

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0039305</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Linden Estate</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2024</u> to <u>06/30/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1000 Linden Street</u> <u>Morton</u> <u>61550</u> Number City Zip Code																									
County: <u>Tazewell</u>																									
Telephone Number: <u>309.266.9781</u> Fax # <u>309.266.9468</u>																									
HFS ID Number: _____																									
Date of Initial License for Current Owners: <u>5/9/1994</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Crystal Streitmatter</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Crystal Streitmatter</u>	(Title) <u>Administrator</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Matthew D. Steffen</u> Telephone Number: <u>309.266.9781</u>																									
Email Address: _____																									

Facility Name & ID Number

Linden Estate

#

0039305

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

III. STATISTICAL DATA

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

1

2

3

4

16

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD					0				11
12	SC									12
13	DD 16 OR LESS	5,105							5,105	13
14	TOTALS	5,105							5,105	14

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

87.41%

D. How many bed reserve days during this year were paid by the Department?

143

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

X

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

YES

X

NO

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

Date started

5/9/1994

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

YES

Date

NO

X

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

YES

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

06/30/2025

Fiscal Year:

06/30/2025

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	0	4,102	1,635	5,737	(72)	5,665	0	5,665			1
2	Food Purchase		52,271		52,271	0	52,271	0	52,271			2
3	Housekeeping	46,776	3,863	0	50,639	0	50,639	0	50,639			3
4	Laundry	0	3,702	0	3,702	0	3,702	0	3,702			4
5	Heat and Other Utilities			19,638	19,638	0	19,638	0	19,638			5
6	Maintenance	23,387	4,435	15,894	43,716	0	43,716	0	43,716			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	TOTAL General Services	70,163	68,373	37,167	175,703	(72)	175,631	0	175,631			8
	B. Health Care and Programs											
9	Medical Director	0	0	0	0	0	0	0	0			9
10	Nursing and Medical Records	892,691	14,973	2,100	909,764	0	909,764	0	909,764			10
10a	Therapy	63,853	0	80	63,933	(2,437)	61,496	0	61,496			10a
11	Activities	0	382	0	382	41	423	0	423			11
12	Social Services	162,105	53	4,157	166,315	(18,858)	147,457	0	147,457			12
13	CNA Training	16,242	0	0	16,242	21,431	37,673	0	37,673			13
14	Program Transportation	0	0	1,627	1,627	0	1,627	0	1,627			14
15	Other (specify):* Bad Debt & Day Prog	0	0	0	0	0	0	0	0			15
16	TOTAL Health Care and Programs	1,134,891	15,408	7,964	1,158,263	177	1,158,440	0	1,158,440			16
	C. General Administration											
17	Administrative	25,163	0	0	25,163	0	25,163	0	25,163			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			23,136	23,136	0	23,136	0	23,136			19
20	Dues, Fees, Subscriptions & Promotions			4,016	4,016	0	4,016	0	4,016			20
21	Clerical & General Office Expenses	117,351	627	7,784	125,762	0	125,762	0	125,762			21
22	Employee Benefits & Payroll Taxes			192,787	192,787	0	192,787	0	192,787			22
23	Inservice Training & Education			433	433	0	433	0	433			23
24	Travel and Seminar			898	898	0	898	(898)	0			24
25	Other Admin. Staff Transportation		0	0	0	0	0	0	0			25
26	Insurance-Prop.Liab.Malpractice			6,925	6,925	0	6,925	0	6,925			26
27	Other (specify):*	0	0	7,017	7,017	(6,842)	175	(175)	0			27
28	TOTAL General Administration	142,514	627	242,996	386,137	(6,842)	379,295	(1,073)	378,222			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,347,568	84,408	288,127	1,720,103	(6,737)	1,713,366	(1,073)	1,712,293			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 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	
	D. Ownership											
30	Depreciation			28,294	28,294	0	28,294	(4,903)	23,391			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	0	0			32
33	Real Estate Taxes			0	0	0	0	0	0			33
34	Rent-Facility & Grounds			0	0	0	0	0	0			34
35	Rent-Equipment & Vehicles			0	0	0	0	0	0			35
36	Other (specify):* Investment Fees			0	0	0	0	0	0			36
37	TOTAL Ownership			28,294	28,294	0	28,294	(4,903)	23,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	0	0	0	0	6,737	6,737	0	6,737			39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0			40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0			41
42	Provider Participation Fee	0	0	59,408	59,408	0	59,408	0	59,408			42
43	Other (specify):* Newsletter	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	0	59,408	59,408	6,737	66,145	0	66,145			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,347,568	84,408	375,829	1,807,805	0	1,807,805	(5,976)	1,801,829			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	(175)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)	\$ (175)		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (175)		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	0		2
3	Out-of-state Travel (Administrative Staff)	0	24	3
4	Depreciation of non-care vehicles	(4,903)	30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming	0	22	6
7	Out-of-state Travel (Board of Directors)	(898)	24	7
8	Interest Expense	0	36	8
9	Out-of-state Travel (Administrative Staff)	0	10	9
10	Offset day training transportation income	0	10	10
11	Offset day training transportation income	0	14	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	(5,801)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	0	0	0	0	0	0	0	0	0	0	0	0	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	(898)	0	0	0	0	0	0	0	0	0	0	(898)	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):*	(175)	0	0	0	0	0	0	0	0	0	0	(175)	27
28	TOTAL General Administration	(1,073)	0	0	0	0	0	0	0	0	0	0	(1,073)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,073)	0	0	0	0	0	0	0	0	0	0	(1,073)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(4,903)	0	0	0	0	0	0	0	0	0	0	(4,903)	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	(4,903)	0	0	0	0	0	0	0	0	0	0	(4,903)	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)	(5,976)	0	0	0	0	0	0	0	0	0	0	(5,976)	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 LifePoints, Inc.	100%	Oakwood Estate #0033712	Morton	Apostolic Christian CI	Morton	CILA Residential
		Apostolic Christian Timber Ridge #0016220	Morton			Services for
						Individuals with
						Developmental
						and Intellectual
						Disabilitites

