

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,479			5,479	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,479			5,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.82%

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

206 (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: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	24,822	1,810	987	27,619	42	27,661	0	27,661		1
2	Food Purchase		26,947		26,947	0	26,947	0	26,947		2
3	Housekeeping	0	644	0	644	0	644	0	644		3
4	Laundry	0	719	0	719	0	719	0	719		4
5	Heat and Other Utilities			18,679	18,679	0	18,679	0	18,679		5
6	Maintenance	21,953	948	6,604	29,505	40	29,545	0	29,545		6
7	Other (specify):*	0	0	0	0	0	0	0	0		7
8	TOTAL General Services	46,775	31,068	26,270	104,113	82	104,195	0	104,195		8
	B. Health Care and Programs										
9	Medical Director	0	0	0	0	0	0	0	0		9
10	Nursing and Medical Records	22,709	10,049	348	33,106	(2,087)	31,019	0	31,019		10
10a	Therapy	252,889	0	850	253,739	(8,590)	245,149	0	245,149		10a
11	Activities	0	853	0	853	168	1,021	0	1,021		11
12	Social Services	41,402	10	3,331	44,743	(134)	44,609	0	44,609		12
13	CNA Training	0	0	0	0	2,273	2,273	0	2,273		13
14	Program Transportation	0	6,539	0	6,539	0	6,539	0	6,539		14
15	Other (specify):*	0	0	0	0	0	0	0	0		15
16	TOTAL Health Care and Programs	317,000	17,451	4,529	338,980	(8,370)	330,610	0	330,610		16
	C. General Administration										
17	Administrative	27,578	0	0	27,578	(3)	27,575	0	27,575		17
18	Directors Fees			0	0	0	0	0	0		18
19	Professional Services			4,994	4,994	0	4,994	0	4,994		19
20	Dues, Fees, Subscriptions & Promotions			2,014	2,014	0	2,014	0	2,014		20
21	Clerical & General Office Expenses	29,537	2,324	0	31,861	0	31,861	0	31,861		21
22	Employee Benefits & Payroll Taxes			123,477	123,477	8,574	132,051	0	132,051		22
23	Inservice Training & Education			405	405	0	405	0	405		23
24	Travel and Seminar			795	795	0	795	(102)	693		24
25	Other Admin. Staff Transportation		0	0	0	0	0	0	0		25
26	Insurance-Prop.Liab.Malpractice			9,140	9,140	0	9,140	0	9,140		26
27	Other (specify):*	0	0	5,316	5,316	(2,991)	2,325	0	2,325		27
28	TOTAL General Administration	57,115	2,324	146,141	205,580	5,580	211,160	(102)	211,058		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	420,890	50,843	176,940	648,673	(2,708)	645,965	(102)	645,863		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:

07/01/2008

Ending:

06/30/2009

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			26,654	26,654	0	26,654	0	26,654			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):*			0	0	0	0	0	0			36
37	TOTAL Ownership			26,654	26,654	0	26,654	0	26,654			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	2,708	2,708	0	2,708			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	33,488	33,488	0	33,488	0	33,488			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	0	33,488	33,488	2,708	36,196	0	36,196			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	420,890	50,843	237,082	708,815	0	708,815	(102)	708,713			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.)

		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		(102)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(102)	\$	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))	\$	(102)	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	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44					44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

Linden Estate

ID# 0039305

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Out-of-state Travel (Board of Directors)	\$ (102)	24	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(102)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate# 0039305

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	(102)	0	0	0	0	0	0	0	0	0	0	(102)	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	(102)	0	0	0	0	0	0	0	0	0	0	(102)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102)	0	0	0	0	0	0	0	0	0	0	(102)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(102)	0	(102)	45									

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
<u>Apostolic Christian Home for the Handicapped, Inc.</u>	<u>100%</u>	<u>Apostolic Christian Timber Ridge</u>	<u>Morton</u>	<u>Community</u>	<u>Morton</u>	<u>Residential</u>
		<u>Oakwood Estate</u>	<u>Morton</u>	<u>Residential</u>		<u>Services for the</u>
				<u>Services</u>		<u>Developmentally</u>
						<u>Disabled</u>

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		\$			\$	\$	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.

