FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0039305

Facility Name: Linden Estate

Address: 1000 Linden Street (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: 309-266-9781 **Fax #** 309-266-9468

HFS ID Number:

Date of Initial License for Current Owners: 5/9/1994

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/14 to 6/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Crystal Strietmatter

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Matthew D. Steffen Telephone Number: 309-266-9781
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)		5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS		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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,482			5,482	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,482			5,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.87%

D. How many bed-hold days during this year were paid by the Department?
15 (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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 5/9/94

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	49,790	3,964	660	54,414	(28)	54,386		54,386			1
2	Food Purchase		39,302		39,302		39,302		39,302			2
3	Housekeeping		2,433		2,433		2,433		2,433			3
4	Laundry		3,560		3,560		3,560		3,560			4
5	Heat and Other Utilities			16,630	16,630		16,630		16,630			5
6	Maintenance	13,631	1,323	7,998	22,952	(19)	22,933		22,933			6
7	Other (specify):*											7
8	**TOTAL General Services**	63,421	50,582	25,288	139,291	(47)	139,244		139,244			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	61,348	13,364	1,476	76,188	(4,413)	71,775		71,775			10
10a	Therapy	267,293		956	268,249	(71)	268,178		268,178			10a
11	Activities		970		970	(17)	953		953			11
12	Social Services	52,745		4,607	57,352	(198)	57,154		57,154			12
13	CNA Training					4,746	4,746		4,746			13
14	Program Transportation			5,504	5,504		5,504		5,504			14
15	Other (specify):* DD Training											15
16	**TOTAL Health Care and Programs**	381,386	14,334	12,543	408,263	47	408,310		408,310			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			4,468	4,468		4,468		4,468			19
20	Dues, Fees, Subscriptions & Promotions			2,403	2,403		2,403	(493)	1,910			20
21	Clerical & General Office Expenses	56,888	4,107		60,995		60,995		60,995			21
22	Employee Benefits & Payroll Taxes			91,978	91,978		91,978		91,978			22
23	Inservice Training & Education			618	618		618		618			23
24	Travel and Seminar			1,002	1,002		1,002	(785)	217			24
25	Other Admin. Staff Transportation			165	165		165		165			25
26	Insurance-Prop.Liab.Malpractice			11,534	11,534		11,534		11,534			26
27	Other (specify):* Miscellaneous			2,940	2,940	(5,628)	(2,688)		(2,688)			27
28	**TOTAL General Administration**	56,888	4,107	115,108	176,103	(5,628)	170,475	(1,278)	169,197			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	501,695	69,023	152,939	723,657	(5,628)	718,029	(1,278)	716,751			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:** 7/1/14 **Ending:** 6/30/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,281	27,281		27,281		27,281			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):* **Management Fees**											36
37	**TOTAL Ownership**			27,281	27,281		27,281		27,281			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					5,628	5,628		5,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,756	34,756		34,756		34,756			42
43	Other (specify):* **Newsletter**											43
44	**TOTAL Special Cost Centers**			34,756	34,756	5,628	40,384		40,384			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	501,695	69,023	214,976	785,694		785,694	(1,278)	784,416			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: 7/1/14 Ending: 6/30/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$	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	(493)	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)**	$ (493)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (493)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Linden Estate

ID# 0039305

Report Period Beginning: 7/1/14

Ending: 6/30/15

	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)	(287)	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)	(498)	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**	(785)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate # 0039305 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	(493)	0	0	0	0	0	0	0	0	0	0	(493)	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	(785)	0	0	0	0	0	0	0	0	0	0	(785)	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**	(1,278)	0	0	0	0	0	0	0	0	0	0	(1,278)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,278)	0	0	0	0	0	0	0	0	0	0	(1,278)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Linden Estate # 0039305 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	**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)**	(1,278)	0	0	0	0	0	0	0	0	0	0	(1,278)	45

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES

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

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

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 [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Roger Beutel	BOD						5
6	Bryan Stoller	BOD						6
7	Kathy Woodruff	BOD						7
8	Ed Leman	BOD						8
9	Tim Steffen	BOD						9
10	Royce Scheiler	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 # 39305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Virgil Metzger	Vice-Chairman	Director	0.00	777	0.5		Travel	$ 145		1
2	Roger Aberle	Director	Director	0.00	1,505	0.5		Travel	280	line 24; col. 3	2
3	Paul Kelson	Director	Director	0.00	235	0.5		Travel	44		3
4	Dennis Mott	Director	Director	0.00	254	0.5		Travel	47	line 24; col. 3	4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		5
6	Bryan Stoller	Chairman	Director	0.00	151	0.5		Travel	28		6
7	Kathy Woodruff	Director	Director	0.00	457	0.5		Travel	85	line 24; col. 3	7
8	Ed Leman	Director	Director	0.00	0	0.5			0		8
9	Tim Steffen	Director	Director	0.00	462	0.5		Travel	86	line 24; col. 3	9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	$ 715		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: 7/1/14 Ending: 6/30/15

