

		FOR OHF USE				

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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

<p>I. IDPH Facility ID Number: <u>0023952</u></p> <p>Facility Name: <u>Apostolic Christian Restmor</u></p> <p>Address: <u>935 E. Jefferson</u> <u>Morton</u> <u>61550</u> Number City Zip Code</p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>309-266-7141</u> Fax # <u>309-266-7877</u></p> <p>IDPA ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>April 1978</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 c-3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Kaiser</u> Telephone Number: <u>309-266-7141</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 c-3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-1-2003</u> to <u>12-31-2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>John Kelley</u></td> </tr> <tr> <td data-bbox="1144 828 1281 876"></td> <td data-bbox="1281 828 1921 876">(Title) <u>Administrator</u></td> </tr> <tr> <td data-bbox="1144 876 1281 1039">Paid Preparer</td> <td data-bbox="1281 876 1921 1039">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (_____)</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>John Kelley</u>		(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (_____)
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (_____)																														

Facility Name & ID Number Apostolic Christian Restmor

0023952 Report Period Beginning: 1-1-2003 Ending: 12-31-2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>26</u>	Sheltered Care (SC)	<u>26</u>	<u>9,490</u>	5
6		ICF/DD 16 or Less			6
7	<u>146</u>	TOTALS	<u>146</u>	<u>53,290</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>9,462</u>	<u>28,760</u>	<u>2,949</u>	<u>41,171</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>1</u>	<u>6,211</u>		<u>6,212</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,463</u>	<u>34,971</u>	<u>2,949</u>	<u>47,383</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.92%

D. How many bed-hold days during this year were paid by Public Aid? 25 (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)

Meals on wheels, pharmacy

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 4-1-78

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4-1-78 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 2,949

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 12/31

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2003 Ending: 12-31-2003

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	292,061	20,982	137,216	450,259		450,259	450,259			1
2	Food Purchase		268,498		268,498	(5,600)	262,898	(14,260)	248,638		2
3	Housekeeping	112,897	3,181	40,189	156,267		156,267		156,267		3
4	Laundry	76,914	21,439	26,793	125,146		125,146		125,146		4
5	Heat and Other Utilities			128,637	128,637		128,637		128,637		5
6	Maintenance	115,676	31,359	153,735	300,770		300,770	(4,562)	296,208		6
7	Other (specify):* <u>waste, 17002; sec, 73</u>			17,075	17,075		17,075		17,075		7
8	TOTAL General Services	597,548	345,459	503,645	1,446,652	(5,600)	1,441,052	(18,822)	1,422,230		8
	B. Health Care and Programs										
9	Medical Director			2,525	2,525		2,525		2,525		9
10	Nursing and Medical Records	2,478,817	136,672	199,441	2,814,930	(130,458)	2,684,472		2,684,472		10
10a	Therapy			160,104	160,104		160,104		160,104		10a
11	Activities	138,902	5,385		144,287		144,287	(1,050)	143,237		11
12	Social Services	150,784	816		151,600		151,600		151,600		12
13	Nurse Aide Training					8,524	8,524		8,524		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,768,503	142,873	362,070	3,273,446	(121,934)	3,151,512	(1,050)	3,150,462		16
	C. General Administration										
17	Administrative	151,839			151,839		151,839	(21,900)	129,939		17
18	Directors Fees										18
19	Professional Services			49,133	49,133		49,133	(3,684)	45,449		19
20	Dues, Fees, Subscriptions & Promotions			41,371	41,371		41,371	(22,571)	18,800		20
21	Clerical & General Office Expenses	270,327	37,954	55,618	363,899	(14,632)	349,267	(2,954)	346,313		21
22	Employee Benefits & Payroll Taxes			1,076,337	1,076,337	6,783	1,083,120	(17,250)	1,065,870		22
23	Inservice Training & Education										23
24	Travel and Seminar			42,972	42,972	(8,340)	34,632	(18,200)	16,432		24
25	Other Admin. Staff Transportation			4,885	4,885	379	5,264	(4,885)	379		25
26	Insurance-Prop.Liab.Malpractice			122,291	122,291		122,291		122,291		26
27	Other (specify):*										27
28	TOTAL General Administration	422,166	37,954	1,392,607	1,852,727	(15,810)	1,836,917	(91,444)	1,745,473		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,788,217	526,286	2,258,322	6,572,825	(143,344)	6,429,481	(111,316)	6,318,165		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

Apostolic Christian Restmor

#0023952

Report Period Beginning:

1-1-2003

Ending:

12-31-2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			207,061	207,061		207,061	(3,153)	203,908			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					28,045	28,045		28,045			35
36	Other (specify):*											36
37	TOTAL Ownership			207,061	207,061	28,045	235,106	(3,153)	231,953			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	273,630	1,336,035	27,612	1,637,277	115,299	1,752,576	(913,289)	839,287			39
40	Barber and Beauty Shops	30,913	3,010		33,923		33,923		33,923			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			65,700	65,700		65,700		65,700			43
44	TOTAL Special Cost Centers	304,543	1,339,045	93,312	1,736,900	115,299	1,852,199	(913,289)	938,910			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,092,760	1,865,331	2,558,695	8,516,786		8,516,786	(1,027,758)	7,489,028			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 Apostolic Christian Restmor

0023952

Report Period Beginning: 1-1-2003

Ending: 12-31-2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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

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

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

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

Apostolic Christian Restmor

ID# 0023952

Report Period Beginning: 1-1-2003

Ending: 12-31-2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Items qualifying for deferred maintenance	\$ (5,986)	6	1
2	Current year deferred maintenance	4,137	6	2
3	Non allowable maint cost not capitalized	(2,713)	6	3
4	Non Illinois seminar	(5,193)	24	4
5	Pharmacy and non allowable dues and subs	(11,629)	20	5
6	Outside pharmacy	(910,558)	39	6
7	Non care promotion	(10,942)	20	7
8	Employee meal income	(5,600)	22	8
9	Guest meal income	(743)	2	9
10	Telephone Income	(370)	21	10
11	W/C refund	(11,650)	22	11
12	Misc Expense	(2,584)	21	12
13	Adm auto expense	(4,885)	25	13
14	Depreciation	(3,153)	30	14
15	SIA D-Merc billing	(2,400)	19	15
16	MOW Cost	(11,859)	2	16
17	Activities Income	(1,050)	11	17
18	Parkside Management Fee	(21,900)	17	18
19	Out of State Travel	(13,007)	24	19
20	Employee meal income	(1,658)	2	20
21	Income Tax	(2,731)	39	21
22	Non Care Letal	(1,284)	19	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	(1,027,758)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor# 0023952 Report Period Beginning:

1-1-2003

Ending:

12-31-2003

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	(14,260)	0	0	0	0	0	0	0	0	0	0	(14,260)	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	(4,562)	0	0	0	0	0	0	0	0	0	0	(4,562)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,822)	0	0	0	0	0	0	0	0	0	0	(18,822)	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	(1,050)	0	0	0	0	0	0	0	0	0	0	(1,050)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	(1,050)	0	0	0	0	0	0	0	0	0	0	(1,050)	16
	C. General Administration													
17	Administrative	(21,900)	0	0	0	0	0	0	0	0	0	0	(21,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,684)	0	0	0	0	0	0	0	0	0	0	(3,684)	19
20	Fees, Subscriptions & Promotions	(22,571)	0	0	0	0	0	0	0	0	0	0	(22,571)	20
21	Clerical & General Office Expenses	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	21
22	Employee Benefits & Payroll Taxes	(17,250)	0	0	0	0	0	0	0	0	0	0	(17,250)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(18,200)	0	0	0	0	0	0	0	0	0	0	(18,200)	24
25	Other Admin. Staff Transportation	(4,885)	0	0	0	0	0	0	0	0	0	0	(4,885)	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	(91,444)	0	0	0	0	0	0	0	0	0	0	(91,444)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,316)	0	0	0	0	0	0	0	0	0	0	(111,316)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor# 0023952 Report Period Beginning:

1-1-2003 Ending: 12-31-2003

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(3,153)	0	0	0	0	0	0	0	0	0	0	(3,153) 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	(3,153)	0	0	0	0	0	0	0	0	0	0	(3,153) 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	(913,289)	0	0	0	0	0	0	0	0	0	0	(913,289) 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	(913,289)	0	0	0	0	0	0	0	0	0	0	(913,289) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(1,027,758)	0	0	0	0	0	0	0	0	0	0	(1,027,758) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Greg Kaiser, Director	0					
Ken Baum, Director	0					
Ted Staker, Director	0					
Bruce Sauder, Director	0					
Steve Roeschley, Director	0					
Ed Kaiser, Director	0					
John Zimmerman, Director	0					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2003 Ending: 12-31-2003

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	No compensation to board members								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2003 Ending: 2-31-2003

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1					NONE			\$	\$			\$	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 **Apostolic Christian Restmor**# **0023952** Report Period Beginning: **1-1-2003** Ending: **12-31-2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2002 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 2003 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:		1998	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0023952

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 2002 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 2002.