Facility Name & ID Number

Linden Estate

0039305

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Virgil Metzger	Director	Director	0.00	423	0.5		Travel	\$ 61		1
2	Roger Aberle	Director	Director	0.00	2,081	0.5		Travel	297	line 24; col.3	2
3	Dan Schumacher	Chairman	Director	0.00		0.5					3
4	Dennis Mott	Director	Director	0.00	218	0.5		Travel	31	line 24; col.3	4
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	887	0.5		Travel	127		7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Stan Virkler	Vice-Chairman	Director	0.00	715	0.5		Travel	102	line 24; col.3	9
10	Warren Zahner	Director	Director	0.00	936	0.5		Travel	134	line 24; col.3	10
11											11
12											12
13								TOTAL	\$ 752		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:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	0 3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	0 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006		10
	2007		11
	2008		12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

07/01/2008 Ending:

06/30/2009

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? [x] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [x] NO

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Nursing Home, 87,120, 1993, \$ 52,959, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 87,120, (blank), \$ 52,959, 3.

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16			1994	\$ 244,343	\$ 8,145	30	\$ 8,145	\$	\$ 128,058	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		295	13
14	401--Painting /Dumpster			1994	405	14	30	14		204	14
15	402--Generator Wing			1999	527	18	30	18		184	15
16	598--Livingroom carpet			2003	710	71	10	71		461	16
17	625--Bathroom remodel			2004	899	60	15	60		330	17
18	520--Lobby Carpet			2001	1,256	84	15	84		712	18
19	437--Cabinetry/Countertops/Vanities			1994	8,191	214	15	214		8,191	19
20	430--Lawn Sprinkler System			1994	4,083	163	25	163		2,465	20
21	432--Lighting & Down Spout Trenches			1994	5,315	266	20	266		4,095	21
22	433--Sod for Lawn			1994	5,259	263	20	263		3,966	22
23	431--Concrete for Porches			1994	7,365	368	20	368		5,642	23
24	399--Shelter			1996	8,900	445	20	445		6,230	24
25	441--Heating & Air Conditioning			1994	19,683	712	15	712		19,683	25
26	428--Asphalt			1994	25,150	756	15	756		25,150	26
27	438--Fire Prevention System			1994	14,174	567	25	567		8,923	27
28	398--Garage			1994	25,346	1,014	25	1,014		16,222	28
29	440--Electrical			1994	30,570	1,529	20	1,529		23,611	29
30	439--Plumbing			1994	32,699	1,635	20	1,635		24,962	30
31	427--Sewer System			1994	33,335	1,111	30	1,111		20,694	31
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		1,133	32
33	747--Flooring-Men's bathroom			2006	496	33	15	33		116	33
34	772--Fiber Optic Cable			2006	1,250	83	15	83		292	34
35	860--Interior Painting			2008	5,097	340	15	340		680	35
36	861--Telephone System			2008	610	41	15	41		81	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 862--Landscape upgrade	2008	\$ 553	\$ 37	15	\$ 37	\$	\$ 74	37
38 863--Exit Ramps	2008	3,430	229	15	229		457	38
39 884--Bathroom Floors	2009	4,091	584	7	584		584	39
40 885--Lighting Project	2009	2,500	167	15	167		167	40
41 886--Hot water heater	2009	2,899	414	7	414		414	41
42 930--Landscaping	2008	185	12	15	12		12	42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 521,059	\$ 19,719		\$ 19,719	\$ 0	\$ 330,579	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:

07/01/2008

Ending:

06/30/2009

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	\$ 46,738	\$ 6,938	\$ 6,938	\$ 0	9	\$ 27,950	71
72	Current Year Purchases	15,893	0	0	0	7	0	72
73	Fully Depreciated Assets	85,983	0	0	0	10	85,983	73
74	Disposed Assets	0	0	0	0		0	74
75	TOTALS	\$ 148,614	\$ 6,938	\$ 6,938	\$ 0		\$ 113,933	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)	\$ 722,632	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,657	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)	\$ 444,512	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	\$ 0	\$ 0	\$ 0	86
87	Capitalized repairs	0	0	0	87
88	Vehicle Equipment	0	0	0	88
89	Vehicles	0	0	0	89
90	Disposed Assets	0	0	0	90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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	N/A		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