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 (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.

STATE OF ILLINOIS

Ownership Listing-1

Linden Estate

ID#0039305

Report Period Beginning:07/01/2024

Ending:06/30/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Place of Residence

Ownership

Building Co.

Ownership

First Name

M.I.

Last Name

City

State

Percentage

Percentage

1	Apostolic Christian Church of America		Peoria	IL	100.00000	
2						
3						
4						
5						
6						
7						
8						
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10						
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47						
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49						
50						

STATE OF ILLINOIS

Ownership Listing-2

Linden Estate

ID#0039305

Report Period Beginning:07/01/2024

Ending:06/30/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Building Co.

Place of Residence

Ownership

Ownership

First Name

M.I.

Last Name

City

State

Percentage

Percentage

76

77

78

79

80

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83

84

85

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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	Blair Metzger	BOD						1
2	Matt Zimmerman	BOD						2
3	John Sauder	BOD						3
4	Heidi Haerr	BOD						4
5	Greg Wiegand	BOD						5
6	Ben Knochel	BOD						6
7	Daniel Leman	BOD						7
8	Kent Schmidgall	BOD						8
9	Wendy Sauder	BOD						9
10	Lee Klopfenstein	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: 07/01/2024 Ending: 06/30/2025

VII. RELATED PARTIES (continued)

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

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

	1 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	Blair Metzger	Director	Director	0.00	1,944	0.5		Travel	\$ 362	line24 col 3	1
2	Matt Zimmerman	President	Director	0.00	0	0.5			0		2
3	John Sauder	Treasurer	Director	0.00	0	0.5			0		3
4	Heidi Haerr	Secretary	Director	0.00	0	0.5			0		4
5	Greg Wiegand	Director	Director	0.00	0	0.5			0		5
6	Ben Knochel	Director	Director	0.00	0	0.5			0		6
7	Daniel Leman	Director	Director	0.00	0	0.5			0		7
8	Kent Schmidgall	Vice President	Director	0.00	1,127	0.5		Travel	210	line24 col 3	8
9	Wendy Sauder	Director	Director	0.00	0	0.5			0		9
10	Lee Klopfenstein	Director	Director	0.00	1,759	0.5		Travel	327	line24 col 3	10
11											11
12											12
13								TOTAL	\$ 898		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: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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	Morgan Stanley (LAL)		X	Timing of State Payments and Interest		12/2008	4,667,000	0	None	6.4337			6
7													7
8													8
9	TOTAL Facility Related						\$ 4,667,000	\$ 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)						\$ 4,667,000	\$ 0			\$ 0	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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

[illegible]

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	Linden Estate	COUNTY	Tazewell
---------------	---------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

