		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

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		

In the event there are further questions about this report, please contact:
Name: Matthew D. Steffen **Telephone Number:** 309.266.9781
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2019 to 06/30/2020 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 Streitmatter
(Title) Administrator

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: 07/01/2019 Ending: 06/30/2020

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		Intermediate (ICF)			3
4		Intermediate/DD	0	0	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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					11
12	SC					12
13	DD 16 OR LESS	5,657			5,657	13
14	TOTALS	5,657			5,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.60%

D. How many bed reserve days during this year were paid by the Department?
171 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 [X] NO [ ]

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: 06/30/2020 Fiscal Year: 06/30/2020

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

STATE OF ILLINOIS

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	59,965	1,595	932	62,492	0	62,492	0	62,492			1
2	Food Purchase		37,109		37,109	0	37,109	0	37,109			2
3	Housekeeping	0	2,176	0	2,176	0	2,176	0	2,176			3
4	Laundry	0	2,184	0	2,184	0	2,184	0	2,184			4
5	Heat and Other Utilities			12,246	12,246	0	12,246	0	12,246			5
6	Maintenance	12,767	3,309	10,297	26,373	0	26,373	0	26,373			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	**TOTAL General Services**	72,732	46,373	23,475	142,580	0	142,580	0	142,580			8
	B. Health Care and Programs											
9	Medical Director	0	0	0	0	0	0	0	0			9
10	Nursing and Medical Records	389,793	10,295	1,281	401,369	(6,741)	394,628	0	394,628			10
10a	Therapy	19,307	0	561	19,868	0	19,868	0	19,868			10a
11	Activities	0	914	0	914	0	914	0	914			11
12	Social Services	64,322	0	4,737	69,059	0	69,059	0	69,059			12
13	CNA Training	0	0	0	0	6,741	6,741	0	6,741			13
14	Program Transportation	0	0	3,884	3,884	0	3,884	660	4,544			14
15	Other (specify):*	0	0	6,662	6,662	0	6,662	0	6,662			15
16	**TOTAL Health Care and Programs**	473,422	11,209	17,125	501,756	0	501,756	660	502,416			16
	C. General Administration											
17	Administrative	0	0	0	0	0	0	0	0			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			1,503	1,503	0	1,503	0	1,503			19
20	Dues, Fees, Subscriptions & Promotions			1,356	1,356	0	1,356	0	1,356			20
21	Clerical & General Office Expenses	94,710	569	6,186	101,465	0	101,465	0	101,465			21
22	Employee Benefits & Payroll Taxes			145,565	145,565	0	145,565	0	145,565			22
23	Inservice Training & Education			151	151	0	151	0	151			23
24	Travel and Seminar			500	500	0	500	(500)	0			24
25	Other Admin. Staff Transportation		0	92	92	0	92	0	92			25
26	Insurance-Prop.Liab.Malpractice			8,723	8,723	0	8,723	0	8,723			26
27	Other (specify):*			3,590	3,590	(3,263)	327	0	327			27
28	**TOTAL General Administration**	94,710	569	167,666	262,945	(3,263)	259,682	(500)	259,182			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	640,864	58,151	208,266	907,281	(3,263)	904,018	160	904,178			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Linden Estate #0039305 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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			35,982	35,982	0	35,982	(660)	35,322			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	0	0			32
33	Real Estate Taxes			0	0	0	0	0	0			33
34	Rent-Facility & Grounds			0	0	0	0	0	0			34
35	Rent-Equipment & Vehicles			0	0	0	0	0	0			35
36	Other (specify):*			2,652	2,652	0	2,652	0	2,652			36
37	**TOTAL Ownership**			38,634	38,634	0	38,634	(660)	37,974			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			0	0	0	0	0	0			38
39	Ancillary Service Centers			0	0	3,263	3,263	0	3,263			39
40	Barber and Beauty Shops			0	0	0	0	0	0			40
41	Coffee and Gift Shops			0	0	0	0	0	0			41
42	Provider Participation Fee			40,476	40,476	0	40,476	0	40,476			42
43	Other (specify):*			0	0	0	0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	40,476	40,476	3,263	43,739	0	43,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	640,864	58,151	287,376	986,391	0	986,391	(500)	985,891			45