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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 7/1/14 Ending: 6/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

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

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

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

Facility Name & ID Number Linden Estate # 39305 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

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

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 7/1/14 Ending: 6/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood 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).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LTC Facility	87,120	1993	$ 52,959	1
2					2
3	TOTALS	87,120		$ 52,959	3

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1994	$ 244,343	$ 8,145	30	$ 8,145	$	$ 176,926	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	403--Mirrors			1994	330		10			330	9
10	429--Landscaping			1994	11,829		10			11,829	10
11	435--Organizational Costs			1994	11,887		5			11,887	11
12	436--Light Fixtures			1994	2,445		10			2,445	12
13	434--Concrete for Water Spillway			1995	393		20			393	13
14	401--Painting /Dumpster			1994	405	14	30	14		285	14
15	402--Generator Wing			1999	527	18	30	18		290	15
16	598--Livingroom carpet			2003	710		10			710	16
17	625--Bathroom remodel			2004	899	60	15	60		689	17
18	520--Lobby Carpet			2001	1,256	84	15	84		1,214	18
19	437--Cabinetry/Countertops/Vanities			1994	8,191		15			8,191	19
20	430--Lawn Sprinkler System			1994	4,083	163	25	163		3,445	20
21	432--Lighting & Down Spout Trenches			1994	5,315		20			5,315	21
22	433--Sod for Lawn			1994	5,259		20			5,259	22
23	431--Concrete for Porches			1994	7,365		20			7,365	23
24	399--Shelter			1996	8,900	445	20	445		8,900	24
25	441--Heating & Air Conditioning			1994	19,683		15			19,683	25
26	428--Asphalt			1994	25,150		15			25,150	26
27	438--Fire Prevention System			1994	14,174	567	25	567		12,324	27
28	398--Garage			1994	25,346	1,014	25	1,014		22,305	28
29	440--Electrical			1994	30,570		20			30,570	29
30	439--Plumbing			1994	32,699		20			32,699	30
31	427--Sewer System			1994	33,335	1,111	30	1,111		27,361	31
32	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		3,074	32
33	747--Flooring-Men's bathroom			2006	496	33	15	33		314	33
34	772--Fiber Optic Cable			2006	1,250	83	15	83		792	34
35	860--Interior Painting			2008	5,097	340	15	340		2,718	35
36	861--Telephone System			2008	610	41	15	41		326	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	862--Landscape upgrade	2008	$ 553	$ 37	15	$ 37	$	$ 295	37
38	863--Exit Ramps	2008	3,430	229	15	229		1,829	38
39	884--Bathroom Floors	2009	4,091	584	7	584		4,091	39
40	885--Lighting Project	2009	2,500	167	15	167		1,167	40
41	886--Hot water heater	2009	2,899	414	7	414		2,899	41
42	1062--Men's Floor Coverings	2014	5,099	340	15	340		680	42
43	1135--HVAC Unit	2015	6,317	421	15	421		421	43
44	1136--Linden Expansion of Porch - Drawings, Demolition, Constru	2015	75,377	5,025	15	5,025		5,025	44
45	1165--LE Roof Project	2015	11,919	596	20	596		596	45
46	1170--LE flooring--Dining, living, kitchen, med rooms	2015	786	79	10	79		79	46
47	1171--LE 2 a/c units, crawl space insul./vapor barrier	2015	2,290	153	15	153		153	47
48	930--Landscaping	2008	185	12	15	12		86	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)		$ 622,847	$ 20,499		$ 20,499	$	$ 440,110	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: 7/1/14 Ending: 6/30/15

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	$ 25,107	$ 3,266	$ 3,266	$	10	$ 19,801	71
72	Current Year Purchases	20,917	3,387	3,387		8	3,387	72
73	Fully Depreciated Assets	127,481	129	129		9	127,481	73
74	Disposed Assets							74
75	TOTALS	$ 173,505	$ 6,782	$ 6,782	$		$ 150,669	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)	$ 849,311	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,281	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,281	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)	$ 590,779	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.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		2,890		2,890
4	Clinical Wages (b)		5,780		5,780
5	In-House Trainer Wages (c)		8,965		8,965
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 17,635	$	$ 17,635
10	SUM OF line 9, col. 1 and 2 (e)	$ 17,635			

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	8
2. From other facilities (f)	35
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	5
TOTAL TRAINED	48

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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.