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>	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
	HOURS PER CNA <u>40</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 0	\$	\$	\$ 0
2	Books and Supplies	0	199		199
3	Classroom Wages (a)	0	1,360		1,360
4	Clinical Wages (b)	0	2,720		2,720
5	In-House Trainer Wages (c)	0	2,020		2,020
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 6,299	\$ 0	\$ 6,299
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,299			

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	4
2. From other facilities (f)	65
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	6
TOTAL TRAINED	76

- (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
					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: 07/01/2008

Ending:

06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 400	\$ 290,895	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	166,900	1,895,529	3
4	Supply Inventory (priced at)	3,289	25,600	4
5	Short-Term Investments	0	2,296,577	5
6	Prepaid Insurance	2,359	(2,870)	6
7	Other Prepaid Expenses	0	0	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): <u>Employees</u>	(1,037)	33,972	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 171,911	\$ 4,539,703	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	52,959	382,033	13
14	Buildings, at Historical Cost	303,473	4,715,767	14
15	Leasehold Improvements, at Historical Cost	96,897	572,892	15
16	Equipment, at Historical Cost	257,416	2,567,807	16
17	Accumulated Depreciation (book methods)	(432,622)	(4,660,407)	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	5,649,405	21
22	Other Long-Term Assets (spe Cash Value of Life Ins	0	36,270	22
23	Other(specify): <u>Investment in other facilities</u>	0	5,556,062	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 278,123	\$ 14,819,829	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 450,034	\$ 19,359,532	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 18,927	\$ 1,369,863	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	30,860	579,307	30
31	Accrued Taxes Payable (excluding real estate taxes)	0	(6,786)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36		0	0	36
37		0	0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 49,787	\$ 1,942,384	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	0	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43	<u>Capital Lease</u>	0	17,566	43
44	<u>Rounding Errors</u>	0	1	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 17,567	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 49,787	\$ 1,959,951	46
47	TOTAL EQUITY(page 18, line 24)	\$ 400,247	\$ 17,399,581	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 450,034	\$ 19,359,532	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 405,322	1
2	Restatements (describe):	0	2
3		0	3
4		0	4
5		0	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 405,322	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(73,305)	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	0	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe) Rounding	2	15
16	Other (describe)	0	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (73,303)	17
	B. Transfers (Itemize):		
18	Investment from Other Facilites	68,228	18
19		0	19
20		0	20
21		0	21
22		0	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 68,228	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 400,247	24 *

* This must agree with page 17, line 47.

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

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 634,690	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 634,690	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	0	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	0	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions	3,093	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,093	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	(2,273)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (2,273)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 635,510	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	104,113	31
32	Health Care	338,980	32
33	General Administration	205,580	33
B. Capital Expense			
34	Ownership	26,654	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	33,488	36
D. Other Expenses (specify):			
37	<u>Rounding Errors</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 708,815	40
41	Income before Income Taxes (line 30 minus line 40)**	(73,305)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (73,305)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

07/01/2008

Ending:

06/30/2009

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	921	22,709	24.66	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	104	2,401	23.09	13
14	Head Cook				14
15	Cook Helpers/Assistants	1,186	22,421	16.37	15
16	Dishwashers				16
17	Maintenance Workers	1,226	21,953	17.91	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	677	19,409	28.67	20
21	Assistant Administrator	219	8,169	37.30	21
22	Other Administrative	67	1,996	29.79	22
23	Office Manager				23
24	Clerical	1,394	27,541	19.76	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,863	41,402	19.67	29
30	Habilitation Aides (DD Homes)	18,664	252,061	11.71	30
31	Medical Records				31
32	Other Health C: <u>OT/PT</u>	40	828	20.70	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	26,361	420,890 *	14.19	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	\$ 987	1-3 35
36	Medical Director	Flat Fee	114	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	314	10-3 40
41	Occupational Therapy Consultant	9	536	10a-3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	28	1,953	10a-3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psychologist</u>	7	585	12-3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	73	\$ 4,723	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

