

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	5,747			5,747
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	5,747			5,747

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.14%

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

109 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 7/1/1994

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

YES Date _____ NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	26,525	2,761	1,355	30,641	(11)	30,630	0	30,630		1
2	Food Purchase		33,628		33,628		33,628	0	33,628		2
3	Housekeeping		467		467		467	0	467		3
4	Laundry		947		947		947	0	947		4
5	Heat and Other Utilities			19,202	19,202		19,202	0	19,202		5
6	Maintenance	18,938	1,794	4,832	25,564	(15)	25,549	0	25,549		6
7	Other (specify):*				0		0	0	0		7
8	TOTAL General Services	45,463	39,597	25,389	110,449	(26)	110,423	0	110,423		8
	B. Health Care and Programs										
9	Medical Director			442	442		442	0	442		9
10	Nursing and Medical Records	31,974	7,428	0	39,402	(809)	38,593	0	38,593		10
10a	Therapy	233,266	0	714	233,980	(812)	233,168	0	233,168		10a
11	Activities	0	1,203		1,203	(1)	1,202	0	1,202		11
12	Social Services	47,140	148	1,941	49,229	(131)	49,098	0	49,098		12
13	CNA Training	0	0		0	993	993	0	993		13
14	Program Transportation		4,879		4,879	(3,140)	1,739	0	1,739		14
15	Other (specify):* Day Programming	0	0		0		0	0	0		15
16	TOTAL Health Care and Programs	312,380	13,658	3,097	329,135	(3,900)	325,235	0	325,235		16
	C. General Administration										
17	Administrative	17,861			17,861	(3)	17,858	0	17,858		17
18	Directors Fees				0		0	0	0		18
19	Professional Services			3,942	3,942		3,942	0	3,942		19
20	Dues, Fees, Subscriptions & Promotions			1,338	1,338		1,338	0	1,338		20
21	Clerical & General Office Expenses	29,049	2,879		31,928		31,928	0	31,928		21
22	Employee Benefits & Payroll Taxes			107,608	107,608	789	108,397	0	108,397		22
23	Inservice Training & Education			727	727		727	0	727		23
24	Travel and Seminar			1,024	1,024		1,024	(790)	234		24
25	Other Admin. Staff Transportation				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice			10,842	10,842		10,842	0	10,842		26
27	Other (specify):* See Schedule			3,255	3,255	(3,227)	28	0	28		27
28	TOTAL General Administration	46,910	2,879	128,736	178,525	(2,441)	176,084	(790)	175,294		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	404,753	56,134	157,222	618,109	(6,367)	611,742	(790)	610,952		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.

Facility Name & ID Number Linden Estate #0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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			28,837	28,837		28,837	0	28,837		30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0		31
32	Interest			0	0		0	0	0		32
33	Real Estate Taxes			0	0		0	0	0		33
34	Rent-Facility & Grounds			2,520	2,520		2,520	0	2,520		34
35	Rent-Equipment & Vehicles			0	0		0	0	0		35
36	Other (specify):*			0	0		0	0	0		36
37	TOTAL Ownership			31,357	31,357	0	31,357	0	31,357		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			0	0	3,140	3,140	(3,140)	0		38
39	Ancillary Service Centers			0	0	3,227	3,227	0	3,227		39
40	Barber and Beauty Shops			0	0	0	0	0	0		40
41	Coffee and Gift Shops			0	0	0	0	0	0		41
42	Provider Participation Fee			36,750	36,750	0	36,750	0	36,750		42
43	Other (specify):*			0	0	0	0	0	0		43
44	TOTAL Special Cost Centers	0	0	36,750	36,750	6,367	43,117	(3,140)	39,977		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	404,753	56,134	225,329	686,216	0	686,216	(3,930)	682,286		45

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

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(3,930)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,930)		\$ 0	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			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))	\$ (3,930)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 3,140	14	38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,140		47

BHF USE ONLY					
48		49		50	51
					52

Linden Estate

ID# 0039305

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Medical Transportation income	\$ (3,140)	38	1
2	Out-of-state Travel (Board of Directors)	(790)	24	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,930)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	(790)	0	0	0	0	0	0	0	0	0	0	(790)	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	(790)	0	0	0	0	0	0	0	0	0	0	(790)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(790)	0	0	0	0	0	0	0	0	0	0	(790)	29

