

		FOR BHF USE						

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**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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

<p><b>I. IDPH License ID Number:</b> <u>0039305</u></p> <p><b>Facility Name:</b> <u>Linden Estate</u></p> <p><b>Address:</b> <u>1000 Linden St</u> <u>Morton</u> <u>61550</u>          Number City Zip Code</p> <p><b>County:</b> <u>Tazewell</u></p> <p><b>Telephone Number:</b> <u>(309) 266-9781</u> <b>Fax #</b> <u>(309) 266-9468</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/17/1994</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Matthew D. Steffen</u> <b>Telephone Number:</b> <u>(309) 266-9781</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/12</u> to <u>6/30/13</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Crystal Streitmatter</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td>(Telephone) ( ) ( ) Fax # ( ) ( )</td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Crystal Streitmatter</u> (Date) _____		(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) ( ) ( ) Fax # ( ) ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																		
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	(Telephone) ( ) ( ) Fax # ( ) ( )																																			

Facility Name & ID Number Linden Estate

# 0039305 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

**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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,415			5,415	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,415			5,415	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 92.72%

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

0 (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 7/1/94

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

YES  Date \_\_\_\_\_ NO

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

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

**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
	<b>A. General Services</b>										
1	Dietary	32,538	3,721	720	36,979	(33)	36,946	36,946		1	
2	Food Purchase		38,320		38,320		38,320	38,320		2	
3	Housekeeping		1,505		1,505		1,505	1,505		3	
4	Laundry		2,973		2,973		2,973	2,973		4	
5	Heat and Other Utilities			18,876	18,876		18,876	18,876		5	
6	Maintenance	15,873	788	7,458	24,119	(30)	24,089	24,089		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	48,411	47,307	27,054	122,772	(63)	122,709	122,709		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director									9	
10	Nursing and Medical Records	47,377	9,625	1,358	58,360	(5,757)	52,603	52,603		10	
10a	Therapy	232,495		1,004	233,499	(7,104)	226,395	226,395		10a	
11	Activities		1,055		1,055	33	1,088	1,088		11	
12	Social Services	49,312	2	5,476	54,790	(277)	54,513	54,513		12	
13	CNA Training	1,241			1,241	6,164	7,405	7,405		13	
14	Program Transportation			5,043	5,043		5,043	5,043		14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	330,425	10,682	12,881	353,988	(6,941)	347,047	347,047		16	
	<b>C. General Administration</b>										
17	Administrative									17	
18	Directors Fees									18	
19	Professional Services			6,385	6,385		6,385	6,385		19	
20	Dues, Fees, Subscriptions & Promotions			1,553	1,553		1,553	(373)	1,180	20	
21	Clerical & General Office Expenses	46,525	2,476		49,001		49,001	49,001		21	
22	Employee Benefits & Payroll Taxes			97,180	97,180	7,037	104,217	104,217		22	
23	Inservice Training & Education			1,518	1,518		1,518	1,518		23	
24	Travel and Seminar			661	661		661	(556)	105	24	
25	Other Admin. Staff Transportation			217	217		217	217		25	
26	Insurance-Prop.Liab.Malpractice			10,851	10,851		10,851	10,851		26	
27	Other (specify):* <a href="#">See Pg 24</a>			4,050	4,050	(4,054)	(4)	(4)		27	
28	<b>TOTAL General Administration</b>	46,525	2,476	122,415	171,416	2,983	174,399	(929)	173,470	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	425,361	60,465	162,350	648,176	(4,021)	644,155	(929)	643,226	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 &amp; ID Number

Linden Estate

#0039305

Report Period Beginning:

7/1/12

Ending:

6/30/13

## 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	
	<b>D. Ownership</b>											
30	Depreciation			23,808	23,808		23,808		23,808			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Investment Expenses											36
37	<b>TOTAL Ownership</b>			23,808	23,808		23,808		23,808			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					4,021	4,021		4,021			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,928	38,928		38,928		38,928			42
43	Other (specify):* Facility Bulletin											43
44	<b>TOTAL Special Cost Centers</b>			38,928	38,928	4,021	42,949		42,949			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	425,361	60,465	225,086	710,912		710,912	(929)	709,983			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$	6	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance		26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(373)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (373)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (373)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

Linden Estate

ID# 0039305

Report Period Beginning: 7/1/12

Ending: 6/30/13

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)		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)	(556)	24	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	<b>Total</b>	(556)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate

# 0039305

Report Period Beginning:

7/1/12

Ending:

6/30/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(373)	0	0	0	0	0	0	0	0	0	0	(373)	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	(556)	0	0	0	0	0	0	0	0	0	0	(556)	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	<b>TOTAL General Administration</b>	<b>(929)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(929)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(929)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(929)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate

# 0039305

Report Period Beginning:

7/1/12

Ending:

6/30/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY 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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(929)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(929)</b>	<b>45</b>



**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</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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number

Linden Estate

# 0039305

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7/1/12

Ending:

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**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Virgil Metzger	BOD						1
2	Roger Aberle	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Ron Hodel	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

