

Facility Name & ID Number Linden Estate

0039305 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,430			5,430	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,430			5,430	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.98%

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

27 (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)

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 05/09/1994

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: 06/30/14 Fiscal Year: 06/30/14

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

Facility Name & ID Number

Linden Estate

0039305

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	32,418	3,236	720	36,374	(8)	36,366	0	36,366		1
2	Food Purchase		36,420		36,420	0	36,420	0	36,420		2
3	Housekeeping	6,314	1,121	0	7,435	0	7,435	0	7,435		3
4	Laundry	0	4,444	0	4,444	0	4,444	0	4,444		4
5	Heat and Other Utilities			18,553	18,553	0	18,553	0	18,553		5
6	Maintenance	12,371	1,756	8,977	23,104	(15)	23,089	0	23,089		6
7	Other (specify):*	0	0	0	0	0	0	0	0		7
8	TOTAL General Services	51,103	46,977	28,250	126,330	(23)	126,307	0	126,307		8
	B. Health Care and Programs										
9	Medical Director				0		0	0	0		9
10	Nursing and Medical Records	56,074	11,949	1,358	69,381	(119)	69,262	0	69,262		10
10a	Therapy	262,261	0	924	263,185	(410)	262,775	0	262,775		10a
11	Activities	0	837	0	837	209	1,046	0	1,046		11
12	Social Services	51,197	0	6,054	57,251	(88)	57,163	0	57,163		12
13	CNA Training	0	0	0	0	265	265	0	265		13
14	Program Transportation	0	0	3,692	3,692	0	3,692	0	3,692		14
15	Other (specify):*	0	0	0	0	0	0	0	0		15
16	TOTAL Health Care and Programs	369,532	12,786	12,028	394,346	(143)	394,203	0	394,203		16
	C. General Administration										
17	Administrative	0	0	0	0	0	0	0	0		17
18	Directors Fees			0	0	0	0	0	0		18
19	Professional Services			6,592	6,592	0	6,592	0	6,592		19
20	Dues, Fees, Subscriptions & Promotions			1,695	1,695	0	1,695	(137)	1,558		20
21	Clerical & General Office Expenses	65,009	3,060	0	68,069	0	68,069	0	68,069		21
22	Employee Benefits & Payroll Taxes			121,331	121,331	381	121,712	0	121,712		22
23	Inservice Training & Education			649	649	0	649	0	649		23
24	Travel and Seminar			708	708	0	708	(617)	91		24
25	Other Admin. Staff Transportation		0	238	238	0	238	0	238		25
26	Insurance-Prop.Liab.Malpractice			10,547	10,547	0	10,547	0	10,547		26
27	Other (specify):*	0	0	2,838	2,838	(2,708)	130	0	130		27
28	TOTAL General Administration	65,009	3,060	144,598	212,667	(2,327)	210,340	(754)	209,586		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	485,644	62,823	184,876	733,343	(2,493)	730,850	(754)	730,096		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:

07/01/2013

Ending:

06/30/2014

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			20,810	20,810	0	20,810	0	20,810			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			20,810	20,810	0	20,810	0	20,810			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	2,493	2,493	0	2,493			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	35,991	35,991	0	35,991	0	35,991			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	0	35,991	35,991	2,493	38,484	0	38,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	485,644	62,823	241,677	790,144	0	790,144	(754)	789,390			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: 07/01/2013

Ending: 06/30/2014

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	\$	6	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance		26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		15		24
25	Fund Raising, Advertising and Promotional	(137)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137)		\$ 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*	\$ 215		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)	\$ 215		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 78		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.			\$		38
39	Dental	x				39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Linden EstateID# 0039305Report Period Beginning: 07/01/2013Ending: 06/30/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset day draining transportation income	\$	10	1
2	Offset day draining transportation income		14	2
3	Out-of-state Travel (Administrative Staff)	(123)	24	3
4	Depreciation of non-care vehicles		30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming		22	6
7	Out-of-state Travel (Board of Directors)	(494)	24	7
8	Interest Expense		32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(617)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate# 0039305