STATE OF ILLINOIS

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2007 Ending:

Summary B

06/30/2008

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

	Capital Expense	PAGES	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	(3,140)	0	0	0	0	0	0	0	0	0	0	(3,140)	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	(3,140)	0	(3,140)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,930)	0	(3,930)	45									

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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.	100	Apostolic Christian Timber Ridge	Morton	Community	Morton	Residential
		Oakwood Estate	Morton	Residential	Morton	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	34 Office Rent	\$ 2,520			\$ 2,520	\$
2	V						1
3	V						2
4	V						3
5	V						4
6	V						5
7	V						6
8	V						7
9	V						8
10	V						9
11	V						10
12	V						11
13	V						12
14	Total		\$ 2,520			\$ 2,520	\$ *

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	John Knobloch	Director	Director	0.00		0.5			\$	1
2	Roger Aberle	Director	Director	0.00	2,470	0.5		Travel	353	line 24; col.3
3	Dan Schumacher	Chairman	Director	0.00		0.5				3
4	Dennis Mott	Director	Director	0.00	191	0.5		Travel	27	line 24; col.3
5	Ron Hodel	Director	Director	0.00		0.5				5
6	Roger Beutel	Director	Director	0.00		0.5				6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	782	0.5		Travel	112	line 24; col.3
8	Cleve Klopfenstein	Director	Director	0.00		0.5				8
9	Stan Virkler	Vice-Chairman	Director	0.00	638	0.5		Travel	91	line 24; col.3
10	Warren Zahner	Director	Director	0.00	1,450	0.5		Travel	207	line 24; col.3
11										11
12										12
13								TOTAL	\$ 790	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: 07/01/2007

Ending: 6/30/2008

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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	34	Office Rent	Number of Residents	148.99	148.99	\$ 23,467	\$ 0	16	\$ 2,520	1
2										2
3	6,10a,17,21	Wages	Direct Cost/# of Hours	4,435	4,435	96,792	96,792	4,435	96,792	3
4										4
5	22	Benefits	Direct Cost/# of Hours	4,435	4,435	25,228	0	4,435	25,228	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					\$ 145,487	\$ 96,792		\$ 124,540	25

Facility Name & ID Number

Linden Estate

0039305

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 0	\$ 0			\$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)						\$ 0	\$ 0			\$ 0	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Linden Estate COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0039305

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Frame Number of Stories 1

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>87,120</u>	<u>1993</u>	<u>\$ 52,959</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	87,120		\$ 52,959	3

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1994	\$ 244,343	\$ 8,145	30	\$ 8,145	\$	\$ 119,913	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	403--Mirrors			1994	330	0	10	0		330	9
10	429--Landscaping			1994	11,829	0	10	0		11,829	10
11	435--Organizational Costs			1994	11,887	0	5	0		11,887	11
12	436--Light Fixtures			1994	2,445	0	10	0		2,445	12
13	434--Concrete for Water Spillway			1995	393	20	20	20		275	13
14	401--Painting /Dumpster			1994	405	14	30	14		190	14
15	402--Generator Wing			1999	527	18	30	18		167	15
16	598--Livingroom carpet			2003	710	71	10	71		390	16
17	625--Bathroom remodel			2004	899	60	15	60		270	17
18	520--Lobby Carpet			2001	1,256	84	15	84		628	18
19	437--Cabinetry/Countertops/Vanities			1994	8,191	546	15	546		7,977	19
20	430--Lawn Sprinkler System			1994	4,083	163	25	163		2,302	20
21	432--Lighting & Down Spout Trenches			1994	5,315	266	20	266		3,829	21
22	433--Sod for Lawn			1994	5,259	263	20	263		3,703	22
23	431--Concrete for Porches			1994	7,365	368	20	368		5,274	23
24	399--Shelter			1996	8,900	445	20	445		5,785	24
25	441--Heating & Air Conditioning			1994	19,683	1,312	15	1,312		18,971	25
26	428--Asphalt			1994	25,150	1,677	15	1,677		24,394	26
27	438--Fire Prevention System			1994	14,174	567	25	567		8,356	27
28	398--Garage			1994	25,346	1,014	25	1,014		15,209	28
29	440--Electrical			1994	30,570	1,529	20	1,529		22,082	29
30	439--Plumbing			1994	32,699	1,635	20	1,635		23,327	30
31	427--Sewer System			1994	33,335	1,111	30	1,111		19,582	31
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		809	32
33	747--Flooring-Men's bathroom			2006	496	33	15	33		83	33
34	772--Fiber Optic Cable			2006	1,250	83	15	83		208	34
35	860--Interior Painting			2008	5,097	340	15	340		340	35
36	861--Telephone System			2008	610	41	15	41		41	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:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	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	\$	\$ 37	37
38	863--Exit Ramps	2008	3,430	229	15	229		229	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 511,384	\$ 20,392		\$ 20,392	\$ 0	\$ 310,862	70