- A. Square Feet: 7,329
- B. General Construction Type: Exterior Brick VeneerFrame Wood ConstructionNumber 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	LTC Facility	87,120	1993	\$ 52,959	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	\$ 0	30	\$ 0	\$	244,343	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	398--Garage			1994	25,346	0	25	0		25,346	9
10	399--Shelter			1996	8,900	0	20	0		8,900	10
11	401--Painting /Dumpster			1994	405	0	30	0		405	11
12	402--Generator Wing			1999	527	18	30	18		465	12
13	403--Mirrors			1994	330	0	10	0		330	13
14	427--Sewer System			1994	33,335	0	30	0		33,335	14
15	1441--Brookside Landscapes - Landscape renovations			2024	7,260	484	15	484		726	15
16	429--Landscaping			1994	11,829	0	10	0		11,829	16
17	430--Lawn Sprinkler System			1994	4,083	0	25	0		4,083	17
18	432--Lighting & Down Spout Trenches			1994	5,315	0	20	0		5,315	18
19	433--Sod for Lawn			1994	5,259	0	20	0		5,259	19
20	434--Concrete for Water Spillway			1995	393	0	20	0		393	20
21	435--Organizational Costs			1994	11,887	0	5	0		11,887	21
22	436--Light Fixtures			1994	2,445	0	10	0		2,445	22
23	437--Cabinetry/Countertops/Vanities			1994	8,191	0	15	0		8,191	23
24	438--Fire Prevention System			1994	14,174	0	25	0		14,174	24
25	439--Plumbing			1994	32,699	0	20	0		32,699	25
26	440--Electrical			1994	30,570	0	20	0		30,570	26
27	441--Heating & Air Conditioning			1994	19,683	0	15	0		19,683	27
28	1408--Ductless HVAC unit			2023	3,300	220	15	220		550	28
29	1525--Keyless Door Entry			2025	6,814	681	5	681		681	29
30	625--Bathroom remodel			2004	899	0	15	0		899	30
31	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	0	15	0		4,854	31
32	772--Fiber Optic Cable			2006	1,250	0	15	0		1,250	32
33	860--Interior Painting			2008	5,097	0	15	0		5,097	33
34	862--Landscape upgrade			2008	553	0	15	0		553	34
35	863--Exit ramps			2008	3,430	0	15	0		3,430	35
36	884--Bathroom Floors			2009	4,091	0	7	0		4,091	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:

07/01/2024 Ending: 06/30/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	885--Lighting Project	2009	\$ 2,500	\$ 0	15	\$ 0	\$	\$ 2,500	37
38	930--Landscaping	2008	185	0	15	0		185	38
39	1062--5 Men's Floor Coverings	2014	5,099	340	15	340		4,079	39
40	1135--HVAC Unit	2015	6,317	421	15	421		4,632	40
41	1136--Linden Expansion of Porch - Drawings	2015	99,614	6,641	15	6,641		71,434	41
42	1136.1--LE Porch Expansion - Landscaping	2016	4,871	325	15	325		3,247	42
43	1139.1--Designer screen shades for Res bedrooms	2016	3,375	225	15	225		2,250	43
44	1165--LE Roof Project	2015	11,919	596	20	596		6,555	44
45	1170--LE flooring--Dining, living, kitchen, med rooms	2015	13,599	1,281	10	1,281		13,599	45
46	1171--LE 2 a/c units, crawl space insul./vapor barrier	2015	2,290	153	15	153		1,679	46
47	1173--Linden built-in cabinets	2016	4,470	298	15	298		2,980	47
48	1175--LE Driveway/Parking Lot Resurfacing	2016	13,500	900	15	900		9,000	48
49	1178--LE House roof	2016	14,003	560	25	560		5,601	49
50	1179--LE Garage roof	2016	3,278	131	25	131		1,311	50
51	1185--2 Carrier Furnaces & Condensers	2016	25,660	1,711	15	1,711		17,107	51
52	1189--Laundry Hopper	2016	5,561	556	10	556		5,561	52
53	1220--New Linoleum at LE	2017	6,141	0	5	0		6,141	53
54	1225--LE - Tazewell Flooring, Shower materials	2017	13,997	1,400	10	1,400		12,597	54
55	1310--Wascomat Washing Machine	2019	3,000	429	7	429		3,000	55
56	1311--FloorFolio Flooring	2019	2,912	194	15	194		1,359	56
57	1320--Commercial Dishwasher	2019	6,799	971	7	971		6,799	57
58	1334--Window Replacment	2020	20,987	1,399	15	1,399		7,695	58
59	1388--Upgrade Computer Hardware	2022	9,965	336	10	336		349	59
60	1435--Garber Heating & Air Cond. - Fix Compressor	2024	3,102	207	15	207		310	60
61	1344--Install Heat Detectors in Attic Space	2020	2,648	177	15	177		971	61
62	1403--Door Security	2022	848	0	0	0		0	62
63								0	63
64								0	64
65								0	65
66								0	66
67								0	67
68								0	68
69								0	69
70	TOTAL (lines 4 thru 69)		\$ 783,902	\$ 20,654		\$ 20,654	\$ 0	\$ 672,724	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	\$ 24,572	\$ 1,638	\$ 1,638	\$ 0	15	\$ 14,121	71
72	Current Year Purchases	0	0	0	0		0	72
73	Fully Depreciated Assets	51,919	1,100	1,100	0	7	51,919	73
74	Disposed Assets	0	0	0	0		0	74
75	TOTALS	\$ 76,491	\$ 2,738	\$ 2,738	\$ 0		\$ 66,040	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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 913,352	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,392	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,392	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)	\$ 738,764	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	Fully depreciated vehicles	\$ 15,893	\$ 0	\$ 15,893	86
87	Purchased Vehicles/Repairs	34,319	4,903	12,257	87
88					88
89					89
90					90
91	TOTALS	\$ 50,212	\$ 4,903	\$ 28,150	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: _____
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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies	0	0		0
3	Classroom Wages (a)	3,120	5,070		8,190
4	Clinical Wages (b)	1,560	10,140		11,700
5	In-House Trainer Wages (c)	1,681	10,926		12,607
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 6,361	\$ 26,136	\$ 0	\$ 32,497
10	SUM OF line 9, col. 1 and 2 (e)	\$ 32,497			