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	(137)	0	0	0	0	0	0	0	0	0	0	(137)	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	(617)	0	0	0	0	0	0	0	0	0	0	(617)	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	(754)	0	0	0	0	0	0	0	0	0	0	(754)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(754)	0	0	0	0	0	0	0	0	0	0	(754)	29

STATE OF ILLINOIS

Facility Name & ID Number Linden Estate# 0039305

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

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

	Capital Expense	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)	
	D. Ownership													
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)	(754)	0	0	0	0	0	0	0	0	0	0	(754)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Apostolic Christian Home for the Handicapped, Inc.</u>		<u>Timber Ridge</u>	<u>Morton</u>	<u>Community Residential</u>	<u>Morton</u>	<u>CILA Services</u>
		<u>Oakwood Estate</u>	<u>Morton</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:

07/01/2013

Ending:

06/30/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Virgil Metzger	BOD						1
2	Roger Aberle	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Royce Schieler	BOD						5
6	Roger Beutel	BOD						6
7	Bryan Stoller	BOD						7
8	Cleve Klopfenstein	BOD						8
9	Ed Leman	BOD						9
10	Tim Steffen	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Virgil Metzger	Vice-Chairman	Director	0.00	684	0.5		Travel	\$ 133	1
2	Roger Aberle	Director	Director	0.00	1,473	0.5		Travel	288	line 24; col. 3 2
3	Paul Kelson	Director	Director	0.00	193	0.5		Travel	38	3
4	Dennis Mott	Chairman	Director	0.00	422	0.5		Travel	82	line 24; col. 3 4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0	5
6	Bryan Stoller	Director	Director	0.00	221	0.5		Travel	43	6
7	Cleve Klopfenstein	Director	Director	0.00	0	0.5			0	7
8	Ed Leman	Director	Director	0.00	0	0.5			0	8
9	Tim Steffen	Director	Director	0.00	638	0.5		Travel	125	line 24; col. 3 9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0	10
11										11
12										12
13								TOTAL	\$ 708	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: 07/01/2013

Ending: 6/30/2014

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					\$	\$		\$	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:

07/01/2013

Ending:

06/30/2014

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		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 0	\$ 0			\$ 0						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0						
15	TOTALS (line 9+line14)						\$ 0	\$ 0			\$ 0						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009 _____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="width: 5%; text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="width: 5%; text-align: right;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: right;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: right;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: right;">16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

NOTES:

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

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

07/01/2013 Ending:

06/30/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>LTC Facility</u>	<u>9,823</u>	<u>1994</u>	<u>\$ 52,959</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	9,823		\$ 52,959	3