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 27,175	\$ 3,370	\$ 3,370	\$ 0	10	\$ 15,661	71
72	Current Year Purchases	19,563	3,568	3,568	0	7	5,352	72
73	Fully Depreciated Assets	85,983	1,508	1,508	0	10	85,983	73
74	Disposed Assets		0	0	0			74
75	TOTALS	\$ 132,721	\$ 8,446	\$ 8,446	\$ 0		\$ 106,996	75

D. Vehicle Depreciation (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)	\$ 697,064	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,838	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,838	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)	\$ 417,858	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.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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

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>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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: n/a *

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: \$ 0 Description: Food pump & Oxygen concentrators

(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	<u>n/a</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)	493	536		1,029
4	Clinical Wages (b)	247	1,071		1,318
5	In-House Trainer Wages (c)	105	453		558
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 845	\$ 2,060	\$ 0	\$ 2,905
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,905			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>1</u>
2. From other facilities (f)	<u>29</u>
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	<u>25</u>
TOTAL TRAINED	56

- (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.)

	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.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 400	\$ 362,741	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 455)	172,536	1,633,865	3
4	Supply Inventory (priced at)	3,289	25,600	4
5	Short-Term Investments		4,170,651	5
6	Prepaid Insurance	(1,190)		6
7	Other Prepaid Expenses	2,170	2,018	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employees & other related partik</u>	420	21,176	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 177,625	\$ 6,216,051	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	52,959	262,033	13
14	Buildings, at Historical Cost	293,983	4,215,861	14
15	Leasehold Improvements, at Historical Cost	96,897	547,401	15
16	Equipment, at Historical Cost	241,523	2,095,319	16
17	Accumulated Depreciation (book methods)	(405,969)	(4,297,528)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,887	46,122	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,887)	(46,122)	20
21	Restricted Funds		4,466,049	21
22	Other Long-Term Assets (spe <u>Cash Value of Life Insurance Policies</u>)		36,270	22
23	Other(specify): <u>Investment in other facilities</u>		3,738,284	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 279,393	\$ 11,063,689	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 457,018	\$ 17,279,741	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 4,171	\$ 196,786	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,597	333,917	30
31	Accrued Taxes Payable (excluding real estate taxes)		31,366	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	11,928	146,720	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 51,696	\$ 708,789	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>		23,547	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 23,547	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 51,696	\$ 732,336	46
47	TOTAL EQUITY(page 18, line 24)	\$ 405,322	\$ 16,547,405	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 457,018	\$ 17,279,741	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 392,098	1
2	Restatements (describe):		2
3	Auditor adjustment for prior year	13,029	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 405,127	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(33,379)	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)	\$ (33,379)	17
B. Transfers (Itemize):			
18	Investment from other facilities	33,574	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 33,574	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 405,322	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 645,495	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 645,495	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	3,140	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)	\$ 3,140	23
D. Non-Operating Revenue			
24	Contributions	4,202	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,202	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 652,837	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	110,449	31
32	Health Care	329,135	32
33	General Administration	178,525	33
B. Capital Expense			
34	Ownership	31,357	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	36,750	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 686,216	40
41	Income before Income Taxes (line 30 minus line 40)**	(33,379)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (33,379)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning: 07/01/2007

Ending:

06/30/2008

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,306	1,306	31,974	24.48	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,026	1,917	23,719	12.37	15
16	Dishwashers					16
17	Maintenance Workers	989	989	17,094	17.28	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	701	701	17,861	25.48	20
21	Assistant Administrator	226	226	8,077	35.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,171	1,171	20,972	17.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,895	2,138	47,544	22.24	29
30	Habilitation Aides (DD Homes)	20,302	20,999	236,698	11.27	30
31	Medical Records					31
32	Other Health Care OT/PT	42	42	814	19.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,658	29,489	\$ 404,753 *	\$ 13.73	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	\$ 1,355	1-3	35
36	Medical Director	Flat Fee	208	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	234	10-3	39
40	Physical Therapy Consultant	5	258	10-3	40
41	Occupational Therapy Consultant	8	455	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,393	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	7	549	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	63	\$ 4,452		49

C. CONTRACT NURSES

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

Linden Estate
 FYE 06/30/2008 #0039305
 Sub schedules

Schedule V - Costs Center Expenses

Lines	Description	Amount
43	Facility Bulletin / Newsletter	
36	Investment Management Fees	
36	Interest Expense	
27	Dental costs	3,227
27	Charitable Contributions	
27	Fines & Penalties	
27	Miscellaneous	28
	Other Expenses	3,255

Schedule V - Reclassifications Amount

Lines	Description	Increase	Decrease
6	Communication equipment rental		
35	Communication equipment rental		
11	Donated labor	-	
1	Donated labor	-	
4	Donated labor	-	
6	Donated labor	-	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		-
38	Medically necessary transportation	3,140	
14	Medically necessary transportation		3,140
10a	Disability Pay to Benefits		789
22	Disability Pay to Benefits	789	
13	Nurse aid trainer wages	993	
1	Nurse aid trainer wages		11
6	Nurse aid trainer wages		15
10	Nurse aid trainer wages		809
10a	Nurse aid trainer wages		23
11	Nurse aid trainer wages		1
12	Nurse aid trainer wages		131
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		3
39	Dental costs	3,227	
27	Dental costs		3,227
		8,149	8,149

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 31 visits	\$ 3,227
----------------------------	----------

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

Roger Aberle - \$2470 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Stan Virkler - \$638 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Keith Pflum - \$782 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Dennis Mott - \$191 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Warren Zahner - \$1450 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	

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 on Sale of Assets	-
Increase in Cash Value of Life Insurance	-
Miscellaneous	-
Cost to Market Adjustment	-

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	(33,379)
Income from related parties	219,857
Estimated excess for year, Form 990, p.1, line 18	186,478

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	404,753
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(404,753)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	404,753
Add Prior Year PTO Accrual at 06/30/07	14,598
Less Current Year PTO Accrual at 06/30/08	(17,379)
Add Prior Year Wage Accrual at 06/30/07	12,328
Less Current Year Wage Accrual at 06/30/08	(16,513)
Less: Section 125 Wages not applicable to FICA taxes	(17,509)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$0 x 6.2%/7.65%)	-
Less: Wages Allocated to Linden from other facilities	(96,792)
Add: ACCS Wages	-
Add: wages included in employee meal calculation	5,866
Cash basis salaries	289,352
FICA rate	7.650%
Calculated FICA	22,135
FICA per Sch XIX	22,135
Variance	-

Sch. XX - General Information

12. Nurse Aide Trainer Wages:		
	Administrator	3
	Therapy / PT / OT	23
	Activities Director	1
	Day Program	-
	Head Cook	11
	Maintenance	15
	Nursing	809
	Soc. Serv. / QMRP	131
		993

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

16. Out of State Travel

Administration

Administrator	-
	-

Board of Directors

Stan Virkler	91
Roger Aberle	353
Keith Pflum	112
Dennis Mott	27
Warren Zahner	207
	790

Nursing

None	-
	-

Cell: A5
Comment: Done
2007

Cell: F5
Comment: Done
2004

Cell: F7
Comment: Done
2004

Cell: J11
Comment: Done
2004

Cell: F19
Comment: Done
2004

Cell: F36
Comment: Done
2004

Cell: J44
Comment: Done
2004

Cell: A47
Comment: Done
2007

LINDEN ESTATE #0039305

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Oakwood Estate, Morton, IL #0033712
Apostolic Christian Timber Ridge, IL #0016220