(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.

C. CONTRACTUAL INCOME

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

\$2,449

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	48
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	28
TOTAL TRAINED	85

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

12345678										
	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 prescripts							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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 100	\$ 1,323,869	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	90,215	2,157,094	3
4	Supply Inventory (priced at 2,120)	2,120	37,958	4
5	Short-Term Investments	0	24,653,463	5
6	Prepaid Insurance	2,564	42,747	6
7	Other Prepaid Expenses	0	103,043	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): <u>A/R Bequests</u>	0	2,323,013	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 94,999	\$ 30,641,187	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	52,959	605,663	13
14	Buildings, at Historical Cost	540,031	15,083,844	14
15	Leasehold Improvements, at Historical Cost	99,953	1,826,599	15
16	Equipment, at Historical Cost	258,731	4,158,304	16
17	Accumulated Depreciation (book methods)	(755,028)	(11,224,902)	17
18	Deferred Charges	0	0	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	0	17,695,157	21
22	Other Long-Term Assets (specify): <u>Cash Surrender Value</u>	0	390,086	22
23	Other(specify): <u>Inter-Company Assets/Liab</u>	0	31,265,881	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,646	\$ 59,800,632	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 291,645	\$ 90,441,819	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 18,429	\$ 715,962	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	0	29
30	Accrued Salaries Payable	70,590	1,135,617	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,967	1,967	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	38,390	770,048	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 129,376	\$ 2,623,594	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>Inter-Company Assets/Liab</u>	2,539,782	31,265,881	43
44	<u>Rounding / Other</u>	(0)	0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,539,782	\$ 31,265,881	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,669,158	\$ 33,889,475	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,377,513)	\$ 56,552,344	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 291,645	\$ 90,441,819	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,648,358)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,648,358)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(729,155)	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)	\$ (729,155)	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)	\$ (2,377,513)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,075,617	1
2	Discounts and Allowances for all Levels	(0)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,075,617	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	0	6
7	Oxygen	0	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	2,704	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	0	21
22	Laundry	0	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,704	23
	D. Non-Operating Revenue		
24	Contributions	330	24
25	Interest and Other Investment Income***	0	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 330	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	Developmental Training	0	28
28a	Misc Income; Gain on sale of Assets	0	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,078,650	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	175,703	31
32	Health Care	1,158,263	32
33	General Administration	386,137	33
	B. Capital Expense		
34	Ownership	28,294	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	59,408	36
	D. Other Expenses (specify):		
37		0	37
38		0	38
39	Misc Expense; Loss on sale of Assets	0	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,807,805	40
41	Income before Income Taxes (line 30 minus line 40)**	(729,155)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (729,155)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) ICF/DD	1,075,617	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,075,617	56