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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		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)**	$ 0		$ 0	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)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 0		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

Linden Estate

ID# 0039305

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day training transportation income	$ 0	10	1
2	Offset day training transportation income	660	14	2
3	Out-of-state Travel (Administrative Staff)	0	24	3
4	Depreciation of non-care vehicles	(660)	30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming	0	22	6
7	Out-of-state Travel (Board of Directors)	(500)	24	7
8	Interest Expense	0	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**	(500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Linden Estate **#** 0039305 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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	660	0	0	0	0	0	0	0	0	0	0	660	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	660	0	0	0	0	0	0	0	0	0	0	660	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(500)	0	0	0	0	0	0	0	0	0	0	(500)	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**	(500)	0	0	0	0	0	0	0	0	0	0	(500)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	160	0	0	0	0	0	0	0	0	0	0	160	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Linden Estate** **#** **0039305** **Report Period Beginning:** **07/01/2019** **Ending:** **06/30/2020**

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	**(660)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(660)**	**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**	**(660)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(660)**	**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)**	**(500)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(500)**	**45**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 LifePoints, Inc.	100%	Oakwood Estate #0033712	Morton	Apostolic Christian C	Morton	CILA Residential
		Apostolic Christian Timber Ridge #0016220	Morton			Services for
						Individuals with
						Developmental
						& Intellectual
						Disabilities

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: 07/01/2019 Ending: 06/30/2020

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	Blair Metzger	BOD						1
2	Ben Knochel	BOD						2
3	Paul Kelson	BOD						3
4	Matt Zimmerman	BOD						4
5	Bryan Stoller	BOD						5
6	Kathy Woodruff	BOD						6
7	Ed Leman	BOD						7
8	Royce Scheiler	BOD						8
9	Kent Schmidgall	BOD						9
10	Wendy Sauder	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Blair Metzger	Vice President	Director	0.00	1,238	0.5		Travel	$ 232	line24 col 3	1
2	Ben Knochel	Director	Director	0.00	0	0.5			0		2
3	Paul Kelson	President	Director	0.00	0	0.5			0		3
4	Matt Zimmerman	Director	Director	0.00	0	0.5			0		4
5	Bryan Stoller	Director	Director	0.00	0	0.5			0		5
6	Kathy Woodruff	Director	Director	0.00	945	0.5		Travel	176	line24 col 3	6
7	Ed Leman	Director	Director	0.00	0	0.5			0		7
8	Royce Scheiler	Director	Director	0.00	0	0.5			0		8
9	Kent Schmidgall	Treasurer	Director	0.00	492	0.5		Travel	92	line24 col 3	9
10	Wendy Sauder	Secretary	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	$ 500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

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: 07/01/2019 Ending: 06/30/2020

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Morgan Stanley (LAL)		x	Timing of State Payments and C	Interest	10/2008	4,667,000	0	None	2.1558	0	6
7												7
8												8
9	TOTAL Facility Related						$ 4,667,000	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 4,667,000	$ 0			$ 0	15

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

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

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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).		$ 0	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	$	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.

2019 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 2019 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 2019.

	(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	$ 0.00	$ 0.00

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,329 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	1994	$ 52,959	1
2					2
3	TOTALS	87,120		$ 52,959	3