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

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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Apostolic Christian Restmor# 0023952 Report Period Beginning:1-1-2003 Ending:12-31-2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	217,800	1978	\$ 125,000	1
2	Cong Living/Other	45 acres	1991-2003	483,441	2
3	TOTALS	#VALUE!		\$ 608,441	3

Facility Name & ID Number Apostolic Christian Restmor# 0023952

Report Period Beginning:

1-1-2003

Ending:

12-31-2003**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	146		1978	1961	\$ 315,426	\$ 9,909	25		\$ (9,909)	\$ 315,426	4
5				1962	59,373		25			59,373	5
6				1965	324,445		25			324,445	6
7				1971	2,813		20			2,813	7
8				1976	112,250		20			112,250	8
	Improvement Type**										
9				1978	15,000		20			15,000	9
10				1979	7,888		20			7,888	10
11				1980	50,819		16			50,819	11
12				1981	90,107		16			90,107	12
13				1982	96,603		18			96,603	13
14				1983	39,124		16			39,124	14
15				1984	243,503		16			243,503	15
16				1986	660,199	33,010	20	33,010		610,685	16
17				1986	18,532	401	18	507	106	18,532	17
18				1987	122,666		20	6,133	6,133	107,328	18
19				1987	27,395	1,333	20	1,370	37	23,975	19
20				1988	85,020	823	15		(823)	85,020	20
21				1989	46,665	1,435	15	1,555	120	46,665	21
22				1990	7,131	81	8--20	81		6,601	22
23				1991	38,812	569	10--15	804	235	38,812	23
24				1992	55,156		5--10			55,156	24
25				1993	46,959	2,273	10	3,473	1,200	46,959	25
26				1994	3,462	346	10	346		3,171	26
27				1995	64,958	4,330	10--15	4,163	(167)	36,869	27
28	Locking System			1996	12,447	830	15	830		6,639	28
29	Roof Repairs			1996	2,500		5			2,500	29
30	Water Heater			1996	7,066	707	10	707		5,654	30
31	Sink			1996	3,148	210	15	210		1,679	31
32	Carpet			1996	1,824	182	10	182		1,443	32
33	Quick Channels			1996	585	58	10	58		461	33
34	Oxygen Control Manager			1996	5,301	442	12	442		3,461	34
35	Room Closets			1996	44,000	2,200	20	2,200		16,867	35
36											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 Apostolic Christian Restmor# 0023952

Report Period Beginning:

1-1-2003

Ending:

12-31-2003**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Ventilator Remodeling	1996	\$ 34,281	\$ 2,285	15	\$ 2,285	\$	\$ 17,520		37
38	Carpeting	1996	20,762	2,076	10	2,076		15,744		38
39	Sewer Repair	1996	5,534	369	15	369		2,736		39
40	Roofing Repair	1996	2,950		5			2,950		40
41	Wallpaper Drapes	1996	5,409	361	15	361		2,676		41
42	Dining Room Door	1997	1,658	111	15	111		757		42
43	Electric Installed for A/C	1997	2,300	115	20	115		767		43
44	Floor Covering Therapv	1997	656	66	10	66		422		44
45	Fire Alarm System	1998	15,800	1,317	12	1,317		7,901		45
46	Conference Room carpet	1998	1,112	111	10	111		630		46
47	Shower Repairs	1998	1,524	102	15	102		568		47
48	A/C Compressor	1998	6,485	811	8	811		4,527		48
49	Pharmacy Building Improvements	1998	2,503	167	15	167		849		49
50	Broom Closet	1998	700	47	15	47		238		50
51	Ceiling Tile	1999	1,600	160	10	160		800		51
52	Pharmacy Building Improvements	1999	8,585	572	15	572		2,813		52
53	Door Alarm	1999	6,075	868	7	868		4,267		53
54	Bulletin Boards	1999	5,669	567	10	567		2,740		54
55	Wallcovering Room 117	1999	889	89	10	89		423		55
56	Nursing Office	1999	4,401	440	10	440		2,017		56
57	Computer Cables	1999	11,475	1,639	7	1,639		7,239		57
58	Blinds	1999	605	61	10	61		264		58
59	Break Room Carpet	1999	1,515	216	7	216		919		59
60	Marketing Office Electric	1999	2,768	185	15	185		863		60
61	Thin Trees	1999	1,765	353	5	353		1,765		61
62	Mulch	1999	1,300		3			1,300		62
63	Exchange Oil Tanks	1999	15,833	1,056	15	1,056		4,839		63
64	Roof Repair	2000	4,365		2			4,365		64
65	Dining Room Floor	2000	2,788	558	4	697	139	2,509		65
66	Vestibule Alarm	2000	4,618	1,155	4	931	(224)	4,618		66
67	Bathroom Floor Covering	2000	1,229	307	4	307		1,075		67
68	Air Duct for Telephone	2000	3,160	790	4	790		2,765		68
69	Med Room A/C	2000	5,483	1,097	5	1,097		4,296		69
70	TOTAL (lines 4 thru 69)		\$ 2,796,974	\$ 77,190		\$ 74,037	\$ (3,153)	\$ 2,583,990		70