Facility Name & ID Number **Linden Estate**

0039305

Report Period Beginning: **07/01/2008**

Ending: **06/30/2009**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jodi Anliker	Administrator	0	\$ 19,409	Workers' Compensation Insurance	\$ 13,737	IDPH License Fee	\$		
Matthew Steffen	Assistant Administrator	0	8,169	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	0		
				FICA Taxes	40,694	Health Care Worker Background Check	154		
				Employee Health Insurance	36,991	(Indicate # of checks performed <u>22</u>)			
				Employee Meals	25,191	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Participation Fees & Certificates	0		
				Employee Physicals	445	Dues (Employers Assn, IHCA)	1,211		
				Employee Promotional	2,354	Subscriptions (journals, news, etc.)			
				Defined Contribution Pension Plan	631	Driving Records Verification	204		
				Employee Scholarships	0				
				Benefits for Transferred wages	3,434	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,578	TOTAL (agree to Schedule V, line 22, col.8)		\$ 123,477	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,569
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							Board of Directors travel	564	
							Administrative travel	0	
							In-State Travel		
							Board of Directors travel	187	
							Administrative travel	44	
							Seminar Expense		
							Less out of state travel	(564)	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 231
C. Professional Services									
Vendor/Payee	Type		Amount						
Koch Consulting	Accounting		\$ 2,715						
Quantum Solutions Corp	Software Consultant		2,279						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,994						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name & ID Number Linden Estate# 0039305Report Period Beginning: 07/01/2008Ending: 06/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$839
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 11
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,462 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,488
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 25,191 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No, they have been adjusted out
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Koch Consulting
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

Schedule V - Costs Center Expenses

Lines	Description	Amount
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
27	Dental costs	2,708
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	(4,717)
	Other Expenses	(2,009)

Schedule V - Reclassifications

Lines	Description	Increase	Decrease
6	Communication equipment rental	-	
35	Communication equipment rental		-
11	Donated labor	173	
1	Donated labor	55	
4	Donated labor	-	
6	Donated labor	55	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		283
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		8,574
22	Disability Pay to Benefits	8,574	
13	Nurse aid trainer wages	2,273	
1	Nurse aid trainer wages		13
6	Nurse aid trainer wages		15
10	Nurse aid trainer wages		2,087
10a	Nurse aid trainer wages		16
11	Nurse aid trainer wages		5
12	Nurse aid trainer wages		134
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		3
39	Dental costs	2,708	
27	Dental costs		2,708
		13,838	13,838

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 28 visits	\$ 2,708
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Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	\$ 283
	Department	Time in Hours
		Time in Dollars
	Activities	23.00 173
	Kitchen	7.25 55
	Laundry	- -
	Maintenance	5.50 55
	Nursing	- -
	PT/OT	- -
	Social Service Programs	- -
	Office	- -
	Totals	35.75 \$ 283

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - \$423 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Roger Aberle - \$2,081 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Stan Virkler - \$715 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Dennis Mott - \$218 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Keith Pflum - \$887 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Warren Zahner - \$936 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

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	(2,273)
Cost to Market Adjustment on Investments	(2,273)

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

Income before taxes per cost report	(73,305)
Income from related parties	(583,107)
Estimated excess for year, Form 990, p.1, line 18	(656,412)

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	420,890
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(420,890)
Variance	-

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

Salaries, Sch V, Line 45, Col 1	420,890
Prior Year PTO Accrual at 06/30/08	17,379
Current Year PTO Accrual at 06/30/09	(14,442)
Prior Year Wage Accrual at 06/30/08	17,005
Current Year Wage Accrual at 06/30/09	(15,251)
Section 125 Wages not applicable to FICA taxes	(12,035)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$0 x 6.2%/7.65%)	-
Wages Allocated to other facilities	106,547
Add: ACCS Wages	
Add: wages included in employee meal calculation	11,851
Cash basis salaries	531,943
FICA rate	7.650%
Calculated FICA	40,694
FICA per Sch XIX	40,694
Variance	(0)