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	598	709	\$ 36,906	\$ 52.05	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,539	1,775	80,527	45.37	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	178	205	6,750	32.93	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,811	2,065	56,873	27.54	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	693	797	23,387	29.34	17
18	Housekeepers	1,987	2,072	46,776	22.58	18
19	Laundry	0	0	0		19
20	Administrator	336	378	25,163	66.57	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	2,404	2,659	117,351	44.13	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	378	408	16,242	39.81	25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,409	1,553	50,085	32.25	28
29	Resident Services Coordinator	2,178	2,458	105,270	42.83	29
30	Habilitation Aides (DD Homes)	27,349	30,910	718,384	23.24	30
31	Medical Records	0	0	0		31
32	Other Health Care: Other (Speech) / Other (Day Program)	1,767	2,042	63,854	31.27	32
33	Other(specify) Other (Day Program)	0	0	0		33
34	TOTAL (lines 1 - 33)	42,627	48,031	\$ 1,347,568 *	\$ 28.06	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	22	\$ 1,635	L1-C3	35
36	Medical Director	0	0	L9-C3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	Flat Fee	633	L10-C3	38
39	Pharmacist Consultant	Flat Fee	2,100	L10-C3	39
40	Physical Therapy Consultant	1	32	L10-C3	40
41	Occupational Therapy Consultant	1	48	L10a-C3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0	L10a-C3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consultant	9	880	L12-C3	46
47	Dental Consultant	0	0	L10a-C3	47
48	Psychiatrist Consultant	14	3,277	L10a-C3	48
49	TOTAL (lines 35 - 48)	46	\$ 8,605		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	L10- C1	50
51	Licensed Practical Nurses	0	0	L10- C1	51
52	Certified Nurse Assistants/Aides	0	0	L10a- C1	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Page 21 Support

C. Professional Services		
SIKICH	Accounting	1,701
KOCH CONSULTANTS	Accounting	2,575
OTHER DATA PROCESSING	Data Processing	200
MY25	Data Processing	0
QUANTUM SOLUTIONS INC	Data Processing	2,260
CONSTANT CONTACT	Data Processing	107
UKG	Data Processing	11,064
QUALEX/DOCTRAC	Data Processing	341
WHEN TO WORK	Data Processing	0
RELIAS	Data Processing	1,756
TARRYTOWN	Data Processing	314
HEYL, ROYSTER	Legal	1,021
MICHAEL FLEMING	Legal	0
ELIAS, MEGINESS, SEGHETTI	Legal	0
MYRON S. STEEVES	Legal	316
BEN LAZARE CONSULTING - LOBBYIST	Professional Fees	0
TRUE NORTH STRATEGIC ADVISORS	Professional Fees	1,481
Rounding		0
		23,136
		-

D. Employee Benefits and Payroll Taxes		
	Amount	
Workers' Compensation Insurance		
Unemployment Compensation Insurance		
FICA Taxes		
Employee Health Insurance		
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Defined Contribution Pension Plan		38,390
Employee Physicals		1,570
Employee Promotional		209
Rounding		0
	Total	40,169
	From PG21	152,618
		192,787
		-

F. Dues, Fees, Subscriptions and Promotions		
Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment		
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks		
Association Dues (total from pg 22, #4)		
QBS		79
Other Licenses & Permits		354
AAIM Employers' Association		105
Other Dues, Fees, Subs		53
Spotify		17
Driving Records		520
Rounding		0
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
	Total	1,129
	From PG21	2,887
		4,016
		-

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		
Crystal Streitmatter		Administrator	0	\$ 25,163	Workers' Compensation Insurance		\$ 7,790	IDPH License Fee		\$		
			0	0	Unemployment Compensation Insurance		270	Advertising: Employee Recruitment		190		
					FICA Taxes		97,625	Health Care Worker Background Check		39		
					Employee Health Insurance		45,959	(Indicate # of checks performed 3)				
					Employee Meals		974	Patient Background Checks		70		
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		2,588		
					See Support Page 21A		40,169	See Support Page 21A		1,129		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 25,163								
B. Administrative - Other									Less: Public Relations Expense		()	
Description				Amount					Non-allowable advertising		()	
				\$					Yellow page advertising		()	
									TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,016	
					TOTAL (agree to Schedule V, line 22, col.8)			\$ 192,787				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
C. Professional Services					Description		Line #	Amount	Description		Amount	
Vendor/Payee		Type		Amount				\$	Out-of-State Travel		\$	
See Support Page 21A				23,136								
									In-State Travel			
									Seminar Expense			
									Entertainment Expense		()	
									(agree to Sch. V, line 24, col. 8)			
									TOTAL		\$	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 23,136	TOTAL			\$				