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1994	\$ 244,343	\$ 8,145	30	\$ 8,145	\$	\$ 168,782	4
5				0	0		0		0	5
6										6
7										7
8										8
	Improvement Type**									
9	#REF!			0	0		0		0	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	19	20	19		393	13
14	401--Painting /Dumpster		1994	405	14	30	14		271	14
15	402--Generator Wing		1999	527	18	30	18		272	15
16	598--Livingroom carpet		2003	710	0	10	0		710	16
17	625--Bathroom remodel		2004	899	60	15	60		629	17
18	520--Lobby Carpet		2001	1,256	84	15	84		1,131	18
19	437--Cabinetry/Countertops/Vanities		1994	8,191	0	15	0		8,191	19
20	430--Lawn Sprinkler System		1994	4,083	163	25	163		3,281	20
21	432--Lighting & Down Spout Trenches		1994	5,315	157	20	157		5,315	21
22	433--Sod for Lawn		1994	5,259	242	20	242		5,259	22
23	431--Concrete for Porches		1994	7,365	250	20	250		7,365	23
24	399--Shelter		1996	8,900	445	20	445		8,455	24
25	441--Heating & Air Conditioning		1994	19,683	0	15	0		19,683	25
26	428--Asphalt		1994	25,150	0	15	0		25,150	26
27	438--Fire Prevention System		1994	14,174	567	25	567		11,757	27
28	398--Garage		1994	25,346	1,014	25	1,014		21,291	28
29	440--Electrical		1994	30,570	846	20	846		30,570	29
30	439--Plumbing		1994	32,699	1,198	20	1,198		32,699	30
31	427--Sewer System		1994	33,335	1,111	30	1,111		26,249	31
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.		2006	4,854	324	15	324		2,750	32
33	747--Flooring-Men's bathroom		2006	496	33	15	33		281	33
34	772--Fiber Optic Cable		2006	1,250	83	15	83		708	34
35	860--Interior Painting		2008	5,097	340	15	340		2,379	35
36	861--Telephone System		2008	610	41	15	41		285	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	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	\$	\$ 258	37
38	863--Exit Ramps	2008	3,430	229	15	229		1,601	38
39	884--Bathroom Floors	2009	4,091	584	7	584		3,507	39
40	885--Lighting Project	2009	2,500	167	15	167		1,000	40
41	886--Hot water heater	2009	2,899	414	7	414		2,485	41
42	1062--Men's Floor Coverings	2014	5,284	352	15	352		414	42
43			0	0		0		0	43
44			0	0		0		0	44
45			0	0		0		0	45
46			0	0		0		0	46
47			0	0		0		0	47
48			0	0		0		0	48
49			0	0		0		0	49
50			0	0		0		0	50
51			0	0		0		0	51
52			0	0		0		0	52
53			0	0		0		0	53
54			0	0		0		0	54
55			0	0		0		0	55
56			0	0		0		0	56
57			0	0		0		0	57
58			0	0		0		0	58
59			0	0		0		0	59
60			0	0		0		0	60
61			0	0		0		0	61
62			0	0		0		0	62
63			0	0		0		0	63
64			0	0		0		0	64
65			0	0		0		0	65
66			0	0		0		0	66
67			0	0		0		0	67
68			0	0		0		0	68
69			0	0		0		0	69
70	TOTAL (lines 4 thru 69)		\$ 525,828	\$ 16,937		\$ 16,937	\$ 0	\$ 419,282	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:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 28,961	\$ 3,523	\$ 3,523	\$ 0	11	\$ 20,260	71
72	Current Year Purchases	0	0	0	0		0	72
73	Fully Depreciated Assets	123,957	352	352	0	9	123,957	73
74	Disposed Assets	0	0	0	0		0	74
75	TOTALS	\$ 152,918	\$ 3,875	\$ 3,875	\$ 0		\$ 144,217	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 731,705	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,812	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,812	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)	\$ 563,499	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	Conversion from Ambulatory	\$ 0	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: 07/01/2013

Ending: 06/30/2014

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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	<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.

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? <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>40</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>80</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	#REF!	661		#REF!
3	Classroom Wages (a)	0	2,482		2,482
4	Clinical Wages (b)	0	4,964		4,964
5	In-House Trainer Wages (c)	0	738		738
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ #REF!	\$ 8,845	\$ 0	\$ #REF!
10	SUM OF line 9, col. 1 and 2 (e)	\$ #REF!			

- (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.

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	7
2. From other facilities (f)	45
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	12
TOTAL TRAINED	64

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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# 0039305Report Period Beginning: 07/01/2013

Ending:

06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(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	\$ 300	\$ 188,291	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	85,907	1,274,626	3
4	Supply Inventory (priced at)	321	20,456	4
5	Short-Term Investments	0	2,871,477	5
6	Prepaid Insurance	0	48,270	6
7	Other Prepaid Expenses	0	0	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify):	15	409,366	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 86,543	\$ 4,812,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	52,959	572,033	13
14	Buildings, at Historical Cost	308,076	7,216,877	14
15	Leasehold Improvements, at Historical Cost	96,897	597,530	15
16	Equipment, at Historical Cost	188,543	2,665,971	16
17	Accumulated Depreciation (book methods)	(478,483)	(5,878,160)	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	11,736,008	21
22	Other Long-Term Assets (specify):	0	41,448	22
23	Other(specify): <u>Investment in other facilities</u>	0	9,573,788	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 167,992	\$ 26,525,495	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 254,535	\$ 31,337,981	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,316	\$ 1,026,209	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	21,917	479,789	30
31	Accrued Taxes Payable (excluding real estate taxes)	629	71,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	13,338	250,001	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	<u>Rounding</u>	2	245	36
37			0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 40,202	\$ 1,828,046	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	48,850	43
44			0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 48,850	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 40,202	\$ 1,876,896	46
47	TOTAL EQUITY(page 18, line 24)	\$ 214,333	\$ 29,461,085	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 254,535	\$ 31,337,981	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 150,935	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 150,935	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(149,363)	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)	\$ (149,363)	17
B. Transfers (Itemize):			
18	Investment from other facilities	212,761	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 212,761	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 214,333	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Linden Estate# 0039305Report Period Beginning: 07/01/2013Ending: 06/30/2014