Sch. XX - General Information

12. Nurse Aide Trainer Wages:		
	Administrator	3
	Therapy / PT / OT	16
	Activities Director	5
	Day Program	-
	Head Cook	13
	Maintenance	15
	Nursing	2,087
	Soc. Serv. / QMRP	134
		2,273

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

16. Out of State Travel

Administration

Administrator	-
	-

Board of Directors

Virgil Metzger (Not out of State)	
Stan Virkler	102
Roger Aberle	297
Keith Pflum (Not out of State)	
Dennis Mott	31
Warren Zahner	134
	564

Nursing

None	-
	-

Linden Estate, #0039305

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, IL #0016220

Oakwood Estate, Morton, IL #0033712

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

Daniel Schumacher, Chairman (term ended 03/21/2009)

Stan Virkler, Vice Chairman

Keith Pflum, Secretary/ Treasurer

Virgil Metzger, Director (term began 03/21/2009)

Warren Zahner, Director

Ron Hodel, Director

Cleve Klopfenstein, Director

Roger Aberle, Director

Roger Beutel, Director

Dennis Mott, Director

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.

Linden Estate, #0039305

	Pioneer Park	PARC	TCRC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	1	2	0								
Miles per trip	40	40	5	40								
Gas/Depreciation Price per Mile	\$1.25	\$1.35	\$1.25	\$0.75								
Hours per trip	1 1/4	1 1/4	3/4	1 1/4								
Attendant Wages	\$8.50	\$8.50	\$8.50									
Driver Wages	\$12.75	\$12.75	\$12.75	\$10.50								
Gas & Depreciation	\$ 50.00	\$ 54.00	\$ 6.25	\$ 30.00	\$ 110.25	\$ 166.50	56.63%	-	-	-	14	Sch. VI Ln. 29
Depreciation						\$ -					Sch XI (F)	Sch. VI Ln. 29
Driver Wages	\$ 15.94	\$ 31.88	\$ 9.56	\$ 13.13	\$ 57.38	\$ 82.88	28.19%	-	-	-	6	Sch. VI Ln. 1
Attendant Wages	\$ 10.63	\$ 10.63	\$ 6.38	\$ -	\$ 27.64	\$ 44.65	15.19%	-	-	-	10	Sch. VI Ln. 29
Total	\$ 76.57	\$ 96.51	\$ 22.19	\$ 43.13	\$ 195.27	\$ 294.03		-		-		

