

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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
Number City Zip Code

County: Tazewell

Telephone Number: 309-266-9781 Fax # 309-266-9468

HFS ID Number:

Date of Initial License for Current Owners: 5/9/1994

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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2015 to 6/30/2016 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) Matthew D. Steffen
(Title) Finance and Operations Director

Paid
Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,856	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	5,666			5,666	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,666			5,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.76%

D. How many bed-hold days during this year were paid by the Department? 87 (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)

N/A

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 5/9/94

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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/16 Fiscal Year: 6/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	40,433	4,867	780	46,080	(35)	46,045		46,045			1
2	Food Purchase		31,451		31,451		31,451		31,451			2
3	Housekeeping	6,020	542		6,562		6,562		6,562			3
4	Laundry		2,156		2,156		2,156		2,156			4
5	Heat and Other Utilities			17,236	17,236		17,236		17,236			5
6	Maintenance	18,895	7,770	6,462	33,127	(41)	33,086		33,086			6
7	Other (specify):*											7
8	TOTAL General Services	65,348	46,786	24,478	136,612	(76)	136,536		136,536			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	57,271	16,386	1,416	75,073	(3,807)	71,266		71,266			10
10a	Therapy	227,857		908	228,765	(89)	228,676		228,676			10a
11	Activities		2,694		2,694	(23)	2,671		2,671			11
12	Social Services	41,462	11	4,369	45,842	(273)	45,569		45,569			12
13	CNA Training					4,273	4,273		4,273			13
14	Program Transportation			3,708	3,708		3,708		3,708			14
15	Other (specify):* DD Training					(5)	(5)		(5)			15
16	TOTAL Health Care and Programs	326,590	19,091	10,401	356,082	76	356,158		356,158			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			3,968	3,968		3,968		3,968			19
20	Dues, Fees, Subscriptions & Promotions			2,400	2,400		2,400	(608)	1,792			20
21	Clerical & General Office Expenses	68,151	4,012		72,163		72,163		72,163			21
22	Employee Benefits & Payroll Taxes			110,720	110,720		110,720		110,720			22
23	Inservice Training & Education			613	613		613		613			23
24	Travel and Seminar			639	639		639	(502)	137			24
25	Other Admin. Staff Transportation			111	111		111		111			25
26	Insurance-Prop.Liab.Malpractice			6,277	6,277		6,277		6,277			26
27	Other (specify):* Miscellaneous			2,984	2,984	(2,568)	416		416			27
28	TOTAL General Administration	68,151	4,012	127,712	199,875	(2,568)	197,307	(1,110)	196,197			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	460,089	69,889	162,591	692,569	(2,568)	690,001	(1,110)	688,891			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			34,546	34,546		34,546		34,546			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):* Management Fees											36
37	TOTAL Ownership			34,546	34,546		34,546		34,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					2,568	2,568		2,568			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,792	36,792		36,792		36,792			42
43	Other (specify):* Newsletter											43
44	TOTAL Special Cost Centers			36,792	36,792	2,568	39,360		39,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	460,089	69,889	233,929	763,907		763,907	(1,110)	762,797			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	\$	6	\$	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		36		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		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance		26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(608)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (608)		\$	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)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (608)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset day training transportation income	\$	10	1
2	Offset day training transportation income		14	2
3	Out-of-state Travel (Administrative Staff)	(46)	24	3
4	Depreciation of non-care vehicles		30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming		22	6
7	Out-of-state Travel (Board of Directors)	(456)	24	7
8	Interest Expense		32	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	(502)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate# 0039305

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(608)	0	0	0	0	0	0	0	0	0	0	(608)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(502)	0	0	0	0	0	0	0	0	0	0	(502)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,110)	0	0	0	0	0	0	0	0	0	0	(1,110)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,110)	0	0	0	0	0	0	0	0	0	0	(1,110)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,110)	0	0	0	0	0	0	0	0	0	0	(1,110)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicapped, Inc.		Oakwood Estate	Morton	Community Residential Services	Morton	CILA Residential Services for the Developmentally Disabled

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

YES

NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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 (continued)

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

☐ YES☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$*	39

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

Facility Name & ID Number

Linden Estate

0039305

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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	Virgil Metzger	BOD						1
2	Ben Knochel	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Roger Beutel	BOD						5
6	Bryan Stoller	BOD						6
7	Kathy Woodruff	BOD						7
8	Ed Leman	BOD						8
9	Tim Steffen	BOD						9
10	Royce Scheiler	BOD						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: 7/1/2015 Ending: 6/30/2016