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- | | | |
|-----|--|--------------------------------|
| (1) | Are nursing employees (RN,LPN,NA) represented by a union? | <u>NO</u> |
| (2) | Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association. | |
| | <u>Association Name</u> | <u>Amount</u> |
| | <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,344</u> |
| | <u>Other, please specify INSTITUTE ON PUBLIC POLICY</u> | <u>889</u> |
| | <u>Other, please specify DON MOSS & ASSOCIATES</u> | <u>356</u> |
| | | <u>2,588 Total</u> |
| (3) | List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1. | |
| | <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u> </u> |
| | <u>Other, please specify INSTITUTE ON PUBLIC POLICY</u> | <u> </u> |
| | <u>Other, please specify DON MOSS & ASSOCIATES</u> | <u> </u> |
| | <u>Other, please specify</u> | <u> </u> |
| | | <u>0 Total</u> |
| (4) | EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined) | |
| | <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,344</u> |
| | <u>Other, please specify INSTITUTE ON PUBLIC POLICY</u> | <u>889</u> |
| | <u>Other, please specify DON MOSS & ASSOCIATES</u> | <u>356</u> |
| | <u>Other, please specify 0</u> | <u>0</u> |
| | | <u>2,588 Total</u> |
| (5) | Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. | \$ <u>2,821</u> Line <u>10</u> |
| (6) | Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation. | |
| (7) | Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. | \$ <u>59,408</u> |
| | This amount is to be recorded on line 42 of Schedule V. | |
| (8) | Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>YES</u> If YES, attach an explanation of the allocation. | |

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (12) 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 64
- 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. \$ 0
- (13) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Koch Consultants, Ltd.
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. 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	-
34	Facility Rental	-
15	Bad Debt	-
27	Dental costs	6,737
27	Charitable Contributions	-
27	Fines & Penalties	175
27	Miscellaneous	-
	Other Expenses	6,912

Schedule V - Reclassifications				Amount
Lines	Description	Increase	Decrease	
34	Facility Rental	-		
35	Facility Rental		-	
32	Interest Expense	-		
36	Interest Expense		-	
11	Donated labor	105		
1	Donated labor	-		
4	Donated labor	-		
6	Donated labor	-		
21	Donated labor	-		
10	Donated labor	-		
15	Donated labor	-		
10a	Donated labor	-		
12	Donated labor	-		
27	Donated labor		105	
38	Medically necessary transportation	-		
14	Medically necessary transportation		-	
10a	Disability Pay to Benefits			
22	Disability Pay to Benefits			
13	Nurse aid trainer wages	21,431		
1	Nurse aid trainer wages		72	
6	Nurse aid trainer wages		-	
10	Nurse aid trainer wages		-	
10a	Nurse aid trainer wages		2,437	
11	Nurse aid trainer wages		64	
12	Nurse aid trainer wages		18,858	
10a	Nurse aid trainer wages		-	
17	Nurse aid trainer wages		-	
10	Sundry	-		
27	Sundry		-	
39	Dental costs	6,737		
27	Dental costs		6,737	
		28,273	28,273	

Schedule V, Line 39 - Ancillary Service Centers		
Dental costs for 20 visits	\$	6,737

Schedule VI B - Non-paid workers			
Lines	Description	Amount	
31	Donated Labor	\$	105
	Department	Time in Hours	Time in Dollars
	Activities	7.00	105
	Kitchen	-	-
	Laundry	-	-
	Day Program	-	-
	Maintenance	-	-
	Nursing	-	-
	PT/OT	-	-
	Social Service Programs	-	-
	Office	-	-
	Totals	7.00	\$ 105

Schedule VII - Compensation Received From Other Nursing Homes	
Blair Metzger - \$1,943.56 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
John Sauder - \$0.00 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Lee Klopfenstein - \$1,758.66 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate	
Kent Schmidgall - \$1,126.88 - 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	-
A/R - Bequests	-
A/R - Health Insurance	-
A/R - Employees	-

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

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

Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	(729,155)
Income from related parties	4,828,822
Estimated excess for year, Form 990, p.1, line 19	4,099,667