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$	$ 217,650	4
5	0										5
6											6
7											7
8											8
	Improvement Type**										
9	398--Garage			1994	25,346	0	25	0		25,346	9
10	399--Shelter			1996	8,900	0	20	0		8,900	10
11	401--Painting /Dumpster			1994	405	14	30	14		352	11
12	402--Generator Wing			1999	527	18	30	18		378	12
13	403--Mirrors			1994	330	0	10	0		330	13
14	427--Sewer System			1994	33,335	1,111	30	1,111		32,916	14
15	428--Asphalt			1994	25,150	0	15	0		25,150	15
16	429--Landscaping			1994	11,829	0	10	0		11,829	16
17	430--Lawn Sprinkler System			1994	4,083	0	25	0		4,083	17
18	432--Lighting & Down Spout Trenches			1994	5,315	0	20	0		5,315	18
19	433--Sod for Lawn			1994	5,259	0	20	0		5,259	19
20	434--Concrete for Water Spillway			1995	393	0	20	0		393	20
21	435--Organizational Costs			1994	11,887	0	5	0		11,887	21
22	436--Light Fixtures			1994	2,445	0	10	0		2,445	22
23	437--Cabinetry/Countertops/Vanities			1994	8,191	0	15	0		8,191	23
24	438--Fire Prevention System			1994	14,174	0	25	0		14,174	24
25	439--Plumbing			1994	32,699	0	20	0		32,699	25
26	440--Electrical			1994	30,570	0	20	0		30,570	26
27	441--Heating & Air Conditioning			1994	19,683	0	15	0		19,683	27
28	520--Lobby Carpet			2001	1,256	0	15	0		1,256	28
29	598--Livingroom carpet			2003	710	0	10	0		710	29
30	625--Bathroom remodel			2004	899	0	15	0		899	30
31	741--Tile&Carpet-Men's hall, 1 Men's bedroom, off.			2006	4,854	324	15	324		4,692	31
32	772--Fiber Optic Cable			2006	1,250	83	15	83		1,208	32
33	860--Interior Painting			2008	5,097	340	15	340		4,417	33
34	862--Landscape upgrade			2008	553	37	15	37		480	34
35	863--Exit ramps			2008	3,430	229	15	229		2,973	35
36	884--Bathroom Floors			2009	4,091	0	7	0		4,091	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	885--Lighting Project	2009	$ 4,091	$ 0	7	$ 0	$	$ 4,091	37
38	930--Landscaping	2009	2,500	167	15	167		2,000	38
39	1062--5 Men's Floor Coverings	2008	185	12	15	12		148	39
40	1135--HVAC Unit	2014	5,099	340	15	340		2,380	40
41	1136--Linden Expansion of Porch - Drawings	2015	6,317	421	15	421		2,527	41
42	1136.1--LE Porch Expansion - Landscaping	2015	99,614	6,641	15	6,641		38,230	42
43	1139.1--Designer screen shades for Res bedrooms	2016	4,871	325	15	325		1,624	43
44	1165--LE Roof Project	2016	3,375	225	15	225		1,125	44
45	1170--LE flooring--Dining, living, kitchen, med rooms	2015	11,919	596	20	596		3,576	45
46	1171--LE 2 a/c units, crawl space insul./vapor barrier	2015	13,599	1,360	10	1,360		6,878	46
47	1173--Linden built-in cabinets	2015	2,290	153	15	153		916	47
48	1175--LE Driveway/Parking Lot Resurfacing	2016	4,470	298	15	298		1,490	48
49	1178--LE House roof	2016	13,500	900	15	900		4,500	49
50	1179--LE Garage roof	2016	14,003	560	25	560		2,801	50
51	1185--2 Carrier Furnaces & Condensers	2016	3,278	131	25	131		656	51
52	1189--Laundry Hopper	2016	25,660	1,711	15	1,711		8,553	52
53	1220--New Linoleum at LE	2016	5,561	556	10	556		2,781	53
54	1225--LE - Tazewell Flooring, Shower materials	2017	6,141	1,228	5	1,228		4,913	54
55	1310--Wascomat Washing Machine	2017	13,997	1,400	10	1,400		5,599	55
56	1311--FloorFolio Flooring	2019	3,000	429	7	429		857	56
57	1320--Commercial Dishwasher	2019	2,912	194	15	194		388	57
58	1334--Window Replacment	2019	6,799	971	7	971		1,943	58
59	1344--Install Heat Detectors in Attic Space	2020	20,987	700	15	700		700	59
60	--	2020	2,648	88	15	88		88	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)		$ 783,820	$ 29,707		$ 29,707	$ 0	$ 577,040	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: 7/1/2019 Ending: 6/30/2020