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	Vice-Chairman	Director	0.00	682	0.5		Travel	\$ 127		1
2	Ben Knochel	Director	Director	0.00	0	0.5		Travel	0		2
3	Paul Kelson	Director	Director	0.00	152	0.5		Travel	28		3
4	Dennis Mott	Director	Director	0.00	455	0.5		Travel	85	line 24; col. 3	4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		5
6	Bryan Stoller	Chairman	Director	0.00	150	0.5		Travel	28		6
7	Kathy Woodruff	Director	Director	0.00	1,271	0.5		Travel	236	line 24; col. 3	7
8	Ed Leman	Director	Director	0.00	0	0.5			0		8
9	Tim Steffen	Director	Director	0.00	724	0.5		Travel	135	line 24; col. 3	9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	\$ 639		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: 7/1/2015 Ending: 7/30/2016

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						\$					\$	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 # _____

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Linden Estate</u>	COUNTY	<u>Tazewell</u>
---------------	----------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

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.)

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: 7,329

B. General Construction Type: Exterior Brick Veneer Frame Wood Construction 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>LTC Facility</u>	<u>87,120</u>	<u>1993</u>	<u>\$ 52,959</u>	1
2					2
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	\$	\$ 185,071	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			393	13	
14	401--Painting /Dumpster			1994	405	14	30	14		298	14	
15	402--Generator Wing			1999	527	18	30	18		307	15	
16	598--Livingroom carpet			2003	710		10			710	16	
17	625--Bathroom remodel			2004	899	60	15	60		749	17	
18	520--Lobby Carpet			2001	1,256	42	15	42		1,256	18	
19	437--Cabinetry/Countertops/Vanities			1994	8,191		15			8,191	19	
20	430--Lawn Sprinkler System			1994	4,083	163	25	163		3,608	20	
21	432--Lighting & Down Spout Trenches			1994	5,315		20			5,315	21	
22	433--Sod for Lawn			1994	5,259		20			5,259	22	
23	431--Concrete for Porches			1994	7,365		20			7,365	23	
24	399--Shelter			1996	8,900		20			8,900	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		12,891	27	
28	398--Garage			1994	25,346	1,014	25	1,014		23,319	28	
29	440--Electrical			1994	30,570		20			30,570	29	
30	439--Plumbing			1994	32,699		20			32,699	30	
31	427--Sewer System			1994	33,335	1,111	30	1,111		28,472	31	
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		3,398	32	
33	1179--LE Garage roof			2016	3,278	131	25	131		131	33	
34	772--Fiber Optic Cable			2006	1,250	83	15	83		875	34	
35	860--Interior Painting			2008	5,097	340	15	340		3,058	35	
36	861--Telephone System			2008	610	41	15	41		366	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:

7/1/2015

Ending:

6/30/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 862--Landscape upgrade	2008	\$ 553	\$ 37	15	\$ 37	\$	\$ 332	37
38 863--Exit ramps	2008	3,430	229	15	229		2,058	38
39 884--Bathroom Floors	2009	4,091		7			4,091	39
40 885--Lighting Project	2009	2,500	167	15	167		1,333	40
41 886--Hot water heater	2009	2,899		7			2,899	41
42 1062--5 Men's Floor Coverings	2014	5,099	340	15	340		1,020	42
43 1135--HVAC Unit	2015	6,317	421	15	421		842	43
44 1136--Linden Expansion of Porch - Drawings	2015	99,614	6,641	15	6,641		11,666	44
45 1165--LE Roof Project	2015	11,919	596	20	596		1,192	45
46 1170--LE flooring--Dining, living, kitchen, med rooms	2015	13,599	1,360	10	1,360		1,438	46
47 1171--LE 2 a/c units, crawl space insul./vapor barrier	2015	2,290	153	15	153		305	47
48 1139.1--Designer screen shades for Res bedrooms	2016	3,375	225	15	225		225	48
49 1178--LE House roof	2016	14,003	560	25	560		560	49
50 1189--Laundry Hopper	2016	5,561	556	10	556		556	50
51 1136.1--LE Porch Expansion - Landscaping	2016	4,871	325	15	325		325	51
52 1175--LE Driveway/Parking Lot Resurfacing	2016	13,500	900	15	900		900	52
53 1173--Linden built-in cabinets	2016	4,470	298	15	298		298	53
54 1185--2 Carrier Furnaces & Condensers	2016	25,660	1,711	15	1,711		1,711	54
55 930--Landscaping	2008	185	12	15	12		99	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)		\$ 734,119	\$ 26,584		\$ 26,584	\$	\$ 466,375	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	\$ 28,634	\$ 4,169	\$ 4,169	\$	10	\$ 12,452	71
72	Current Year Purchases	14,169	1,311	1,311		13	1,311	72
73	Fully Depreciated Assets	72,024	2,484	2,484		9	72,024	73
74	Disposed Assets							74
75	TOTALS	\$ 114,827	\$ 7,964	\$ 7,964	\$		\$ 85,787	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 901,905	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,548	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,548	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 552,162	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. ☐ YES ☐ NO