Linden Estate -- 0039305

	Wages	Supplies	Other	Total	Reclass- ification	Total	Cost / Day Resident Days 5,479	Adjust- ments	Adjusted Total	Cost / Day Resident Days 5,479	% of Total Costs	% of Daily Rate	Staff Hours/ Day
A. General Services													
1 Dietary	24,822	1,810	987	27,619	42	27,661	\$5.05	-	27,661	\$5.05	3.9%	4.5%	0.24
2 Food Purchase	-	26,947	-	26,947	-	26,947	\$4.92	-	26,947	\$4.92	3.8%	4.4%	-
3 Housekeeping	-	644	-	644	-	644	\$0.12	-	644	\$0.12	0.1%	0.1%	-
4 Laundry	-	719	-	719	-	719	\$0.13	-	719	\$0.13	0.1%	0.1%	-
5 Heat and Other Utilities	-	-	18,679	18,679	-	18,679	\$3.41	-	18,679	\$3.41	2.6%	3.0%	-
6 Maintenance	21,953	948	6,604	29,505	40	29,545	\$5.39	-	29,545	\$5.39	4.2%	4.8%	0.22
7 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
8 TOTAL General Services	46,775	31,068	26,270	104,113	82	104,195	\$19.02	-	104,195	\$19.02	14.7%	16.9%	0.46
B. Health Care and Programs													
9 Medical Director	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
10 Nursing and Medical Records	22,709	10,049	348	33,106	(2,087)	31,019	\$5.66	-	31,019	\$5.66	4.4%	5.0%	0.17
10a Therapy	252,889	-	850	253,739	(8,590)	245,149	\$44.74	-	245,149	\$44.74	34.6%	39.9%	3.41
11 Activities	-	853	-	853	168	1,021	\$0.19	-	1,021	\$0.19	0.1%	0.2%	-
12 Social Services	41,402	10	3,331	44,743	(134)	44,609	\$8.14	-	44,609	\$8.14	6.3%	7.3%	0.34
13 CNA Training	-	-	-	-	2,273	2,273	\$0.41	-	2,273	\$0.41	0.3%	0.4%	-
14 Program Transportation	-	6,539	-	6,539	-	6,539	\$1.19	-	6,539	\$1.19	0.9%	1.1%	-
15 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
16 TOTAL Health Care and Programs	317,000	17,451	4,529	338,980	(8,370)	330,610	\$60.34	-	330,610	\$60.34	46.6%	53.8%	3.92
C. General Administration													
17 Administrative	27,578	-	-	27,578	(3)	27,575	\$5.03	-	27,575	\$5.03	3.9%	4.5%	0.16
18 Directors Fees	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
19 Professional Services	-	-	4,994	4,994	-	4,994	\$0.91	-	4,994	\$0.91	0.7%	0.8%	-
20 Dues, Fees, Subscriptions & Promotion	-	-	2,014	2,014	-	2,014	\$0.37	-	2,014	\$0.37	0.3%	0.3%	-
21 Clerical & General Office Expenses	29,537	2,324	-	31,861	-	31,861	\$5.82	-	31,861	\$5.82	4.5%	5.2%	0.27
22 Employee Benefits & Payroll Taxes	-	-	123,477	123,477	8,574	132,051	\$24.10	-	132,051	\$24.10	18.6%	21.5%	-
23 Inservice Training & Education	-	-	405	405	-	405	\$0.07	-	405	\$0.07	0.1%	0.1%	-
24 Travel and Seminar	-	-	795	795	-	795	\$0.15	(102)	693	\$0.13	0.1%	0.1%	-
25 Other Admin. Staff Transportation	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
26 Insurance-Prop.Liab.Malpractice	-	-	9,140	9,140	-	9,140	\$1.67	-	9,140	\$1.67	1.3%	1.5%	-
27 Other (specify):*	-	-	5,316	5,316	(2,991)	2,325	\$0.42	-	2,325	\$0.42	0.3%	0.4%	-
28 TOTAL General Administration	57,115	2,324	146,141	205,580	5,580	211,160	\$38.54	(102)	211,058	\$38.52	29.8%	34.3%	0.43
TOTAL Operating Expense	420,890	50,843	176,940	648,673	(2,708)	645,965	\$117.90	(102)	645,863	\$117.88	91.1%	105.0%	4.81
D. Ownership													
30 Depreciation	-	-	26,654	26,654	-	26,654	\$4.86	-	26,654	\$4.86	3.8%	4.3%	-
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	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
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	-	-	26,654	26,654	-	26,654	\$4.86	-	26,654	\$4.86	3.8%	4.3%	-
Ancillary Expense													
E. Special Cost Centers													
38 Medically Necessary Transportation	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
39 Ancillary Service Centers	-	-	-	-	2,708	2,708	\$0.49	-	2,708	\$0.49	0.4%	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	-	-	33,488	33,488	-	33,488	\$6.11	-	33,488	\$6.11	4.7%	5.4%	-
43 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
44 TOTAL Special Cost Centers	-	-	33,488	33,488	2,708	36,196	\$6.61	-	36,196	\$6.61	5.1%	5.9%	-
45 GRAND TOTAL	420,890	50,843	237,082	708,815	-	708,815	\$129.37	(102)	708,713	\$129.35	100.0%	115.2%	4.81
Current Reimbursement Rate							\$112.26			\$112.26	86.8%	100.0%	
Gain/(Loss) Per Resident / Day							(17.11)			(17.09)	-13.2%	-15.2%	
							-15.2%			-15.2%			
% of Costs Per Area	76.80%	7.17%	16.03%	100.00%									