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

Daniel Schumacher, Chairman
Stan Virkler, Vice Chairman
Keith Pflum, Secretary/ Treasurer
John Knobloch, Director (term ended 03/15/2008)
Warren Zahner, Director
Ron Hodel, Director
Cleve Klopfenstein, Director
Roger Aberle, Director
Roger Beutel, Director
Dennis Mott, Director (term began 03/15/2008)

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 #009395

From: 07/01/2007 to 06/30/2008

CLASS DATE	TR												OE												LE												CILA											
	CLASS				OJT				CLASS				OJT				CLASS				OJT				CLASS				OJT																			
	# of Students	Hrs	Wages	HRS	Wages	# of Students	Hrs	Wages	HRS	Wages	# of Students	Hrs	Wages	HRS	Wages	# of Students	Hrs	Wages	HRS	Wages	# of Students	Hrs	Wages	HRS	Wages																							
completed	30	25	1,000	8,500.00	2000	2	80	680.00	160	1,360.00	1	40	340.00	80	680.00	2	80	680.00	160	1,360.00	2	80	680.00	160	1,360.00																							
still enrolled, not complete	19	15	757	1,334.50	314	2	6	51.00	12	102.00	1	23	195.50	46	391.00	1	11	93.50	22	187.00																												
dropouts	26	25	971	3,153.50	792	0	0	-	0	-	1	29	246.50	58	493.00	0	0	-	0	-																												
Total	1797	65	1528	12,988.00	3056	4	86	731.00	172	1,462.00	3	92	782.00	184	1,564.00	3	91	773.50	182	1,547.00																												

TRAINER WAGES

Classification	Hours	Hourly Rate	Wages	Hours/Class	# of Classes	WAGES				Hours					
						TR	OE	LE	CILA	TR	OE	LE	CILA		
Abuse/Neglect/Etc.	17m	7	18.71	137.97	3.5	2	117.32	6.60	7.06	6.99	5.95	0.34	0.36	0.35	19.71
Abuse/Neglect/Etc.	17	3	22.44	67.32	3	1	57.24	3.22	3.45	3.41	2.55	0.14	0.15	0.15	32.44
Aggression Management - 1,2,3	12a	30	17.69	528.00	6	5	448.96	25.27	27.03	26.74	25.51	1.44	1.54	1.52	17.69
Body Mechanics / Eating & Food Sa	10a	9	20.85	187.65	3	3	159.56	8.98	9.81	9.50	7.65	0.43	0.46	0.46	20.85
Community Integration	10a	2	18.90	27.75	0.5	3	23.60	1.33	1.42	1.41	1.28	0.07	0.08	0.08	18.90
Community Integration	11	2	18.51	27.77	0.5	3	23.61	1.33	1.42	1.41	1.28	0.07	0.08	0.08	18.51
Community Integration	12r	2	21.35	32.03	0.5	3	27.23	1.53	1.64	1.62	1.28	0.07	0.08	0.08	21.35
Community Integration	12r	2	17.98	26.25	0.5	3	22.32	1.26	1.34	1.33	1.28	0.07	0.08	0.08	17.98
Community Integration	12r	2	22.44	33.66	0.5	3	28.62	1.61	1.72	1.70	1.28	0.07	0.08	0.08	22.44
CPR	12r	15	22.44	336.60	3	5	286.21	16.11	17.23	17.05	12.75	0.72	0.77	0.76	22.44
CPR	10	81	24.50	1,984.50	3	27	1,687.43	94.97	101.60	100.49	68.87	3.88	4.15	4.10	24.50
Environmental Safety	6	12	24.93	299.16	3	4	254.38	14.32	15.32	15.15	10.20	0.57	0.61	0.61	24.93
First Aid	12r	4	22.44	89.76	2	2	76.32	4.30	4.60	4.55	3.40	0.19	0.20	0.20	22.44
First Aid	10	36	24.50	882.00	2	18	749.97	42.21	45.16	44.66	30.61	1.72	1.84	1.82	24.50
Grief Counseling	12r	4	24.92	99.68	1	4	84.76	4.77	5.10	5.05	3.40	0.19	0.20	0.20	24.92
Human Interaction	10a	11	14.42	151.41	3.5	3	128.74	7.25	7.75	7.67	8.93	0.50	0.54	0.53	14.42
Introduction to DD / Human Rights	12r	40	24.92	996.80	8	5	847.69	47.70	51.03	50.48	34.01	1.91	2.05	2.03	24.92
ISP Development	12a	16	14.90	238.40	4	4	202.71	11.41	12.21	12.07	13.60	0.77	0.82	0.81	14.90
Nursing 1 class	10	12	24.12	289.44	4	3	246.11	13.85	14.82	14.66	10.20	0.57	0.61	0.61	24.12
Nursing 2 class	10	12	33.16	397.92	3	4	338.35	19.04	20.37	20.15	10.20	0.57	0.61	0.61	33.16
Nutrition	1	6	20.67	124.02	3	2	105.45	5.94	6.35	6.28	5.10	0.29	0.31	0.30	20.67
Nutrition	1	8	14.90	89.40	3	2	76.02	4.28	4.58	4.53	5.10	0.29	0.31	0.30	14.90
On the Job Trainer - RN	10	500	24.50	12,250.13			10,421.46	596.55	627.47	620.65	425.37	23.94	25.61	25.33	24.50
Sign Language	10a	6	14.42	86.52	2	3	73.57	4.14	4.43	4.38	5.10	0.29	0.31	0.30	14.42
On the Job Trainer - Aide	12ojt	0	-	-			-	-	-	-	-	-	-	-	-
RDD - Rob Mowery	12r	0	22.44	-	5	-	-	-	-	-	-	-	-	-	-
Speech - Cheryl Hays	10a	0	14.42	-	3	-	-	-	-	-	-	-	-	-	-
Maintenance - Gary Folkerts	6	0	24.93	-	4	-	-	-	-	-	-	-	-	-	-
None - Kathy Kolch RN	10	0	24.50	-	27	-	-	-	-	-	-	-	-	-	-
						16,487.54	927.96	992.71	981.92	694.91	39.11	41.84	41.39		