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Pg 4, Column 1, Row 45	1,347,568
Sch. XVIII - A. Staffing and Salary Costs, Pg 20, Column 3, Row 34	(1,347,568)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	1,347,568
Prior Year PTO Accrual	33,247
Current Year PTO Accrual	(36,687)
Prior Year Wage Accrual	19,570
Current Year Wage Accrual	(33,903)
Section 125 Wages not applicable to FICA taxes	(54,623)
Less: Wages over FICA taxation limit of SS Wages (\$0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilities	-
Add: ACCS Wages	
Add: wages included in employee meal calculation	974
Cash basis salaries	1,276,146
FICA rate	7.650%
Calculated FICA	97,625
FICA per Sch XIX	97,625
Variance	0

Sch. XX - General Information		
8. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	2,437
	Activities Director	64
	Day Program	-
	Head Cook	72
	Maintenance	-
	Nursing	-
	Soc. Serv. / QMRP	18,858
		21,431

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

16. Out of State Travel	
	Administration
	Blake Stahl - CEO
	-
	-
	-
	Board of Directors
	Blair Metzger
	362
	John Sauder
	-
	Kent Schmidgall
	210
	Lee Klopfenstein
	327
	898
	Nursing
	Jon D
	-
	-

LINDEN ESTATE - - #0039305

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:

Matt Zimmermann, President/Chairman
Kent Schmidgall, Vice President
Ben Knochel, Treasurer (term ended 05/17/2025)
Heidi Haerr, Secretary
Greg Wiegand, Director
Blair Metzger, Director
Daniel Leman, Director
Lee Klopfenstein, Director
Wendy Sauder, Director
John Sauder, Treasurer (term began 05/17/2025)

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: 07/01/2024 to 06/30/2025



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				
DSP Starting Wage	completed	53	24	960	\$ 18,720.00	1920	\$ 37,440.00	6	240	\$ 4,680.00	480	\$ 9,360.00	5	200	\$ 3,900.00	400	\$ 7,800.00	18	720	\$ 14,040.00	1,440	\$ 28,080.00			
\$ 19.50	still enrolled, not complete	21	12	240	\$ 4,680.00	480	\$ 9,360.00	4	80	\$ 1,560.00	160	\$ 3,120.00	3	60	\$ 1,170.00	120	\$ 2,340.00	2	40	\$ 780.00	80	\$ 1,560.00			
	dropouts	32	16	320	\$ 6,240.00	640	\$ 12,480.00	7	140	\$ 2,730.00	280	\$ 5,460.00	4	80	\$ 1,560.00	160	\$ 3,120.00	5	100	\$ 1,950.00	200	\$ 3,900.00			
				\$ -	0	\$ -			\$ -	0	\$ -			\$ -	0	\$ -			\$ -	0	\$ -				
Total		3180	52	1520	\$ 29,640.00	3040	\$ 59,280.00	17	460	\$ 8,970.00	920	\$ 17,940.00	12	340	\$ 6,630.00	680	\$ 13,260.00	25	860	\$ 16,770.00	1720	\$ 33,540.00			
		8,280		1,280		2,560		380		760			280		560			820		1,640					