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	$ 56,623	$ 5,618	$ 5,618	$ 0	10	$ 24,354	71
72	Current Year Purchases	0	0	0	0		0	72
73	Fully Depreciated Assets	19,868	0	0	0	7	19,868	73
74	Disposed Assets	3,925	0	0	0	12	3,925	74
75	TOTALS	$ 80,416	$ 5,618	$ 5,618	$ 0		$ 48,147	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 917,195	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,325	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,325	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 625,187	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	$ 15,893	$ 0	$ 15,893	86
87	Capitalized repairs	0	0	0	87
88	Vehicle Equipment	0	0	0	88
89	Vehicles	9,240	660	660	89
90	Disposed Assets	17,079	0	17,079	90
91	TOTALS	$ 42,212	$ 660	$ 33,632	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: 7/1/2019 Ending: 6/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [x] 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 [x] 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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO
16. Rental Amount for movable equipment: $ 0 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			$	$	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: 7/1/2019 Ending: 6/30/2020

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	$	$	$	$ 0
2	Books and Supplies		0		0
3	Classroom Wages (a)		1,190		1,190
4	Clinical Wages (b)		2,380		2,380
5	In-House Trainer Wages (c)		4,494		4,494
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 8,064	$ 0	$ 8,064
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,064			

C. CONTRACTUAL INCOME

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

$ #REF!

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	45
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	9
TOTAL TRAINED	57

(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 & ID Number Linden Estate # 0039305 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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.

Facility Name & ID Number Linden Estate # 0039305 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2020 (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	$ 700	$ 729,229	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	109,544	1,992,530	3
4	Supply Inventory (priced at)	321	25,002	4
5	Short-Term Investments	0	12,478,409	5
6	Prepaid Insurance	2,833	771,576	6
7	Other Prepaid Expenses	0	31,404	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): A/R Bequests	0	1,416,621	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 113,398	$ 17,444,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	52,959	575,663	13
14	Buildings, at Historical Cost	526,816	9,857,891	14
15	Leasehold Improvements, at Historical Cost	82,753	1,456,507	15
16	Equipment, at Historical Cost	232,779	3,127,316	16
17	Accumulated Depreciation (book methods)	(594,716)	(7,528,023)	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	11,887	46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,887)	(46,121)	20
21	Restricted Funds	0	13,370,107	21
22	Other Long-Term Assets (specify):	0	131,626	22
23	Other(specify): Inter-Company Assets/Liab	0	14,232,141	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 300,591	$ 35,223,228	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 413,989	$ 52,667,999	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,180	$ 2,650,358	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	0	29
30	Accrued Salaries Payable	47,324	946,768	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,967	1,967	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	16,025	428,613	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 108,496	$ 4,027,706	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	Inter-Company Assets/Liab	1,519,210	14,281,419	43
44	Rounding / Other	(1)	3	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,519,209	$ 14,281,422	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,627,705	$ 18,309,128	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,213,716)	$ 34,358,871	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 413,989	$ 52,667,999	48

***(See instructions.)**

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,044,295)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,044,295)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(169,421)	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)**	$ (169,421)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,213,716)	24 *

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 816,718	1
2	Discounts and Allowances for all Levels	(0)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 816,718	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		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)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions	252	24
25	Interest and Other Investment Income***	0	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 252	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Developmental Training Income		28
28a	Farm Income		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 816,970	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	142,580	31
32	Health Care	501,756	32
33	General Administration	262,945	33
	B. Capital Expense		
34	Ownership	35,982	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	40,476	36
	D. Other Expenses (specify):		
37	Loss on Sale/Retirement of Asset	2,652	37
38		0	38
39		0	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 986,391	40
41	**Income before Income Taxes (line 30 minus line 40)****	(169,421)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (169,421)	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) ICF DD Care	816,718	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 816,718	49