STATE OF ILLINOIS

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (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	$ 282,810	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	95,851	1,161,502	3
4	Supply Inventory (priced at)	321	20,456	4
5	Short-Term Investments		3,350,733	5
6	Prepaid Insurance	(20,796)	33,526	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2	513,167	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 75,678	$ 5,362,194	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	52,959	550,863	13
14	Buildings, at Historical Cost	404,766	7,481,529	14
15	Leasehold Improvements, at Historical Cost	96,897	605,051	15
16	Equipment, at Historical Cost	209,459	3,027,139	16
17	Accumulated Depreciation (book methods)	(505,730)	(6,342,095)	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		11,334,291	21
22	Other Long-Term Assets (specify):		41,448	22
23	Other(specify):		9,697,750	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 258,351	$ 26,395,976	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 334,029	$ 31,758,170	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,698	$ 412,185	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,681	544,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,967	1,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	15,915	279,923	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rounding	(1)	178	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 77,260	$ 1,237,547	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Lease		37,523	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 37,523	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 77,260	$ 1,275,070	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 256,769	$ 30,483,100	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 334,029	$ 31,758,170	48

***(See instructions.)**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,572	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,572	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(137,270)	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)**	$ (137,270)	17	
	B. Transfers (Itemize):			
18	**Investment from other facilities**	392,467	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 392,467	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 256,769	24	*

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 647,984	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 647,984	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
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	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	440	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 440	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule		28
28a	Cost to Market Gain on Investments		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 648,424	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	139,291	31
32	Health Care	408,263	32
33	General Administration	176,103	33
	B. Capital Expense		
34	Ownership	27,281	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,756	36
	D. Other Expenses (specify):		
37			37
38	Cost to Market Loss on Investments		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 785,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	(137,270)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (137,270)	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) ICFID/DD	647,984	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 647,984	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: 7/1/14 Ending: 6/30/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	350	385	$ 11,501	$ 29.87	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,565	1,717	42,424	24.71	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	278	312	8,447	27.07	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	2,709	2,844	32,737	11.51	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	786	888	14,206	16.00	17
18	Housekeepers	547	547	6,247	11.42	18
19	Laundry	168	191	2,653	13.89	19
20	Administrator	594	672	25,829	38.44	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,055	1,180	30,407	25.77	22
23	Office Manager	160	207	4,045	19.54	23
24	Clerical	191	214	3,161	14.77	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	1,856	2,080	52,745	25.36	29
30	Habilitation Aides (DD Homes)	21,880	23,466	267,293	11.39	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)	32,139	34,703	$ 501,695 *	$ 14.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	22	$ 660	1-3	35
36	Medical Director	Flat Fee	390	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	1,086	10-3	39
40	Physical Therapy Consultant	7	429	10-3	40
41	Occupational Therapy Consultant	8	526	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	33	2,298	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consulta	4	351	12-3	46
47	Dental Consultant	0	0	10a-3	47
48	Psychiatrist Consultant	9	1,958	10a-3	48
49	TOTAL (lines 35 - 48)	82	$ 7,699		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10-3	50
51	Licensed Practical Nurses	0	0	10-3	51
52	Certified Nurse Assistants/Aides	0	0	10a-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Streitmatter	Administrator	0	$ 25,829
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 25,829

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Quantum Solutions Inc	Data Processing	$ 0
SIKICH LLP	Data Processing	0
BrookeRose, Inc.	Data Processing	1,494
Kronos Incorporated	Data Processing	0
Silverchair Learning Center	Data Processing	0
Morris, Duane & Associates	Legal	0
Howard & Howard Attorneys	Legal	0
Margel Peddicord, CPA	Accounting	0
Apostolic Christian Restmor	Accounting	0
Koch Consultants, LTD	Accounting	1,799
Heinold-Banwart, LTD	Accounting	1,175
Other	Various non-legal	0
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 4,468

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,262
Unemployment Compensation Insurance	0
FICA Taxes	25,165
Employee Health Insurance	27,318
Employee Meals	280
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	761
Employee Promotional	1,362
Defined Contribution Pension Plan	15,915
Benefits Allocated to Day Program	0
Disability Insurance	0
Benefits for Transferred wages	11,915
Employee Scholarships	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 91,978