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 640,263	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 640,263	3
B. Ancillary Revenue			
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	0	6
7	Oxygen	0	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	0	21
22	Laundry	0	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions	733	24
25	Interest and Other Investment Income***	0	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 733	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	See attached schedule	0	28
28a	Cost to Market Gain on Investments	0	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 640,996	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	126,330	31
32	Health Care	394,346	32
33	General Administration	212,667	33
B. Capital Expense			
34	Ownership	20,810	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	35,991	36
D. Other Expenses (specify):			
37			37
38	Cost to Market Loss on Investments	0	38
39	Loss on Sale of Assets	215	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 790,359	40
41	Income before Income Taxes (line 30 minus line 40)**	(149,363)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (149,363)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>ICFID/DD</u>	640,263	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 640,263	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

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

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

Facility Name & ID Number Linden Estate

0039305

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	444	444	\$ 12,761	\$ 28.74	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,700	1,700	41,201	24.24	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	0	0	0		5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	330	330	8,645	26.20	13
14	Head Cook	902	902	9,917	10.99	14
15	Cook Helpers/Assistants	929	1,053	11,789	11.20	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,110	1,110	17,043	15.35	17
18	Housekeepers	614	614	6,429	10.47	18
19	Laundry	0	0	0		19
20	Administrator	725	725	27,396	37.79	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,089	1,089	29,107	26.73	22
23	Office Manager	264	264	5,422	20.54	23
24	Clerical	229	229	3,335	14.56	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	1,950	2,087	51,635	24.74	29
30	Habilitation Aides (DD Homes)	22,042	23,343	260,964	11.18	30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	32,328	33,890	\$ 485,644 *	\$ 14.33	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	\$ 720	1-3	35
36	Medical Director	Flat Fee	300	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	1,058	10-3	39
40	Physical Therapy Consultant	6	393	10-3	40
41	Occupational Therapy Consultant	8	531	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	33	2,394	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) <u>Psychologist Consult.</u>	9	750	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	81	\$ 6,146		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

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 07/01/2013 Ending: 06/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$839
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,977 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,991
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 165 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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Koch Consultants, LTD.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V - Costs Center Expenses

Lines	Description	Amount
1	Day Program Costs	
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	
36	Interest Expense	
15	Bad Debt	
27	Dental costs	#REF!
27	Charitable Contributions	#REF!
27	Fines & Penalties	
27	Miscellaneous	#REF!
	Other Expenses	#REF!

Schedule V - Reclassifications

Lines	Description	Increase	Decrease
6	Communication equipment rental	-	
35	Communication equipment rental		-
32	Interest Expense	-	
36	Interest Expense		-
11	Donated labor	#REF!	
1	Donated labor	#REF!	
4	Donated labor	#REF!	
6	Donated labor	#REF!	
21	Donated labor	#REF!	
10	Donated labor	#REF!	
10a	Donated labor	#REF!	
12	Donated labor	#REF!	
27	Donated labor		#REF!
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		#REF!
22	Disability Pay to Benefits	#REF!	
13	Nurse aid trainer wages	265	
1	Nurse aid trainer wages		8
6	Nurse aid trainer wages		15

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	#REF!
Department	Time in Hours	Time in Dollars
Activities	#REF!	#REF!
Kitchen	#REF!	#REF!
Laundry	#REF!	#REF!
Maintenance	#REF!	#REF!
Nursing	#REF!	#REF!
PT/OT	#REF!	#REF!
Social Service Programs	#REF!	#REF!
Office	#REF!	#REF!
Totals	#REF!	#REF!

