,414	\$18.49	-	104,414
23 Inservice Training & Education	-	-	634	634	-	634	\$0.11	-	634
24 Travel and Seminar	-	-	992	992	-	992	\$0.18	(411)	581
25 Other Admin. Staff Transportation	-	-	-	-	-	-	\$0.00	-	-
26 Insurance-Prop.Liab.Malpractice	-	-	9,587	9,587	-	9,587	\$1.70	-	9,587
27 Other (specify):*	-	-	3,740	3,740	(3,727)	13	\$0.00	-	13
28 TOTAL General Administration	49,364	2,935	122,122	174,421	(1,358)	173,063	\$30.64	(714)	172,349
TOTAL Operating Expense	401,785	59,734	150,285	611,804	(3,727)	608,077	\$107.66	(714)	607,363

D. Ownership										
30	Depreciation	-	-	26,015	26,015	-	26,015	\$4.61	-	26,015
31	Amortization of Pre-Op. & Org.	-	-	-	-	-	-	\$0.00	-	-
32	Interest	-	-	-	-	-	-	\$0.00	-	-
33	Real Estate Taxes	-	-	-	-	-	-	\$0.00	-	-
34	Rent-Facility & Grounds	-	-	-	-	-	-	\$0.00	-	-
35	Rent-Equipment & Vehicles	-	-	-	-	-	-	\$0.00	-	-
36	Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
37 TOTAL Ownership		-	-	26,015	26,015	-	26,015	\$4.61	-	26,015
Ancillary Expense										
E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-	-	-	\$0.00	-	-
39	Ancillary Service Centers	-	-	-	-	3,727	3,727	\$0.66	-	3,727
40	Barber and Beauty Shops	-	-	-	-	-	-	\$0.00	-	-
41	Coffee and Gift Shops	-	-	-	-	-	-	\$0.00	-	-
42	Provider Participation Fee	-	-	32,724	32,724	-	32,724	\$5.79	-	32,724
43	Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
44 TOTAL Special Cost Centers		-	-	32,724	32,724	3,727	36,451	\$6.45	-	36,451
45 GRAND TOTAL		401,785	59,734	209,024	670,543	-	670,543	\$118.72	(714)	669,829
Current Reimbursement Rate								\$117.96		
Gain/(Loss) Per Resident / Day								(0.76)		
								-0.6%		
% of Costs Per Area		75.14%	8.91%	15.95%	100.00%					

Cost / Day Resident Days 5,648	% of Total Costs	% of Daily Rate	Staff Hours/ Day
\$6.08	5.1%	5.2%	0.62
\$6.42	5.4%	5.4%	
\$0.11	0.1%	0.1%	0.29
\$0.50	0.4%	0.4%	0.37
\$3.15	2.7%	2.7%	
\$3.94	3.3%	3.3%	0.13
\$0.00	0.0%	0.0%	
\$20.19	17.0%	17.1%	1.42
\$0.19	0.2%	0.2%	
\$2.50	2.1%	2.1%	1.29
\$38.40	32.4%	32.6%	4.25
\$0.17	0.1%	0.1%	0.82
\$7.78	6.6%	6.6%	0.41
\$7.25	6.1%	6.1%	0.07
\$0.54	0.5%	0.5%	
(\$0.00)	0.0%	0.0%	
\$56.83	47.9%	48.2%	6.83
\$2.61	2.2%	2.2%	0.08
\$0.00	0.0%	0.0%	
\$0.68	0.6%	0.6%	
\$0.17	0.1%	0.1%	
\$6.65	5.6%	5.6%	0.13
\$18.49	15.6%	15.7%	
\$0.11	0.1%	0.1%	
\$0.10	0.1%	0.1%	
\$0.00	0.0%	0.0%	
\$1.70	1.4%	1.4%	
\$0.00	0.0%	0.0%	
\$30.52	25.7%	25.9%	0.22
\$107.54	90.7%	91.2%	8.47

\$4.61	3.9%	3.9%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$4.61	3.9%	3.9%	-

\$0.00	0.0%	0.0%	
\$0.66	0.6%	0.6%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$5.79	4.9%	4.9%	
\$0.00	0.0%	0.0%	
\$6.45	5.4%	5.5%	-
\$118.60	100.0%	100.5%	8.47
\$117.96	99.5%	100.0%	
(0.64)	-0.5%	-0.5%	
-0.5%			