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

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

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

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

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: \$ _____ 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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

* 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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER CNA80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		850		850
4	Clinical Wages (b)		1,700		1,700
5	In-House Trainer Wages (c)		2,848		2,848
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,398	\$	\$ 5,398
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,398			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$97,937

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	48
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	50

(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	\$ 500	\$ 626,858	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	448,409	844,176	3
4	Supply Inventory (priced at)	19,489	20,456	4
5	Short-Term Investments	4,210,788	4,210,788	5
6	Prepaid Insurance	285,135	28,424	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	436,894	437,701	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,401,215	\$ 6,168,403	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,227	551,258	13
14	Buildings, at Historical Cost	3,075,875	7,593,602	14
15	Leasehold Improvements, at Historical Cost	358,315	646,351	15
16	Equipment, at Historical Cost	2,239,241	3,146,086	16
17	Accumulated Depreciation (book methods)	(4,392,479)	(6,737,633)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,121)	20
21	Restricted Funds	11,605,276	11,605,276	21
22	Other Long-Term Assets (specify):	41,448	41,448	22
23	Other(specify): <u>Investment in Other Facilities</u>	10,486,365	10,486,365	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,447,268	\$ 27,332,753	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 28,848,483	\$ 33,501,156	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 444,910	\$ 475,909	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	357,805	583,687	30
31	Accrued Taxes Payable (excluding real estate taxes)	(358)	680	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	173,504	280,001	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Rounding</u>	(4)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 975,857	\$ 1,340,277	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>	37,523	37,523	43
44	<u>Investment from Other Facilities</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 37,523	\$ 37,523	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,013,380	\$ 1,377,800	46
47	TOTAL EQUITY(page 18, line 24)	\$ 34,107,956	\$ 32,123,356	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,121,336	\$ 33,501,156	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 26,568,755	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 26,568,755	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,539,201	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)	\$ 7,539,201	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)	\$ 34,107,956	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,293,121	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,293,121	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions	9,987	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,987	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,303,108	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	136,612	31
32	Health Care	356,082	32
33	General Administration	199,875	33
	B. Capital Expense		
34	Ownership	34,546	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,792	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 763,907	40
41	Income before Income Taxes (line 30 minus line 40)**	7,539,201	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,539,201	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) ICFID/DD	8,293,121	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,293,121	49