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Linden Estate

# 0039305

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## 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	653	0.5		Travel	\$ 117	line 24; col.3	1
2	Roger Aberle	Director	Director	0.00	1,618	0.5		Travel	289	line 24; col.3	2
3	Paul Kelson	Director	Director	0.00	253	0.5			45	line 24; col.3	3
4	Dennis Mott	Vice-Chairman	Director	0.00	484	0.5		Travel	86	line 24; col.3	4
5	Ron Hodel	Chairman	Director	0.00		0.5					5
6	Roger Beutel	Sec/ Treasurer	Director	0.00		0.5					6
7	Bryan Stoller	Director	Director	0.00	162	0.5		Travel	29	line 24; col.3	7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Ed Leman	Director	Director	0.00		0.5					9
10	Tim Steffen	Director	Director	0.00	533	0.5		Travel	96	line 24; col.3	10
11											11
12											12
13								TOTAL	\$ 661		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

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**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

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**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		7	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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

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.)

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# **0039305**

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**6/30/13**

**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 2012 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2013 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2008	8
	2009	9
	2010	10
	2011	11
	2012	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2012	\$	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.**

**2012 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>          </u>	\$ <u>          </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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**

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# 0039305

Report Period Beginning:

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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? [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:

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



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**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	\$	\$ 160,637	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		403--Mirrors		1995	393	20	20	20		373	9
10		429--Landscaping		1994	405	14	30	14		258	10
11		435--Organizational Costs		1999	527	18	30	18		255	11
12		436--Light Fixtures		2003	710	36	10	36		710	12
13		434--Concrete for Water Spillway		2004	899	60	15	60		569	13
14		401--Painting /Dumpster		2001	1,256	84	15	84		1,047	14
15		402--Generator Wing		1994	8,191		15			8,191	15
16		598--Livingroom carpet		1994	4,083	163	25	163		3,118	16
17		625--Bathroom remodel		1994	5,315	266	20	266		5,157	17
18		520--Lobby Carpet		1994	5,259	263	20	263		5,017	18
19		437--Cabinetry/Countertops/Vanities		1994	7,365	368	20	368		7,115	19
20		430--Lawn Sprinkler System		1996	8,900	445	20	445		8,010	20
21		432--Lighting & Down Spout Trenches		1994	19,683		15			19,683	21
22		433--Sod for Lawn		1994	25,150		15			25,150	22
23		431--Concrete for Porches		1994	14,174	567	25	567		11,190	23
24		399--Shelter		1994	25,346	1,014	25	1,014		20,278	24
25		441--Heating & Air Conditioning		1994	30,570	1,529	20	1,529		29,725	25
26		428--Asphalt		1994	32,699	1,635	20	1,635		31,501	26
27		438--Fire Prevention System		1994	33,335	1,111	30	1,111		25,138	27
28		398--Garage		2006	4,854	324	15	324		2,427	28
29		440--Electrical		2006	496	33	15	33		248	29
30		439--Plumbing		2006	1,250	83	15	83		625	30
31		427--Sewer System		2008	5,097	340	15	340		2,039	31
32		741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.		2008	610	41	15	41		244	32
33		747--Flooring-Men's bathroom		2008	553	37	15	37		221	33
34		772--Fiber Optic Cable		2008	3,430	229	15	229		1,372	34
35		860--Interior Painting		2009	4,091	584	7	584		2,922	35
36		861--Telephone System		2009	2,500	167	15	167		833	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

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# 0039305

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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		\$ 221	37
38	863--Exit Ramps	2008	3,430	229	15	229		1,372	38
39	884--Bathroom Floors	2009	4,091	584	7	584		2,922	39
40	885--Lighting Project	2009	2,500	167	15	167		833	40
41	886--Hot water heater	2009	2,899	414	7	414		2,071	41
42	930--Landscaping	2008	185	12	15	12		62	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)		\$ 505,142	\$ 19,019		\$ 19,019		\$ 381,534	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 32,790	\$ 4,007	\$ 4,007	\$	10	\$ 21,097	71
72	Current Year Purchases	1,104	221	221		5	221	72
73	Fully Depreciated Assets	117,007	154	154		9	117,007	73
74	Disposed Assets							74
75	TOTALS	\$ 150,901	\$ 4,382	\$ 4,382	\$		\$ 138,325	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 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)	\$ 709,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,401	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 519,859	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	\$	\$	\$	86
87	Capitalized repairs				87
88	Vehicle Equipment				88
89	Vehicles				89
90	Disposed Assets				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.

**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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,241		1,241
4	Clinical Wages (b)		2,482		2,482
5	In-House Trainer Wages (c)		4,110		4,110
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 7,833	\$	\$ 7,833
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	7,833		

**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	3
2. From other facilities (f)	41
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	9
<b>TOTAL TRAINED</b>	<b>53</b>

- (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.