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - \$683.63 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
 Roger Aberle - \$1,473.45 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
 Paul Kelson - \$192.67 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
 Dennis Mott - \$421.61 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
 Bryan Stoller - \$220.87 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
 Tim Steffen - \$638.08 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 9; Other Current Assets

A/R - N.A. Training	-
A/R - Bequests	-
A/R - Health Insurance	-
A/R - Employees	-
	-

Sch. XVIII - A. Staffing

Sch. V. Cost Center Expense
 Sch. XVIII - A. Staffing a
 Variance

Schedule XIX, D - Employment

Salaries, Sch V, Line 45,
 Prior Year PTO Accrual
 Current Year PTO Accrual
 Prior Year Wage Accrual
 Current Year Wage Accrual
 Section 125 Wages not a
 Less: Wages over FICA tax
 Add: Wages Allocated to
 Add: ACCS Wages
 Add: wages included in e
 Cash basis salaries
 FICA rate
 Calculated FICA
 FICA per Sch XIX
 Variance

Sch. XX - General Information

12. Nurse Aide Trainer V

10	Nurse aid trainer wages		119
10a	Nurse aid trainer wages		29
11	Nurse aid trainer wages		6
12	Nurse aid trainer wages		88
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
39	Dental costs	#REF!	
27	Dental costs		#REF!
		#REF!	#REF!

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 24 visits	\$ 2,493
----------------------------	----------

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	#REF!
Gain/(Loss) on Sale of Assets	-
Increase in Cash Value of Life Insurance	-
Miscellaneous	-
Cost to Market Adjustment on Investments	- ###
	#REF!

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

Income before taxes per cost report	(149,363)
Income from related parties	#REF!
Estimated excess for year, Form 990, p.1, line 18	#REF!

14. A portion of office sp

16. Out of State Travel

g and Salary Costs

nses, Column 1, Row 45	485,644
nd Salary Costs, Column 3, Row 34	<u>(485,644)</u>
	<u>-</u>

mployee Benefits and Payroll Taxes - FICA calculation

Col 1	485,644
	(12,242)
l	13,029
	7,140
ial	(9,036)
pplicable to FICA taxes	(16,234)
axation limit of SS Wages (\$0 x 6.2%/7.65%)	-
other facilites	23,320
mployee meal calculation	<u>491,621</u>
	7.650%
	<u>37,609</u>
	<u>37,609</u>
	<u>(0)</u>

rmation

Vages:

Administrator	-
Therapy / PT / OT	29
Activities Director	6
Day Program	-
Head Cook	8
Maintenance	15
Nursing	119
Soc. Serv. / QMRP	88
	<u>265</u>

Space is allocated to related entities based on number of beds.

Administration

Administrator	123
Assistant Administrator	-
	<u>123</u>

Board of Directors

Virgil Metzger (Not out of State)	
Roger Aberle	288
Paul Kelson (Not out of State)	
Dennis Mott	82
Bryan Stoller (Not out of State)	
Tim Steffen	125
	<u>494</u>

Nursing

None	-
	<u>-</u>

LINDEN ESTATE, IL #0039305

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

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

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

Dennis Mott, Chairman
Virgil Metzger, Vice Chairman
Roger Beutel, Secretary/Treasurer
Bryan Stoller, Director
Ed Leman, Director
Roger Aberle, Director
Tim Steffen, Director
Virgil Metzger, Vice Chairman
Paul Kelson, Director
Cleve Klopfenstein, Chairman (term ended 5/20/2014)
Royce Scheiler, Director (term began 05/20/2014)