* 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	370	400	\$ 12,237	\$ 30.59	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,634	1,812	45,034	24.85	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	0	0	0		5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	191	210	5,843	27.82	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	2,607	2,919	34,590	11.85	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,011	1,109	18,895	17.04	17
18	Housekeepers	556	556	6,020	10.83	18
19	Laundry	0	0	0		19
20	Administrator	612	698	27,515	39.42	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	956	1,066	28,104	26.36	22
23	Office Manager	370	407	9,342	22.95	23
24	Clerical	190	216	3,190	14.77	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	1,440	1,600	41,462	25.91	29
30	Habilitation Aides (DD Homes)	15,271	16,314	191,958	11.77	30
31	Medical Records	0	0	0		31
32	Other Health Care Therapy	1,531	1,718	31,558	18.37	32
33	Other(specify) Day Program	232	257	4,341	16.89	33
34	TOTAL (lines 1 - 33)	26,971	29,282	\$ 460,089 *	\$ 15.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 780	1-3	35
36	Medical Director	Flat Fee	324	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	1,044	10-3	39
40	Physical Therapy Consultant	6	361	10-3	40
41	Occupational Therapy Consultant	8	546	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	34	2,467	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consultant	3	528	12-3	46
47	Dental Consultant	0	0	10a-3	47
48	Psychiatrist Consultant	6	1,375	10a-3	48
49	TOTAL (lines 35 - 48)	80	\$ 7,425		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	10-3	50
51	Licensed Practical Nurses	0	0	10-3	51
52	Certified Nurse Assistants/Aides	0	0	10a-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Crystal Streitmatter	Administrator	0	\$ 27,515	Workers' Compensation Insurance		\$ 9,016	IDPH License Fee	\$	
				Unemployment Compensation Insurance		0	Advertising: Employee Recruitment	0	
				FICA Taxes		21,590	Health Care Worker Background Check	6	
				Employee Health Insurance		25,218	(Indicate # of checks performed 1)	0	
				Employee Meals		319	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*			Participation Fees & Certificates	35	
				Employee Physicals		459	Dues (Employers Assn, IHCA, Don Moss)	1,691	
				Employee Promotional		1,885	Subscriptions (journals, news, etc.)	0	
				Defined Contribution Pension Plan		13,940	Driving Records Verification	60	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				Benefits Allocated to Day Program		0	Secretary of State	0	
				Disability Insurance		0	Less: Public Relations Expense	()	
				Benefits for Transferred wages		38,293	Non-allowable advertising	()	
				Employee Scholarships		0	Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 110,720			\$ 1,792		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
				Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$ 502	
							See Page 24 (XX-16)	(502)	
							In-State Travel	137	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
				\$			TOTAL	\$ 137	
C. Professional Services									
Vendor/Payee	Type		Amount						
HEINOLD-BANWART, LTD.	Accounting		\$ 1,026						
KOCH CONSULTANTS	Accounting		985						
SIKICH LLP	Accounting/Data Processing		0						
BROOKEROSE, INC.	Data Processing		0						
KRONOS INCORPORATED	Data Processing		0						
PAPERLESSPAY CORPORATION	Data Processing		282						
PNC BANK	Data Processing		0						
QUANTUM SOLUTIONS INC	Data Processing		855						
RELIAS LEARNING, LLC	Data Processing		821						
BENCKENDORF & BENCKENDORF	Legal		0						
HOWARD & HOWARD ATTORNE	Legal		0						
MORRIS, DUANE	Legal		0						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)									
				\$ 3,968					

*** 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. IHCA - \$947, Institute on Public Policy - \$697
- (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? 15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,722 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. \$ 36,792
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 benefit on Schedule V. \$ 337 Has any meal income been offset against related costs? No 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? No 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? 90%
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? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 66,155
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Koch Consultants, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Schedule V - Costs Center Expenses		
Lines	Description	Amount
1	Day Program Costs	-
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
15	Bad Debt	-
27	Dental costs	2,568
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	-
	Other Expenses	2,568

Schedule V - Reclassifications		Amount	
Lines	Description	Increase	Decrease
6	Communication equipment rental	-	
35	Communication equipment rental		-
32	Interest Expense	-	
36	Interest Expense		-
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	Disability Pay to Benefits		-
22	Disability Pay to Benefits	-	
13	Nurse aid trainer wages	4,273	
1	Nurse aid trainer wages		35
6	Nurse aid trainer wages		41
10	Nurse aid trainer wages		3,807
10a	Nurse aid trainer wages		89
11	Nurse aid trainer wages		23
12	Nurse aid trainer wages		273
15	Nurse aid trainer wages		5
17	Nurse aid trainer wages		-
39	Dental costs	2,568	
27	Dental costs		2,568
		6,841	6,841

Schedule V, Line 39 - Ancillary Service Centers		
Dental costs for 21 visits	\$	2,568

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

Schedule VII - Compensation Received From Other Nursing Homes	
Virgil Metzger - \$682.27 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Ben Knochel - \$0.00 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Paul Kelson - \$152.08 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Dennis Mott - \$455.08 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Bryan Stoller - \$149.57 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Kathy Woodruff - \$1,270.58 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Tim Steffen - \$723.83 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	

Sch. XV - Balance Sheet, Line 9; Other Current Assets	
A/R - N.A. Training	8,681
A/R - Bequests	6,000
A/R - Health Insurance	412,161
A/R - Employees	10,052
	436,894

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets	
Investment in Related Entities	10,486,365

Sch. XVII - Income Statement, Line 28; Other Revenue	
Developmental training	493,159
Farm Income	900
Gain/(Loss) on Sale of Assets	(33,531)
Increase in Cash Value of Life Insurance	-
Miscellaneous	600
Cost to Market Adjustment on Investments	##
	461,128

Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	7,539,201
Income from related parties	#VALUE!
Estimated excess for year, Form 990, p.1, line 18	#VALUE!