Total trainer wages 817.25 \$ 19,390.13

	TR	OE	LE	CILA
Drop-Outs	25	0	1	0
Number from this Facility				
Clinical Wages	\$ 6,307.00	\$ -	\$ 493.00	\$ -
Classroom Wages	\$ 3,154.00	\$ -	\$ 247.00	\$ -
In-House Trainer Wages	\$ 1,335.00	\$ -	\$ 105.00	\$ -
Completed	40	4	2	3
Number from this Facility				
Clinical Wages	\$ 9,835.00	\$ 731.00	\$ 536.00	\$ 774.00
Classroom Wages	\$ 19,669.00	\$ 172.00	\$ 1,071.00	\$ 1,547.00
In-House Trainer Wages	\$ 8,323.00	\$ 177.00	\$ 453.00	\$ 655.00

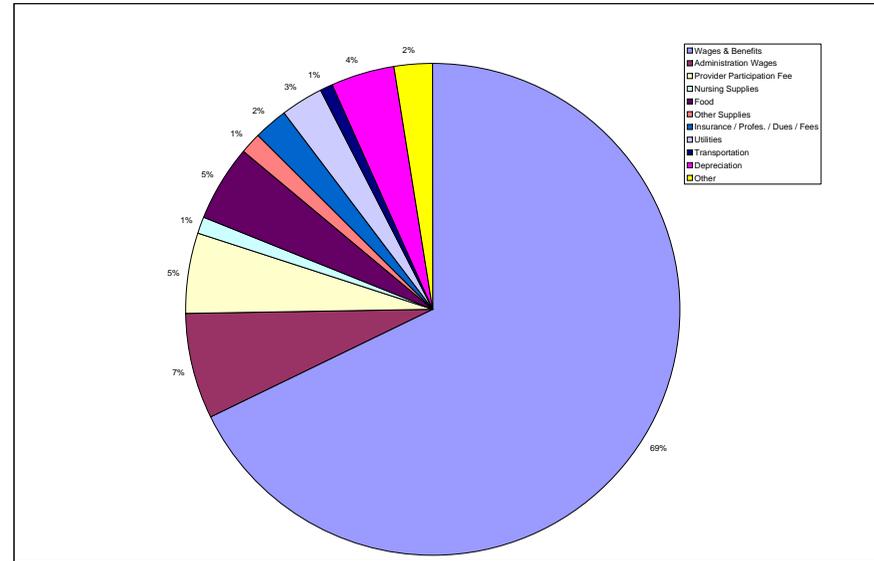
Schedule V

	TR	OE	LE	CILA
Dietary	1	1	(181.00)	(10.00)
Maintenance	6	6	(254.00)	(14.00)
Nursing	10	10	(13,443.00)	(757.00)
Therapy	10a	10a	(24.00)	(1.00)
OT/PT	10ot	10a	(160.00)	(9.00)
Activities	11	11	(24.00)	(1.00)
RSD	12r	12	(1,373.00)	(77.00)
QMRP's	12q	12	(652.00)	(37.00)
MSSD	12m	12	(117.00)	(7.00)
Training Wages	13	13	16,488.00	928.00
Day Program	15	15	-	-
Administrator	17	17	(57.00)	(3.00)
OJT	12ojt	12	-	-
Speech	10s	10a	(202.00)	(11.00)
Adjustment	12		(1.00)	(1.00)

\$ 17,000.00	180	\$ 680.00	\$ 1,360.00
\$ 2,669.00	12	\$ 391.00	\$ 187.00
\$ 6,307.00	0	\$ 493.00	\$ -
\$ 8,500.00	680	\$ 340.00	\$ 680.00
\$ 1,334.50	51	\$ 195.50	\$ 93.50
\$ 3,153.50	-	\$ 246.50	\$ -