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

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning:

1-1-2003

Ending:

12-31-2003

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,796,974	\$ 77,190		\$ 74,037	\$ (3,153)	\$ 2,583,990	1
2	Dining Room Compressor	2000	4,348	870	5	870		3,407	2
3	Trees	2001	3,500	175	20	175		379	3
4	New Sidewalk	2001	2,920	292	10	292		633	4
5	Sealcoating	2003	4,130	860	2	860		860	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,811,872	\$ 79,387		\$ 76,234	\$ (3,153)	\$ 2,589,269	34

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

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning:

1-1-2003

Ending:

12-31-2003

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,457,389	\$ 110,541	\$ 110,541	\$	2--15	\$ 1,143,367	71
72	Current Year Purchases	51,252	8,397	8,397		3--12	8,397	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,508,641	\$ 118,938	\$ 118,938	\$		\$ 1,151,764	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Bus, 1996 dodge van	1990, 1996	\$ 60,654	\$	\$			\$ 60,654	76
77	Pharmacy Transportaion	1992 van	1999	7,459					7,459	77
78	Staff & Administration	1998 century, wagon	1998	44,940	7,490	7,490			44,940	78
79	Facility Operation	Machinery & Equipment		14,719	1,246	1,246			6,229	79
80	TOTALS			\$ 127,772	\$ 8,736	\$ 8,736	\$		\$ 119,282	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)	\$ 5,056,726	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207,061	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,908	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,153)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,860,315	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 28,045 Description: Plants, 2106; Copiers, 12526; vents and O2 concentrators, 13413
 (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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="text" value="84"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER AIDE <input type="text" value="84"/></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="text" value="40"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER AIDE <input type="text" value="40"/></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		2,618		2,618
4	Clinical Wages (b)		2,156		2,156
5	In-House Trainer Wages (c)		3,450		3,450
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		300		300
9	TOTALS	\$	8,524	\$	8,524
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,524		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	1
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$			\$	14,599	\$		\$	14,599	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs					18,557				18,557	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a-3	hrs					24,008				24,008	4	
5	Physician Care		visits					1,400				1,400	5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39	# of prescripts	273,630					1,347,780			1,621,410	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program			115,299								115,299	12	
13	Other (specify): Lab							11,736				11,736	13	
14	TOTAL			\$ 388,929			\$	70,300	\$	1,347,780		\$	1,807,009	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Restmor# 0023952Report Period Beginning: 1-1-2003

Ending:

12-31-2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2003

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 198,996	\$ 1
2	Cash-Patient Deposits	7,557	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,125,293	3
4	Supply Inventory (priced at)	214,619	4
5	Short-Term Investments	2,283,102	5
6	Prepaid Insurance	36,483	6
7	Other Prepaid Expenses	102,380	7
8	Accounts Receivable (owners or related parties)	27,252	8
9	Other(specify): <u>Security Deposits</u>	42,039	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,037,721	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	18,989	12
13	Land	790,488	13
14	Buildings, at Historical Cost	2,182,754	14
15	Leasehold Improvements, at Historical Cost	989,479	15
16	Equipment, at Historical Cost	1,636,413	16
17	Accumulated Depreciation (book methods)	(4,349,616)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):	3,342,743	22
23	Other(specify): <u>WIP- New</u>	62,441	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,673,691	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,711,412	\$ 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 66,653	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	7,557	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	121,979	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,166	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>Accrued Pension</u>	228,970	36
37	<u>Accrued PTO</u>	323,924	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 758,249	\$ 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			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 758,249	\$ 46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,953,163	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,711,412	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,035,263	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,035,263	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	917,899	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)	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 917,900	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,953,163	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,555,135	1
2	Discounts and Allowances for all Levels	(508,402)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,046,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	272,341	6
7	Oxygen	28,182	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 300,523	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	44,765	13
14	Non-Patient Meals	27,638	14
15	Telephone, Television and Radio	370	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,766,701	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,513	19
20	Radiology and X-Ray		20
21	Other Medical Services	241,159	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,118,146	23
D. Non-Operating Revenue			
24	Contributions	865,693	24
25	Interest and Other Investment Income***	63,601	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 929,294	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See page 24	39,989	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 39,989	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,434,685	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,446,652	31
32	Health Care	3,273,446	32
33	General Administration	1,852,727	33
B. Capital Expense			
34	Ownership	207,061	34
C. Ancillary Expense			
35	Special Cost Centers	1,671,200	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,516,786	40
41	Income before Income Taxes (line 30 minus line 40)**	917,899	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 917,899	43