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	107
Health Care Worker Background Check	181
(Indicate # of checks performed 5)	0
Patient Background Checks	0
Participation Fees & Certificates	0
Dues (Employers Assn, IHCA, Don Moss)	1,610
Subscriptions (journals, news, etc.)	0
Driving Records Verification	12
Secretary of State	0
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,910

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 785
See Page 24 (XX-16)	(785)
In-State Travel	217
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 217

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
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 # 0039305 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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 - $912, Institute on Public Policy - $693**

(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. $ **4,203** 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. $ **34,756**
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. $ **280** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No, they have been adjusted out.**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **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. $ **0**

(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 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.

Linden Estate
FYE 6/30/15 **#0039305**
Sub schedules

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	5,628
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	(2,688)
	Other Expenses	2,940

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
6	Communication equipment rental	-	
35	Communication equipment rental		-
32	Interest Expense	-	
36	Interest Expense		-
11	Donated labor	-	
1	Donated labor	-	
4	Donated labor	-	
6	Donated labor	-	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		-
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		-
22	Disability Pay to Benefits	-	
13	Nurse aid trainer wages	4,746	
1	Nurse aid trainer wages		28
6	Nurse aid trainer wages		19

Schedule VI B - Non-paid workers

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

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - $777.21 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Roger Aberle - $1,504.92 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Paul Kelson - $235.12 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Dennis Mott - $254.47 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Bryan Stoller - $151.14 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Kathy Woodruff - $457.24 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate
Tim Steffen - $461.79 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

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

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

Sch. XVIII - A. Staffin

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

Schedule XIX, D - Emp

Salaries, Sch V, Line 45,
Prior Year PTO Accrual
Current Year PTO Accrua
Prior Year Wage Accrual
Current Year Wage Accru
Section 125 Wages not a
Less: Wages over FICA ta
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 Info

12. Nurse Aide Trainer W

10	Nurse aid trainer wages		4,413
10a	Nurse aid trainer wages		71
11	Nurse aid trainer wages		17
12	Nurse aid trainer wages		198
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
39	Dental costs	5,628	
27	Dental costs		5,628
		10,374	10,374

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 25 visits	$ 5,628

A/R - Resident Personal Accounts	2
	2

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	-

Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	-
Farm Income	-
Gain/(Loss) on Sale of Assets	-
Increase in Cash Value of Life Insurance	-
Miscellaneous	-
Cost to Market Adjustment on Investments	##
	-

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

Income before taxes per cost report	(137,270)
Income from related parties	1,468,479
Estimated excess for year, Form 990, p.1, line 18	1,331,209

14. A portion of office sp

16. Out of State Travel

g and Salary Costs

nses, Column 1, Row 45	501,695
nd Salary Costs, Column 3, Row 34	(501,695)
	-

ɔloyee Benefits and Payroll Taxes - FICA calculation

Col 1	501,695
	(13,060)
l	16,207
	8,228
ıal	(9,730)
pplicable to FICA taxes	(31,712)
axation limit of SS Wages ($0 x 6.2%/7.65%)	-
other facilites	(142,673)
mployee meal calculation	
	328,955
	7.650%
	25,165
	25,165
	0

ɪrmation

Vages:

Administrator	-
Therapy / PT / OT	71
Activities Director	17
Day Program	-
Head Cook	28
Maintenance	19
Nursing	4,413
Soc. Serv. / QMRP	198
	4,746

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

Administration	
Administrator	44
Assistant Administrator	243
	287
Board of Directors	
Virgil Metzger (Not out of State)	
Roger Aberle	280
Paul Kelson (Not out of State)	
Dennis Mott	47
Bryan Stoller (Not out of State)	
Kathy Woodruff	85
Tim Steffen	86
	498
Nursing	
None	-
	-

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCHEDUDLE VII A

Related Organizations:

Oakwood Estate #0033712
Apostolic Christian Timber Ridge #0016220

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

Bryan Stoller, Chairman
Virgil Metzger, Vice Chairman
Roger Beutel, Secretary/Treasurer
Dennis Mott, Director
Tim Steffen, Director
Paul Kelson, Director
Ed Leman, Director
Royce Scheiler, Director
Kathy Woodruff, Director (term began 05/16/2015)
Roger Aberle, Director (term ended 5/16/2015)

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.