Linden Estate -- 0039305

	Wages	Supplies	Other	Total	Reclass- ification	Total	Cost / Day Resident Days \$747	Adjust- ments	Adjusted Total	Cost / Day Resident Days \$747	% of Total Costs	% of Daily Rate	Staff Hours/ Day
A. General Services													
1 Dietary	26,525	2,761	1,355	30,641	(11)	30,630	\$5.33	-	30,630	\$5.33	4.5%	3.7%	0.35
2 Food Purchase	-	33,628	-	33,628	-	33,628	\$6.85	-	33,628	\$6.85	4.9%	4.1%	-
3 Housekeeping	-	467	-	467	-	467	\$0.08	-	467	\$0.08	0.1%	0.1%	-
4 Laundry	-	947	-	947	-	947	\$0.16	-	947	\$0.16	0.1%	0.1%	-
5 Heat and Other Utilities	-	-	19,202	19,202	-	19,202	\$3.34	-	19,202	\$3.34	2.8%	2.3%	-
6 Maintenance	18,938	1,794	4,832	25,564	(15)	25,549	\$4.45	-	25,549	\$4.45	3.7%	3.1%	0.17
7 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
8 TOTAL General Services	45,463	39,597	25,389	110,449	(26)	110,423	\$19.21	-	110,423	\$19.21	16.2%	13.5%	0.52
B. Health Care and Programs													
9 Medical Director	-	-	442	442	-	442	\$0.08	-	442	\$0.08	0.1%	0.1%	-
10 Nursing and Medical Records	31,974	7,428	-	39,402	(809)	38,593	\$6.72	-	38,593	\$6.72	5.7%	4.7%	0.23
10A Therapy	233,266	-	714	233,980	(812)	233,168	\$40.57	-	233,168	\$40.57	34.2%	28.4%	3.54
11 Activities	-	1,203	-	1,203	(1)	1,202	\$0.21	-	1,202	\$0.21	0.2%	0.1%	-
12 Social Services	47,140	148	1,941	49,229	(131)	49,098	\$8.54	-	49,098	\$8.54	7.2%	6.0%	0.33
13 CNA Training	-	-	-	993	-	993	\$0.17	-	993	\$0.17	0.1%	0.1%	-
14 Program Transportation	-	4,879	-	4,879	(3,140)	1,739	\$0.30	-	1,739	\$0.30	0.3%	0.2%	-
15 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
16 TOTAL Health Care and Programs	312,380	13,658	3,097	329,135	(3,900)	325,235	\$56.59	-	325,235	\$56.59	47.7%	39.6%	4.10
C. General Administration													
17 Administrative	17,861	-	-	17,861	(3)	17,858	\$3.11	-	17,858	\$3.11	2.6%	2.2%	0.16
18 Director's Fees	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
19 Professional Services	-	-	3,942	3,942	-	3,942	\$0.69	-	3,942	\$0.69	0.6%	0.5%	-
20 Dues, Fees, Subscriptions & Promotion	-	-	1,338	1,338	-	1,338	\$0.23	-	1,338	\$0.23	0.2%	0.2%	-
21 Clerical & General Office Expenses	29,049	2,879	-	31,928	-	31,928	\$5.56	-	31,928	\$5.56	4.7%	3.9%	0.20
22 Employee Benefits & Payroll Taxes	-	-	107,608	107,608	789	108,397	\$18.86	-	108,397	\$18.86	15.9%	13.2%	-
23 Inservice Training & Education	-	-	727	727	-	727	\$0.13	-	727	\$0.13	0.1%	0.1%	-