Facility Name &amp; ID Number Linden Estate

# 0039305

Report Period Beginning: 7/1/12

Ending:

6/30/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 300	\$ 192,899	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	195,065	1,855,742	3
4	Supply Inventory (priced at )	321	20,456	4
5	Short-Term Investments		2,570,622	5
6	Prepaid Insurance		31,000	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		413,205	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 195,686	\$ 5,083,924	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	52,959	543,233	13
14	Buildings, at Historical Cost	303,473	6,067,299	14
15	Leasehold Improvements, at Historical Cost	96,897	582,977	15
16	Equipment, at Historical Cost	259,703	2,512,092	16
17	Accumulated Depreciation (book methods)	(530,544)	(5,788,023)	17
18	Deferred Charges			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		10,642,015	21
22	Other Long-Term Assets (spe Cash Value of Life Ins		36,270	22
23	Other(specify): <u>Investment in other facilities</u>		7,523,109	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 182,488	\$ 22,118,972	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 378,174	\$ 27,202,896	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,350	\$ 281,505	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,928	414,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,520	50,241	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	17,976	225,000	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Rounding</u>	2	(4)	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 47,776	\$ 971,153	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Capital Lease</u>		15,351	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 15,351	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 47,776	\$ 986,504	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 330,398	\$ 26,216,392	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 378,174	\$ 27,202,896	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>174,727</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>174,727</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(71,419)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	(740)	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(72,159)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Investment from other facilities</b>	<b>227,830</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>227,830</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>330,398</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Linden Estate

# 0039305

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**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 638,753	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 638,753	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	740	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 740	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached schedule</u>		28
28a	<u>Cost to Market Gain on Investments</u>		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 639,493	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	122,772	31
32	Health Care	353,988	32
33	General Administration	171,416	33
<b>B. Capital Expense</b>			
34	Ownership	23,808	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	38,928	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding Errors</u>		37
38	<u>Cost to Market Loss on Investments</u>		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 710,912	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(71,419)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (71,419)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 638,753	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 639,493	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

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**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	187	187	\$ 5,046	\$ 26.98	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,722	1,722	41,471	24.08	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	516	571	5,867	10.27	10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	164	164	4,100	25.00	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	2,793	3,042	35,724	11.74	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	919	919	15,898	17.30	17
18	Housekeepers	15	15	130	8.67	18
19	Laundry	0	0	0		19
20	Administrator	55	55	2,748	49.96	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	222	222	9,783	44.07	22
23	Office Manager	0	0	0		23
24	Clerical	1,539	1,539	25,896	16.83	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	1,886	2,087	49,506	23.72	29
30	Habilitation Aides (DD Homes)	18,620	21,039	229,192	10.89	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)	28,638	31,562	\$ 425,361 *	\$ 13.48	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	360	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	386	10-3	40
41	Occupational Therapy Consultant	9	618	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	29	1,968	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consulta	8	627	12-3	46
47	Dental Consultant	0	0		47
48	Psychiatrist Consultant	5	1,064	12-3	48
49	TOTAL (lines 35 - 48)	81	\$ 6,801		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**

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**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	
<b>Crystal Streitmatter</b>	<b>Administrator</b>	<b>0</b>	\$ <b>2,748</b>	<b>Workers' Compensation Insurance</b>	\$ <b>10,049</b>	<b>IDPH License Fee</b>	\$ <b>0</b>	
				<b>Unemployment Compensation Insurance</b>	<b>0</b>	<b>Advertising: Employee Recruitment</b>	<b>0</b>	
				<b>FICA Taxes</b>	<b>21,844</b>	<b>Health Care Worker Background Check</b>	<b>56</b>	
				<b>Employee Health Insurance</b>	<b>22,353</b>	(Indicate # of checks performed <b>2</b> )		
				<b>Employee Meals</b>	<b>340</b>	<b>Patient Background Checks</b>		
				<b>Illinois Municipal Retirement Fund (IMRF)*</b>		<b>Participation Fees &amp; Certificates</b>	<b>119</b>	
				<b>Employee Physicals</b>	<b>636</b>	<b>Dues (Employers Assn, IHCA)</b>	<b>981</b>	
				<b>Employee Promotional</b>	<b>1,388</b>	<b>Subscriptions (journals, news, etc.)</b>		
				<b>Defined Contribution Pension Plan</b>	<b>17,976</b>	<b>Driving Records Verification</b>	<b>24</b>	
				<b>Benefits Allocated to Day Program</b>	<b>0</b>	<b>Secretary of State</b>		
				<b>Disability Insurance</b>	<b>7,037</b>	<b>Less: Public Relations Expense</b>	( )	
				<b>Benefits for Transferred wages</b>	<b>22,594</b>	<b>Non-allowable advertising</b>	( )	
				<b>Employee Scholarships</b>	<b>0</b>	<b>Yellow page advertising</b>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
					\$ <b>104,217</b>			
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$		
<b>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</b>				<b>TOTAL</b>			<b>Out-of-State Travel</b>	
							\$	
							<b>See Ppage 24 (XX-16)</b>	
							<b>In-State Travel</b>	
							<b>Seminar Expense</b>	
							<b>Entertainment Expense</b>	
							( )	
<b>TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
							\$	

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Linden Estate

# 0039305

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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? 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? 13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,742 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. \$ 38,928  
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. \$ 340 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? 80
  - 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) 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