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

	Pioneer Park	PARC	TCRC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	1	2	0								
Miles per trip	40	40	5	40								
Gas/Depreciation Price per Mile	$1.25	$1.35	$1.25	$0.75								
Hours per trip	1 1/4	1 1/4	3/4	1 1/4								
Attendant Wages	$9.50	$9.50	$9.50									
Driver Wages	$15.50	$15.50	$15.50	$13.00								
Gas & Depreciation	$ 50.00	$ 54.00	$ 6.25	$ 30.00	$ 110.25	**$ 166.50**	52.50%	**34,101.08**	#VALUE!	**#VALUE!**	14	**Sch. VI Ln. 29**
Depreciation						**$ -**				**#VALUE!**	Sch XI (F)	**Sch. VI Ln. 29**
Driver Wages	$ 19.38	$ 38.75	$ 11.63	$ 16.25	$ 69.76	**$ 100.77**	31.77%	**20,638.83**		**20,639.00**	6	**Sch. VI Ln. 1**
Attendant Wages	$ 11.88	$ 11.88	$ 7.13	$ -	$ 30.89	**$ 49.90**	15.73%	**10,220.08**		**10,220.00**	10	**Sch. VI Ln. 29**
Total	$ 81.26	$ 104.63	$ 25.01	$ 46.25	$ 210.90	**$ 317.17**		**64,960.00**		**#VALUE!**		

Consultants

		TR	OE	LE
Dietary Consultant	Hrs	110.00	22.00	22.00
	Amount	5,010.72	660.00	660.00
Medical Director	Hrs	Flat Fee	Flat Fee	Flat Fee
	Amount	1,820.00	390.00	390.00
Medical Records Consultant	Hrs			
	Amount			
Nurse Consultant	Hrs			
	Amount			
Pharmacist Consultant	Hrs	73.95	Flat Fee	Flat Fee
	Amount	4,806.10	858.00	1,086.00
Physical Therapy Consultant	Hrs	31.12	6.69	6.69
	Amount	2,004.20	429.48	429.48
Occupational Therapy Consultant	Hrs	37.08	7.96	7.96
	Amount	2,456.13	526.34	526.34
Respiratory Therapy Consultant	Hrs			
	Amount			
Speech Therapy Consultant	Hrs	151.65	32.51	32.51
	Amount	10,725.97	2,298.43	2,298.43
Activity Consultant	Hrs			
	Amount			
Social Service Consultant	Hrs			
	Amount			
Psychologist Consultant	Hrs	19.22	4.14	4.14
	Amount	1,636.22	350.64	350.64
Dental Consultant	Hrs			
	Amount			
Psychiatrist Consultant	Hrs	31.43	4.45	8.71
	Amount	7,075.81	997.46	1,957.72
Podiatrist Consultant	Hrs			
	Amount			

COMPLETED FOR 2015

Dietary Consultant		**22**	**660**
Medical Director		**Flat Fee**	**390**
Medical Records Consultant		**0**	**0**
Nurse Consultant		**0**	**0**
Pharmacist Consultant		**Flat Fee**	**1,086**
Physical Therapy Consultant		**7**	**429**
Occupational Therapy Consultant		**8**	**526**
Respiratory Therapy Consultant		**0**	**0**
Speech Therapy Consultant		**33**	**2,298**
Activity Consultant		**0**	**0**
Social Service Consultant		**0**	**0**
Other(specify)	**Psychologist Consultant**	**4**	**351**
Other(specify)	**Dental Consultant**	**0**	**0**
Other(specify)	**Psychiatrist Consultant**	**9**	**1,958**

		Out of State			In State		
	Board Travel	TR	OE	LE	TR	OE	LE
17	Virgil Metzger				668.78	108.43	144.59
18	Roger Aberle	1,294.95	209.97	279.99			
19	Paul Kelson				202.32	32.80	43.77
20	Dennis Mott	218.96	35.51	47.35			
21	Roger Beutel						
22	Bryan Stoller				130.06	21.08	28.12
23	Kathy Woodruff	393.45	63.79	85.06			
24	Ed Leman						
25	Tim Steffen	397.36	64.43	85.90			
26	Royce Scheiler						
		2,304.72	**373.70**	**498.30**	**1,001.16**	**162.31**	**216.48**
	Admin Travel						
	Ron	205.32	33.30	44.40			
	Matt	1,337.12	181.97	242.63			
	Other (Board Candidates)	960.40					
		1,542.44	**215.27**	**287.03**	**-**	**-**	**-**

	13.1	4.36666667	1.74666667	1.74666667	5.24
33%	2947.5	982.5	393	393	1179