23-70335 23-7033: 23-7033585-004

TRAINER WAGES		Classification	Hours	Wages		WAGES				Hours			
				TR	OE	LE	CILA			TR	OE	LE	CILA
Karen	McKillip	11	12.0	\$ 277.18	\$ 29.64	132.49	40.09	29.64	74.96	5.74	1.74	1.28	3.25
Jill	Gingrich	11	12.0	\$ 325.13	\$ 34.76	155.41	47.03	34.76	87.93	5.74	1.74	1.28	3.25
Jennifer	Smith	10ot	120.0	\$ 5,192.27	\$ 555.15	2,481.84	751.08	555.15	1,404.20	57.36	17.36	12.83	32.45
Vicki	Barnett	1	24.0	\$ 672.73	\$ 71.93	321.56	97.31	71.93	181.93	11.47	3.47	2.57	6.49
Jolene	Wake	12m	24.0	\$ 819.72	\$ 87.64	391.81	118.58	87.64	221.68	11.47	3.47	2.57	6.49
				\$ -	\$ -	-	-	-	-	-	-	-	-
				\$ -	\$ -	-	-	-	-	-	-	-	-
Angie	Frank	13	2,080.00	\$ 91,430.56	\$ 9,775.59	43,702.66	13,225.80	9,775.59	24,726.50	994.21	300.88	222.39	562.52
Michelle	Rogers	10s	48.0	\$ 2,317.87	\$ 247.82	1,107.91	335.29	247.82	626.85	22.94	6.94	5.13	12.98
Christina	Wiegand	12r	48.0	\$ 1,602.05	\$ 171.29	765.76	231.74	171.29	433.26	22.94	6.94	5.13	12.98
Katherine	Martin	21	12.0	\$ 424.90	\$ 45.43	203.10	61.46	45.43	114.91	5.74	1.74	1.28	3.25
Felicia	Burton	21	24.00	\$ 640.27	\$ 68.46	306.04	92.62	68.46	173.16	11.47	3.47	2.57	6.49
Jason	Stevenor	21	24.00	\$ 1,604.64	\$ 171.57	767.00	232.12	171.57	433.96	11.47	3.47	2.57	6.49
Lori	Wright	10a	283.00	\$ 15,282.00	\$ 1,633.92	7,304.60	2,210.60	1,633.92	4,132.87	135.27	40.94	30.26	76.53
Andreyra	Thompson	13	2,080.00	\$ 79,855.36	\$ 8,537.99	38,169.86	11,551.40	8,537.99	21,596.10	994.21	300.88	222.39	562.52
	OE			\$ -	\$ -	-	-	-	-	-	-	-	-
Crystal	Streitmatter	17		\$ -	\$ -	-	-	-	-	-	-	-	-
Brenda	Seggebruch	12r		\$ -	\$ -	-	-	-	-	-	-	-	-
	LE			\$ -	\$ -	-	-	-	-	-	-	-	-
Robert	Mooney	12r		\$ -	\$ -	-	-	-	-	-	-	-	-
				\$ -	\$ -	-	-	-	-	-	-	-	-
	CILA			\$ -	\$ -	-	-	-	-	-	-	-	-
Eric	Williams	12r		\$ -	\$ -	-	-	-	-	-	-	-	-
Leigh	Mason	12q		\$ -	\$ -	-	-	-	-	-	-	-	-
				\$ 21,431.19	95,810.04	28,995.14	21,431.19	54,208.31		2,290.04	693.04	512.25	1,295.68

Total trainer wages 41.8378 4791.0

\$ 200,444.68 \$ 3,470.00 Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits

23-70335 23-7033585-(23-7033585-004

Raise 9% 17990.84045 \$ 218,435.52 8,280 26.38 120Hrs 3,165.73 52.5 Hrs 1,385.01

		TR	OE	LE	CILA
Drop-Outs					
Number from this Facility	\$ 4.00	16	7	4	5
Clinical Wages	\$ 3,120.00	\$ 12,480.00	\$ 280.00	\$ 3,120.00	\$ 3,900.00
Classroom Wages	\$ 1,560.00	\$ 6,240.00	\$ 2,730.00	\$ 1,560.00	\$ 1,950.00
In-House Trainer Wages	\$ 1,681.00	\$ 6,724.00	\$ 8,004.00	\$ 1,681.00	\$ 2,101.00
	\$ -				
Completed	\$ -				
Number from this Facility	\$ 5.00	24	6	5	18
Clinical Wages	\$ 5,070.00	\$ 23,400.00	\$ 6,240.00	\$ 5,070.00	\$ 14,820.00
Classroom Wages	\$ 10,140.00	\$ 46,800.00	\$ 640.00	\$ 10,140.00	\$ 29,640.00
In-House Trainer Wages	\$ 10,926.00	\$ 50,426.00	\$ 1,876.00	\$ 10,926.00	\$ 31,937.00

Supplies 4654.38

Schedule V

		Line	TR Change	OE Change	LE Change	CILA Change
Dietary	1	1	(322.00)	(97.00)	(72.00)	(182.00)
Maintenance	6	6	-	-	-	-
Nursing	10	10	-	-	-	-
Therapy	10a	10a	(7,305.00)	(2,211.00)	(1,634.00)	(4,133.00)
OT/PT	10ot	10a	(2,482.00)	(751.00)	(555.00)	(1,404.00)
Activities	11	11	(288.00)	(87.00)	(64.00)	(163.00)
RSD	12r	12	(766.00)	(232.00)	(171.00)	(433.00)
QMRP's	12q	12	-	-	-	-
MSSD	12m	12	(392.00)	(119.00)	(88.00)	(222.00)
Training Wages	13	13	95,810.00	28,995.00	21,431.00	54,208.00
Day Program	15	15	-	-	-	-
Administrator	17	17	-	-	-	-
OJT	12ojt	12	-	-	-	-
Speech	10s	10a	(1,108.00)	(335.00)	(248.00)	(627.00)
HR	21	21				
Adjustment		12	(83,147.00)	(25,163.00)	(18,599.00)	(47,044.00)
			-	-	-	-