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

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

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

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

Facility Name & ID Number **Apostolic Christian Restmor**# **0023952**Report Period Beginning: **1-1-2003**Ending: **12-31-2003**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 61,912	\$ 29.77	1
2	Assistant Director of Nursing	4,589	4,936	119,702	24.25	2
3	Registered Nurses	17,814	18,941	419,319	22.14	3
4	Licensed Practical Nurses	18,352	19,959	350,067	17.54	4
5	Nurse Aides & Orderlies	100,229	108,275	1,231,614	11.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,476	4,974	59,056	11.87	8
9	Activity Director	2,388	2,541	34,171	13.45	9
10	Activity Assistants	8,531	9,144	104,731	11.45	10
11	Social Service Workers	6,031	6,540	97,652	14.93	11
12	Dietician					12
13	Food Service Supervisor	1,990	2,170	24,266	11.18	13
14	Head Cook	3,327	3,553	41,700	11.74	14
15	Cook Helpers/Assistants	22,659	24,386	226,095	9.27	15
16	Dishwashers					16
17	Maintenance Workers	6,411	7,110	115,676	16.27	17
18	Housekeepers	11,560	13,111	112,897	8.61	18
19	Laundry	7,855	8,697	76,914	8.84	19
20	Administrator	1,816	2,080	80,151	38.53	20
21	Assistant Administrator	1,960	2,080	71,688	34.47	21
22	Other Administrative	3,720	4,160	129,834	31.21	22
23	Office Manager					23
24	Clerical	8,471	9,187	125,149	13.62	24
25	Vocational Instruction	1,815	2,080	59,810	28.75	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,994	4,338	53,132	12.25	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,863	9,588	121,885	12.71	31
32	Other Health C: HIPAA and policy	1,815	2,080	55,452	26.66	32
33	Other(specify) <u>Pharmacy, hair ca</u>	15,852	17,258	319,887	18.54	33
34	TOTAL (lines 1 - 33)	266,518	289,268	\$ 4,092,760 *	\$ 14.15	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	25	2,525	9-3	36
37	Medical Records Consultant	12	1,200	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	\$ 3,725		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	858	\$ 29,964	10-3	50
51	Licensed Practical Nurses	3,340	116,781	10-3	51
52	Nurse Aides	1,894	33,067	10-3	52
53	TOTAL (lines 50 - 52)	6,092	\$ 179,812		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Repair plumbing-dogwood	1/2002/	\$ 2,400	3	\$	\$	\$ 800	\$ 800	\$ 800	\$	\$	\$
2	Replace compressor in din	6/2002	4,500	3			875	1,500	1,500	625		
3	Replace compressor in Elr	8/2002	1,392	3			193	464	464	271		
4	Replace heat exchanger in l	3/2003	2,250	3				750	750	750		
5	new flooring in 216, 115	12/2003	1,062	3				177	354	354	177	
6	Replace compressor in sta	8/2003	1,389	3				232	463	463	231	
7	Replace gas valves on boile	9/2003	1,286	3				214	429	429	214	
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 14,279		\$	\$	\$ 1,868	\$ 4,137	\$ 4,760	\$ 2,892	\$ 622	\$

Facility Name & ID Number Apostolic Christian Restmor# 0023952Report Period Beginning: 1-1-2003Ending: 12-31-2003**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. Life Services Network, \$4635
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,927 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
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? No 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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 5,600 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,258
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? No record
d. Have vehicle usage logs been maintained? partially
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: review The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

DETAIL TO SCHEDULE XVII, LINE 28

Social Activities Income	2170
Personal Supplies Income	3219
Sunshine Cart Income	1050 offset
W/C refunds	11650 offset
Parkside Management Fee	21900 offset
Total per line 28	39989

Reconcile Schedule V, line 39 to Schedule XIV, line 14.

Balance Sch V line 39	839287
Add licensed therapist amounts from line 10a	57164
Add outside pharmacy amounts adusted out	910558
Total per Schedule XIV, line 14	1807009