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Column 1, Row 45	460,089
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(460,089)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	460,089
Prior Year PTO Accrual	(16,207)
Current Year PTO Accrual	16,466
Prior Year Wage Accrual	9,730
Current Year Wage Accrual	(11,659)
Section 125 Wages not applicable to FICA taxes	(20,020)
Less: Wages over FICA taxation limit of SS Wages (\$0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilities	(156,180)
Add: ACCS Wages	
Add: wages included in employee meal calculation	
Cash basis salaries	282,218
FICA rate	7.650%
Calculated FICA	21,590
FICA per Sch XIX	21,590
Variance	(0)

Sch. XX - General Information		
12. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	89
	Activities Director	23
	Day Program	5
	Head Cook	35
	Maintenance	41
	Nursing	3,807
	Soc. Serv. / QMRP	273
		4,273

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

16. Out of State Travel	
Administration	
Administrator	46
Assistant Administrator	-
	46

Board of Directors	
Virgil Metzger (Not out of State)	
Ben Knochel	-
Paul Kelson (Not out of State)	
Dennis Mott	85
Bryan Stoller (Not out of State)	
Kathy Woodruff	236
Tim Steffen	135
	456

Nursing	
None	-
	-

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Oakwood Estate #0033712
Apostolic Christian Timber Ridge #0016220

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

Bryan Stoller, Chairman
Virgil Metzger, Vice Chairman
Paul Kelson, Secretary/Treasurer
Kathy Woodruff, Director
Dennis Mott, Director
Tim Steffen, Director
Ed Leman, Director
Royce Scheiler, Director
Ben Knochel, Director (term began 05/21/2016)
Roger Beutel, Director (term ended 5/21/2016)

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 -- 0039305

From: 7/1/2015

to

6/30/2016

COMPLETED FOR 2016

CLASS DATE	72																								
	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	50	31	1,240	\$	10,540.00	2480	\$	21,080.00	480	\$	4,080.00	2	80	\$	680.00	160	\$	1,360.00	11	440	\$	3,740.00	880	\$	7,480.00
still enrolled, not complete	8	3	60	\$	510.00	120	\$	1,020.00	120	\$	1,020.00	1	20	\$	170.00	40	\$	340.00	1	20	\$	170.00	40	\$	340.00
dropouts	2	2	40	\$	340.00	80	\$	680.00	0	\$	-	0	0	\$	-	0	\$	-	0	0	\$	-	0	\$	-
				\$	-	0	\$	-	0	\$	-			\$	-	0	\$	-			\$	-	0	\$	-
Total	2200	36	1340	\$	11,390.00	2680	\$	22,780.00				3	100	\$	850.00	200	\$	1,700.00	12	460	\$	3,910.00	920	\$	7,820.00