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

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

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

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

Facility Name & ID Number Linden Estate # 0039305 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	462	462	$ 16,902	$ 36.58	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	648	648	20,095	31.01	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	187	236	3,229	13.68	10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	1,965	2,605	37,233	14.29	14
15	Cook Helpers/Assistants	22	22	351	15.95	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	613	613	12,416	20.25	17
18	Housekeepers	1,349	1,335	21,518	16.12	18
19	Laundry	0	0	0		19
20	Administrator	462	462	21,446	46.42	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	2,090	2,090	71,593	34.26	22
23	Office Manager	209	209	5,748	27.50	23
24	Clerical	221	221	3,334	15.09	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	1,858	2,092	65,432	31.28	29
30	Habilitation Aides (DD Homes)	20,802	23,218	346,062	14.90	30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	697	697	15,505	22.25	32
33	Other(specify) Day Program	0	0	0		33
34	TOTAL (lines 1 - 33)	31,585	34,910	$ 640,864 *	$ 18.36	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	18	$ 932	1-3	35
36	Medical Director	0	0	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	Flat Fee	1,281	10-3	38
39	Pharmacist Consultant	Flat Fee	0	10-3	39
40	Physical Therapy Consultant	4	247	10-3	40
41	Occupational Therapy Consultant	5	314	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	31	2,130	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consulta	1	200	12-3	46
47	Dental Consultant	0	0	10a-3	47
48	Psychiatrist Consultant	11	2,407	10a-3	48
49	TOTAL (lines 35 - 48)	69	$ 7,512		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: 07/01/2019 Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Streitmatter	Administrator		$ 21,446
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 21,446

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
HEINOLD-BANWART, LTD.	Accounting	$ 0
KOCH CONSULTANTS	Accounting	0
KRONOS INCORPORATED	Data Processing	0
BROWN BEAR SCHEDULING	Data Processing	0
QUANTUM SOLUTIONS INC	Data Processing	811
RELIAS LEARNING, LLC	Data Processing	692
BENCKENDORF & BENCKENDO	Legal	0
HOWARD & HOWARD ATTORNI	Legal	0
MORRIS, DUANE	Legal	0
OGLETREE DEAKINS NASH & S	Legal	0
ATELIER ARCHITECT / PLANNI	Professional Services	0
KLINGER & ASSOCIATES, P.C.	Professional Services	0
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,503

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 2,410
Unemployment Compensation Insurance	0
FICA Taxes	33,592
Employee Health Insurance	45,850
Employee Meals	209
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	422
Employee Promotional	1,454
Defined Contribution Pension Plan	17,708
Benefits Allocated to Day Program	0
Disability Insurance	3,744
Benefits for Transferred wages	43,920
Employee Scholarships	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 149,309

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	0
Health Care Worker Background Check	116
(Indicate # of checks performed 4)	
Patient Background Checks 1	10
Participation Fees & Certificates	0
Dues (Employers Assn, IHCA, Don Moss)	1,225
Subscriptions (journals, news, etc.)	0
Driving Records Verification	
Secretary of State	0
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,351

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Linden Estate **#** 0039305 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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 - $1,046**

(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? **No**

(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? **9.7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,600** 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. $ **40,476**
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. $ **209** 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? **89%**
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Koch 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 06/30/2020 **#39305**
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	6,662
27	Dental costs	3,263
27	Charitable Contributions	300
27	Fines & Penalties	-
27	Miscellaneous	10
	Other Expenses	10,235

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	6,741	
1	Nurse aid trainer wages		-
6	Nurse aid trainer wages		-
10	Nurse aid trainer wages		6,741
10a	Nurse aid trainer wages		-
11	Nurse aid trainer wages		-
12	Nurse aid trainer wages		-
10a	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
39	Dental costs	3,263	
27	Dental costs		3,263
		10,004	10,004

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 15 visits	$ 3,263

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

Blair Metzger - $1,237.92 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Kathy Woodruff - $944.99 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Kent Schmidgall - $492.24 - 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	-
A/R - Employees	-
	-

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	(2,652)
Increase in Cash Value of Life Insurance	-
Miscellaneous	-
Cost to Market Adjustment on Investments	-
	(2,652)

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

Income before taxes per cost report	(169,421)
Income from related parties	3,607,690
Estimated excess for year, Form 990, p.1, line 18	3,438,269

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	640,864
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(640,864)
Variance	-