24 Travel and Seminar	-	-	1,024	1,024	-	1,024	\$0.18	(790)	234	\$0.04	0.0%	0.0%	-
25 Other Admin. Staff Transportation	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
26 Insurance-Prop.Liab.Malpractice	-	-	10,842	10,842	-	10,842	\$1.89	-	10,842	\$1.89	1.6%	1.3%	-
27 Other (specify):*	-	-	3,255	3,255	(3,227)	28	\$0.00	-	28	\$0.00	0.0%	0.0%	-
28 TOTAL General Administration	46,910	2,879	128,736	178,525	(2,441)	176,084	\$30.64	(790)	175,294	\$30.50	25.7%	21.4%	0.37
TOTAL Operating Expense	404,753	56,134	157,222	618,109	(6,367)	611,742	\$106.45	(790)	610,952	\$106.31	89.5%	74.5%	4.99
D. Ownership													
30 Depreciation	-	-	28,837	28,837	-	28,837	\$5.02	-	28,837	\$5.02	4.2%	3.5%	-
31 Amortization of Pre-Op. & Org.	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
32 Interest	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
33 Real Estate Taxes	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
34 Rent-Facility & Grounds	-	-	2,520	2,520	-	2,520	\$0.44	-	2,520	\$0.44	0.4%	0.3%	-
35 Rent-Equipment & Vehicles	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
36 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
37 TOTAL Ownership	-	-	31,357	31,357	-	31,357	\$5.46	-	31,357	\$5.46	4.6%	3.8%	-
E. Special Cost Centers													
38 Medically Necessary Transportation	-	-	-	-	3,140	3,140	\$0.55	(3,140)	-	\$0.00	0.0%	0.0%	-
39 Ancillary Service Centers	-	-	-	-	3,227	3,227	\$0.56	-	3,227	\$0.56	0.5%	0.4%	-
40 Barber and Beauty Shops	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
41 Coffee and Gift Shops	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
42 Provider Participation Fee	-	-	36,750	36,750	-	36,750	\$6.39	-	36,750	\$6.39	5.4%	4.5%	-
43 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
44 TOTAL Special Cost Centers	-	-	36,750	36,750	6,367	43,117	\$7.50	(3,140)	39,977	\$6.96	5.9%	4.9%	-
45 GRAND TOTAL	404,753	56,134	225,329	686,216	-	686,216	\$119.40	(3,930)	682,286	\$118.72	100.0%	83.2%	4.99
Current Reimbursement Rate							\$142.75			\$142.75	120.2%	100.0%	
Gain/(Loss) Per Resident / Day							23.35			24.03	20.2%	16.8%	
% of Costs Per Area	74.66%	8.18%	17.16%	100.00%									



Wages & Benefi	Administration	Provider Participa	Nursing Supplies	Food	Other Supplie	Insurance / Pr	Utilities	Transportation	Depreciation	Other
\$ 465,451	\$ 46,910	\$ 36,750	\$ 7,428	\$ 33,628	\$ 10,199	\$ 16,122	\$ 19,202	\$ 4,879	\$ 28,837	\$ 16,810