WAGES										Hours							
TRAINER WAGES	Classification	Hours	Hourly Rate	Wages		TR	OE	LE	CILA	TR	OE	LE	CILA				
Kristen Dancey	10			\$	-	-	-	-	-	-	-	-	-				8
Cheryl Hays	10s	81.00		\$	1,381.05	62.78	841.19	188.33	62.78	288.77	49.34	11.05	3.68	16.94			7.25
Don Bowers	12q	49.50		\$	965.25	43.88	587.93	131.63	43.88	201.83	30.15	6.75	2.25	10.35			
Evie Mogler	12r	4.00		\$	101.80	4.63	62.01	13.88	4.63	21.29	2.44	0.55	0.18	0.84			22.936
Gary Folkerts	6	33.00		\$	891.00	40.50	542.70	121.50	40.50	186.30	20.10	4.50	1.50	6.90			
Crystal Streitmatter	17			\$	-	-	-	-	-	-	-	-	-	-			
Jenny Smith	10ot	24.00		\$	579.36	26.33	352.88	79.00	26.33	121.14	14.62	3.27	1.09	5.02			20
Kathy Kelch	10	140.75		\$	3,963.52	180.16	2,414.14	540.48	180.16	828.74	85.73	19.19	6.40	29.43			5.734
Leigh Mason	12q			\$	-	-	-	-	-	-	-	-	-	-			
Lori Brittain	1	28.00		\$	765.24	34.78	466.10	104.35	34.78	160.00	17.05	3.82	1.27	5.85			
Sam Getz	10			\$	-	-	-	-	-	-	-	-	-	-			
Isaac Aberle	11			\$	-	-	-	-	-	-	-	-	-	-			
Randy Mogler	12r	101.00		\$	2,597.72	118.08	1,582.25	354.23	118.08	543.16	61.52	13.77	4.59	21.12			
Rob Mooney	12r	20.00		\$	511.20	23.24	311.37	69.71	23.24	106.89	12.18	2.73	0.91	4.18			
Sherrie Parnham	12r	4.00		\$	104.36	4.74	63.56	14.23	4.74	21.82	2.44	0.55	0.18	0.84			
Tina Leman	12m	39.00		\$	936.00	42.55	570.11	127.64	42.55	195.71	23.75	5.32	1.77	8.15			
Mark Baker	12q	48.00		\$	783.84	35.63	477.43	106.89	35.63	163.89	29.24	6.55	2.18	10.04			
Isaac Aberle	11	24.00		\$	515.76	23.44	314.14	70.33	23.44	107.84	14.62	3.27	1.09	5.02			
Gayle Fidler	10	7.00		\$	161.00	7.32	98.06	21.95	7.32	33.66	4.26	0.95	0.32	1.46			
Vikki Steele	15	6.50		\$	120.64	5.48	73.48	16.45	5.48	25.22	3.96	0.89	0.30	1.36			
Stephanie Barth	10a			\$	-	-	-	-	-	-	-	-	-	-			
Kathy Kelch	10	1,767.25		\$	49,765.76	2,262.08	30,311.87	6,786.24	2,262.08	10,405.57	1,076.42	240.99	80.33	369.52			
Gayle Fidler	10	1,298.00		\$	29,854.00	1,357.00	18,183.80	4,071.00	1,357.00	6,242.20	790.60	177.00	59.00	271.40			
OE				\$	-	-	-	-	-	-	-	-	-	-			
Jodi Fehr	17			\$	-	-	-	-	-	-	-	-	-	-			
Evie Mogler	12r			\$	-	-	-	-	-	-	-	-	-	-			
LE				\$	-	-	-	-	-	-	-	-	-	-			
Rob Mooney	12r			\$	-	-	-	-	-	-	-	-	-	-			
				\$	-	-	-	-	-	-	-	-	-	-			
CILA				\$	-	-	-	-	-	-	-	-	-	-			
Sherrie Parnham	12r			\$	-	-	-	-	-	-	-	-	-	-			
Leigh Wamsley	12q			\$	-	-	-	-	-	-	-	-	-	-			
				\$	-	4,272.61	57,253.02	12,817.84	4,272.61	19,654.02	2,238.41	501.14	167.05	768.41			

Total trainer wages 3675 \$ 93,997.50 \$ 2,660.00 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	0	0	0	0
Clinical Wages	0 \$ 680.00	\$ -	\$ -	\$ -
Classroom Wages	0 \$ 340.00	\$ -	\$ -	\$ -
In-House Trainer Wages	0 \$ 570.00	\$ -	\$ -	\$ -
Completed				
Number from this Facility	2	6	2	11
Clinical Wages	850 \$ 11,050.00	\$ 2,550.00	\$ 850.00	\$ 3,910.00
Classroom Wages	1700 \$ 22,100.00	\$ 600.00	\$ 1,700.00	\$ 7,820.00
In-House Trainer Wages	2848 \$ 37,029.00	\$ 2,441.00	\$ 2,848.00	\$ 13,103.00

Supplies 4654.38

Schedule V		TR	OE	LE	CILA
	Line	Change	Change	Change	Change
Dietary	1	(466.00)	(104.00)	(35.00)	(160.00)
Maintenance	6	(543.00)	(122.00)	(41.00)	(186.00)
Nursing	10	(51,008.00)	(11,420.00)	(3,807.00)	(17,510.00)
Therapy	10a	-	-	-	-
OT/PT	10ot	(353.00)	(79.00)	(26.00)	(121.00)
Activities	11	(314.00)	(70.00)	(23.00)	(108.00)
RSD	12r	(2,019.00)	(452.00)	(151.00)	(693.00)
QMRP's	12q	(1,065.00)	(239.00)	(80.00)	(366.00)
MSSD	12m	(570.00)	(128.00)	(43.00)	(196.00)
Training Wages	13	57,253.00	12,818.00	4,273.00	19,654.00
Day Program	15	(73.00)	(16.00)	(5.00)	(25.00)
Administrator	17	-	-	-	-
OJT	12ojt	-	-	-	-
Speech	10s	(841.00)	(188.00)	(63.00)	(289.00)
Adjustment	12	(1.00)	-	1.00	-
		-	-	-	-