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

Salaries, Sch V, Line 45, Col 1	640,864
Prior Year PTO Accrual	(19,711)
Current Year PTO Accrual	21,670
Prior Year Wage Accrual	17,218
Current Year Wage Accrual	(24,106)
Section 125 Wages not applicable to FICA taxes	(22,181)
Less: Wages over FICA taxation limit of SS Wages ($0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilites	(174,641)
Add: ACCS Wages	
Add: wages included in employee meal calculation	-
Cash basis salaries	439,114
FICA rate	7.650%
Calculated FICA	33,592
FICA per Sch XIX	33,592
Variance	0

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	-
Therapy / PT / OT	-
Activities Director	-
Day Program	-
Head Cook	-
Maintenance	-
Nursing	6,741
Soc. Serv. / QMRP	-
	6,741

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

16. Out of State Travel

Administration

QMRP / RSD	-
	-
	-

Board of Directors

Blair Metzger	232
Kathy Woodruff	176
Kent Schmidgall	92
	500

Nursing

None	-
	-

LINDEN ESTATE - - #0039305

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:

Ben Knochel, Director
Blair Metzger, Vice Chairman
Bryan Stoller, Director (term ended 5/16/2020)
Ed Leman, Director
Kathy Woodruff, Director
Kent Schmidgall, Treasurer
Matt Zimmerman, Director (term began 5/16/2020)
Paul Kelson, Chairman
Royce Scheiler, Director
Wendy Sauder, Secretary

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

AIDE CLASSES **APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220** **From: 07/01/2019 to 06/30/2020**

CLASS DATE		TR					OE					LE					CILA				
		# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages
completed	48	29	1,160	$ 9,860.00	2320	$ 19,720.00	5	200	$ 1,700.00	400	$ 3,400.00	3	120	$ 1,020.00	240	$ 2,040.00	11	440	$ 3,740.00	880	$ 7,480.00
still enrolled, not complete	4	0	0	$ -	0	$ -	2	40	$ 340.00	80	$ 680.00	1	20	$ 170.00	40	$ 340.00	1	20	$ 170.00	40	$ 340.00
dropouts	9	5	100	$ 850.00	200	$ 1,700.00	3	60	$ 510.00	120	$ 1,020.00	0	0	$ -	0	$ -	1	20	$ 170.00	40	$ 340.00
				$ -	0	$ -			$ -	0	$ -			$ -	0	$ -			$ -	0	$ -
Total	2180	34	1260	$ 10,710.00	2520	$ 21,420.00	10	300	$ 2,550.00	600	$ 5,100.00	4	140	$ 1,190.00	280	$ 2,380.00	13	480	$ 4,080.00	960	$ 8,160.00

TRAINER WAGES		Classification	Hours	Hourly Rate	Wages		23-7033585-004 WAGES TR	OE	LE	CILA	Hours TR	OE	LE	CILA
Kathy	Kelch	10	-		$ -	$ -	-	-	-	-	-	-	-	-
Stacy	Brenton	10	1,705.60		$ 40,701.82	$ 2,613.88	23,524.90	5,601.17	2,613.88	8,961.87	985.81	234.72	109.53	375.54
Amanda	Fowler	10	1,299.36		$ 31,789.34	$ 2,041.52	18,373.66	4,374.68	2,041.52	6,999.49	751.01	178.81	83.45	286.10
Asher	Aberle	10	1,911.54		$ 32,470.45	$ 2,085.26	18,767.32	4,468.41	2,085.26	7,149.46	1,104.84	263.06	122.76	420.89
	OE					$ -	-	-	-	-	-	-	-	-
Crystal	Streitmatter	17			$ -	$ -	-	-	-	-	-	-	-	-
Brenda	Seggebruch	12r			$ -	$ -	-	-	-	-	-	-	-	-
	LE					$ -	-	-	-	-	-	-	-	-
Robert	Mooney	12r			$ -	$ -	-	-	-	-	-	-	-	-
					$ -	$ -	-	-	-	-	-	-	-	-
	CILA					$ -	-	-	-	-	-	-	-	-
Cody	Stieglitz	12r			$ -	$ -	-	-	-	-	-	-	-	-
Leigh	Mason	12q			$ -	$ -	-	-	-	-	-	-	-	-
						$ 6,740.65	60,665.88	14,444.26	6,740.65	23,110.81	2,841.65	676.58	315.74	1,082.53