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, IL #0039305

From: 07/01/2013

to

06/30/2014

72

CLASS DATE	TR					OE					# of Students	
	# of Students	CLASS		OJT		# of Students	CLASS		OJT			
		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages		
completed	52	33	1,320	\$ 11,220.00	2640	\$ 22,440.00	1	40	\$ 340.00	80	\$ 680.00	7
still enrolled, not complete	7	3	42	\$ 357.00	84	\$ 714.00	1	30	\$ 255.00	60	\$ 510.00	2
dropouts	12	11	48	\$ 408.00	96	\$ 816.00	0		\$ -	0	\$ -	0
				\$ -	0	\$ -			\$ -	0	\$ -	
Total	2242	47	1410	\$ 11,985.00	2820	\$ 23,970.00	2	70	\$ 595.00	140	\$ 1,190.00	9

WAGES

<u>TRAINER WAGES</u>	<u>Classification</u>	<u>Hours</u>	<u>Hourly Rate</u>	<u>Wages</u>	<u>TR</u>	<u>OE</u>	<u>LE</u>	<u>CILA</u>	<u>TR</u>
Kristen Dancey	10			\$ -	-	-	-	-	-
Cheryl Hays	10s	42.00		\$ 672.00	422.62	20.98	87.52	140.87	26.41
Don Bowers	12q	36.00		\$ 694.08	436.51	21.67	90.40	145.50	22.64
Evie Mogler	12r	2.00		\$ 46.10	28.99	1.44	6.00	9.66	1.26
Gary Folkerts	6	18.00		\$ 486.00	305.65	15.17	63.30	101.88	11.32
Crystal Streitmatter	17			\$ -	-	-	-	-	-
Jenny Smith	10ot	12.00		\$ 271.68	170.86	8.48	35.38	56.95	7.55
Kathy Kelch	10	142.00		\$ 3,821.22	2,403.18	119.31	497.68	801.06	89.30
Leigh Wamsley	12q			\$ -	-	-	-	-	-
Lori Brittain	1	10.00		\$ 251.80	158.36	7.86	32.79	52.79	6.29
Sam Getz	10			\$ -	-	-	-	-	-
Isaac Aberle	11			\$ -	-	-	-	-	-
Randy Mogler	12r	45.00		\$ 1,157.40	727.89	36.14	150.74	242.63	28.30
Rob Mooney	12r	4.00		\$ 95.84	60.27	2.99	12.48	20.09	2.52
Sherrie Parnham	12r	2.00		\$ 43.68	27.47	1.36	5.69	9.16	1.26
Tina Leman	12m	18.00		\$ 405.00	254.71	12.64	52.75	84.90	11.32
Mark Baker	12q	24.00		\$ 361.92	227.61	11.30	47.14	75.87	15.09
Isaac Aberle	11	10.00		\$ 192.40	121.00	6.01	25.06	40.33	6.29
Gayle Fidler	10			\$ -	-	-	-	-	-
Vikki Steele	15			\$ -	-	-	-	-	-
Stephanie Barth	10a			\$ -	-	-	-	-	-
Kathy Kelch	10			\$ -	-	-	-	-	-
Gayle Fidler	10			\$ -	-	-	-	-	-
OE									
Jodi Fehr	17			\$ -	-	-	-	-	-
Evie Mogler	12r			\$ -	-	-	-	-	-

LE					-	-	-	-	-
Rob Mooney	12r		\$	-	-	-	-	-	-
			\$	-	-	-	-	-	-
CILA					-	-	-	-	-
Sherrie Parnham	12r		\$	-	-	-	-	-	-
Leigh Wamsley	12q		\$	-	-	-	-	-	-
					<u>5,345.12</u>	<u>265.36</u>	<u>1,106.93</u>	<u>1,781.71</u>	<u>229.55</u>

COMPLETED FOR 2014

<u>LE</u>				<u>CILA</u>				
<u>CLASS</u>		<u>OJT</u>		<u># of Students</u>	<u>CLASS</u>		<u>OJT</u>	
<u>Hrs</u>	<u>Wages</u>	<u>HRS</u>	<u>Wages</u>		<u>Hrs</u>	<u>Wages</u>	<u>HRS</u>	<u>Wages</u>
280	\$ 2,380.00	560	\$ 4,760.00	11	440	\$ 3,740.00	880	\$ 7,480.00
12	\$ 102.00	24	\$ 204.00	1	30	\$ 255.00	60	\$ 510.00
	\$ -	0	\$ -	1		\$ -	0	\$ -
	\$ -	0	\$ -			\$ -	0	\$ -
292	\$ 2,482.00	584	\$ 4,964.00	13	470	\$ 3,995.00	940	\$ 7,990.00