Total trainer wages 4916.5 $ 104,961.61 $ 2,710.00 **Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits**

		TR	OE	LE	CILA
Drop-Outs					
Number from this Facility	$ -	5	3	0	1
Clinical Wages	$ -	$ 1,700.00	$ 120.00	$ -	$ 340.00
Classroom Wages	$ -	$ 850.00	$ 510.00	$ -	$ 170.00
In-House Trainer Wages	$ -	$ 1,605.00	$ 2,339.00	$ -	$ 321.00
	$ -				
Completed	$ -				
Number from this Facility	$ 3.00	29	5	3	11
Clinical Wages	$ 1,190.00	$ 9,860.00	$ 2,040.00	$ 1,190.00	$ 3,910.00
Classroom Wages	$ 2,380.00	$ 19,720.00	$ 480.00	$ 2,380.00	$ 7,820.00
In-House Trainer Wages	$ 4,494.00	$ 37,234.00	$ 2,201.00	$ 4,494.00	$ 14,765.00
Supplies	4654.38				

Schedule V

		Line	23-7033585-004 TR Change	OE Change	LE Change	CILA Change
Dietary	1	1	-	-	-	-
Maintenance	6	6	-	-	-	-
Nursing	10	10	(60,666.00)	(14,444.00)	(6,741.00)	######
Therapy	10a	10a	-	-	-	-
OT/PT	10ot	10a	-	-	-	-
Activities	11	11	-	-	-	-
RSD	12r	12	-	-	-	-
QMRP's	12q	12	-	-	-	-
MSSD	12m	12	-	-	-	-
Training Wages	13	13	60,666.00	14,444.00	6,741.00	######
Day Program	15	15	-	-	-	-
Administrator	17	17	-	-	-	-
OJT	12ojt	12	-	-	-	-
Speech	10s	10a	-	-	-	-
Adjustment		12	-	-	-	-
			-	-	-	-

$ 17,000.00	$ 19,720.00	400	$ 2,040.00	$ 7,480.00
$ 4,080.00	$ -	80	$ 340.00	$ 340.00
$ 1,700.00	$ 1,700.00	120	$ -	$ 340.00
$ -				
$ -				
$ 8,500.00	$ 9,860.00	$ 1,700.00	$ 1,020.00	$ 3,740.00
$ 2,040.00	$ -	$ 340.00	$ 170.00	$ 170.00
$ 850.00	$ 850.00	$ 510.00	$ -	$ 170.00

23-7033585-004		
1	1	0
6	6	0
10	10	-6741
10a	10a	0
11	11	0
12	12	0
13	13	6741
15	10a	0
17	17	0

LINDEN ESTATE

PER	DATE	VENDOR	EMPLOYEE NAME	EMPLOYEE TITLE	LOCATION	SPONSOR OF INSERVICE	TITLE OF INSERVICE	COST	TRAVEL
3	11/3/2020	CIDDNA	Janet Bradel	DON	Bloomington	CIDDNA	Conference	$ 58.54	
4	10/16/2020	PNC - Visa	Stacy Brenton	Trainor	Springfield	Nation's Best CPR	ARC Instructor Training	$ 27.67	
5	12/17/2019	VISA	Kathy Tanner	Payroll	East Peoria	AAIM Employers' Association	Annual Payroll and Fringe Benefit Update	$ 20.45	
5	12/17/2019	VISA	Tina Leman	HR	East Peoria	AAIM Employers' Association	Annual Payroll and Fringe Benefit Update	$ 20.44	
8	3/23/2020	Visa	Tina Leman	HR	Peoria	Skillpath	HR Law Seminar	$ 9.26	
10	4/20/2020	Ron's Visa	Tina Leman	HR	Webinar	Fred Pryor	Managing Emotions under Pressure	$ 14.81	
							Total:	**$ 151.17**	