Hours

<u>OE</u>	<u>LE</u>	<u>CILA</u>	
-	-	-	8
1.31	5.47	8.80	7.25
1.12	4.69	7.55	
0.06	0.26	0.42	22.936
0.56	2.34	3.77	
-	-	-	
0.37	1.56	2.52	20
4.43	18.49	29.77	5.734
-	-	-	
0.31	1.30	2.10	
-	-	-	
-	-	-	
1.40	5.86	9.43	
0.12	0.52	0.84	
0.06	0.26	0.42	
0.56	2.34	3.77	
0.75	3.13	5.03	
0.31	1.30	2.10	
-	-	-	
-	-	-	
-	-	-	
-	-	-	
-	-	-	
-	-	-	
-	-	-	
-	-	-	
-	-	-	

-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
11.40	47.54	76.52

LINDEN ESTATE, IL

#0039305

	Wages	Supplies	Other	Total	Reclass-ification	Total	Cost / Day Resident Days 5,430	Adjust-ments	Adjusted Total
A. General Services									
1 Dietary	32,418	3,236	720	36,374	(8)	36,366	\$6.70	-	36,366
2 Food Purchase	-	36,420	-	36,420	-	36,420	\$6.71	-	36,420
3 Housekeeping	6,314	1,121	-	7,435	-	7,435	\$1.37	-	7,435
4 Laundry	-	4,444	-	4,444	-	4,444	\$0.82	-	4,444
5 Heat and Other Utilities	-	-	18,553	18,553	-	18,553	\$3.42	-	18,553
6 Maintenance	12,371	1,756	8,977	23,104	(15)	23,089	\$4.25	-	23,089
7 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
8 TOTAL General Services	51,103	46,977	28,250	126,330	(23)	126,307	\$23.26	-	126,307
B. Health Care and Programs									
9 Medical Director	-	-	-	-	-	-	\$0.00	-	-
10 Nursing and Medical Records	56,074	11,949	1,358	69,381	(119)	69,262	\$12.76	-	69,262
10a Therapy	262,261	-	924	263,185	(410)	262,775	\$48.39	-	262,775
11 Activities	-	837	-	837	209	1,046	\$0.19	-	1,046
12 Social Services	51,197	-	6,054	57,251	(88)	57,163	\$10.53	-	57,163
13 CNA Training	-	-	-	-	265	265	\$0.05	-	265
14 Program Transportation	-	-	3,692	3,692	-	3,692	\$0.68	-	3,692
15 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
16 TOTAL Health Care and Programs	369,532	12,786	12,028	394,346	(143)	394,203	\$72.60	-	394,203
C. General Administration									
17 Administrative	-	-	-	-	-	-	\$0.00	-	-
18 Directors Fees	-	-	-	-	-	-	\$0.00	-	-
19 Professional Services	-	-	6,592	6,592	-	6,592	\$1.21	-	6,592
20 Dues, Fees, Subscriptions & Promotion	-	-	1,695	1,695	-	1,695	\$0.31	(137)	1,558
21 Clerical & General Office Expenses	65,009	3,060	-	68,069	-	68,069	\$12.54	-	68,069
22 Employee Benefits & Payroll Taxes	-	-	121,331	121,331	381	121,712	\$22.41	-	121,712
23 Inservice Training & Education	-	-	649	649	-	649	\$0.12	-	649
24 Travel and Seminar	-	-	708	708	-	708	\$0.13	(617)	91
25 Other Admin. Staff Transportation	-	-	238	238	-	238	\$0.04	-	238
26 Insurance-Prop.Liab.Malpractice	-	-	10,547	10,547	-	10,547	\$1.94	-	10,547
27 Other (specify):*	-	-	2,838	2,838	(2,708)	130	\$0.02	-	130
28 TOTAL General Administration	65,009	3,060	144,598	212,667	(2,327)	210,340	\$38.74	(754)	209,586
TOTAL Operating Expense	485,644	62,823	184,876	733,343	(2,493)	730,850	\$134.59	(754)	730,096

D. Ownership										
30	Depreciation	-	-	20,810	20,810	-	20,810	\$3.83	-	20,810
31	Amortization of Pre-Op. & Org.	-	-	-	-	-	-	\$0.00	-	-
32	Interest	-	-	-	-	-	-	\$0.00	-	-
33	Real Estate Taxes	-	-	-	-	-	-	\$0.00	-	-
34	Rent-Facility & Grounds	-	-	-	-	-	-	\$0.00	-	-
35	Rent-Equipment & Vehicles	-	-	-	-	-	-	\$0.00	-	-
36	Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
37	TOTAL Ownership	-	-	20,810	20,810	-	20,810	\$3.83	-	20,810
Ancillary Expense										
E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-	-	-	\$0.00	-	-
39	Ancillary Service Centers	-	-	-	-	2,493	2,493	\$0.46	-	2,493
40	Barber and Beauty Shops	-	-	-	-	-	-	\$0.00	-	-
41	Coffee and Gift Shops	-	-	-	-	-	-	\$0.00	-	-
42	Provider Participation Fee	-	-	35,991	35,991	-	35,991	\$6.63	-	35,991
43	Other (specify):*	-	-	-	-	-	-	\$0.00	-	-
44	TOTAL Special Cost Centers	-	-	35,991	35,991	2,493	38,484	\$7.09	-	38,484
45	GRAND TOTAL	485,644	62,823	241,677	790,144	-	790,144	\$145.51	(754)	789,390
								\$117.96		
Current Reimbursement Rate								(27.55)		
Gain/(Loss) Per Resident / Day								-23.4%		
% of Costs Per Area		76.82%	7.95%	15.23%	100.00%					

Cost / Day Resident Days 5,430	% of Total Costs	% of Daily Rate	Staff Hours/ Day
\$6.70	4.6%	5.7%	0.40
\$6.71	4.6%	5.7%	
\$1.37	0.9%	1.2%	0.11
\$0.82	0.6%	0.7%	-
\$3.42	2.4%	2.9%	
\$4.25	2.9%	3.6%	0.20
\$0.00	0.0%	0.0%	
\$23.26	16.0%	19.7%	0.72
\$0.00	0.0%	0.0%	
\$12.76	8.8%	10.8%	0.39
\$48.39	33.3%	41.0%	4.06
\$0.19	0.1%	0.2%	-
\$10.53	7.2%	8.9%	0.36
\$0.05	0.0%	0.0%	-
\$0.68	0.5%	0.6%	
\$0.00	0.0%	0.0%	
\$72.60	49.9%	61.5%	4.81
\$0.00	0.0%	0.0%	0.13
\$0.00	0.0%	0.0%	
\$1.21	0.8%	1.0%	
\$0.29	0.2%	0.2%	
\$12.54	8.6%	10.6%	0.29
\$22.41	15.4%	19.0%	
\$0.12	0.1%	0.1%	
\$0.02	0.0%	0.0%	
\$0.04	0.0%	0.0%	
\$1.94	1.3%	1.6%	
\$0.02	0.0%	0.0%	
\$38.60	26.6%	32.7%	0.42
\$134.46	92.5%	114.0%	5.95

\$3.83	2.6%	3.2%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$3.83	2.6%	3.2%	-

\$0.00	0.0%	0.0%	
\$0.46	0.3%	0.4%	
\$0.00	0.0%	0.0%	
\$0.00	0.0%	0.0%	
\$6.63	4.6%	5.6%	
\$0.00	0.0%	0.0%	
\$7.09	4.9%	6.0%	-
\$145.38	100.0%	123.2%	5.95
\$117.96	81.1%	100.0%	
(27.42)	-18.9%	-23.2%	
-23.2%			