



Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN

# 0029892 Report Period Beginning: Jan. 1, 2004 Ending: Dec. 31, 2004

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 n/a

	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	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,300	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	2,566	5,237		7,803	8
9	SNF/PED					9
10	ICF	1,122	8,966		10,088	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,688	14,203		17,891	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.77%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

Meals, hair care, personal care for apartment residents

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 11/07/1985

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: December 31 Fiscal Year: December 31

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

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2004 Ending: Dec. 31, 2004

**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
	<b>A. General Services</b>										
1	Dietary	232,278	11,156		243,434		243,434	25	243,459		1
2	Food Purchase		101,942		101,942		101,942	(19,399)	82,543		2
3	Housekeeping	55,668	8,604		64,272		64,272		64,272		3
4	Laundry	34,830	4,515		39,345		39,345		39,345		4
5	Heat and Other Utilities			58,983	58,983		58,983		58,983		5
6	Maintenance	51,749	2	29,245	80,996		80,996		80,996		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>374,525</b>	<b>126,219</b>	<b>88,228</b>	<b>588,972</b>		<b>588,972</b>	<b>(19,374)</b>	<b>569,598</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,205,436	10,066	9,298	1,224,800		1,224,800	105	1,224,905		10
10a	Therapy		328	2,930	3,258		3,258		3,258		10a
11	Activities	60,292	6,170	1,668	68,130		68,130	1,093	69,223		11
12	Social Services	24,942	284	1,535	26,761		26,761		26,761		12
13	Nurse Aide Training			4,248	4,248	(4,248)					13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,290,670</b>	<b>16,848</b>	<b>21,679</b>	<b>1,329,197</b>	<b>(4,248)</b>	<b>1,324,949</b>	<b>1,198</b>	<b>1,326,147</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	83,451			83,451		83,451		83,451		17
18	Directors Fees										18
19	Professional Services			19,856	19,856		19,856	(250)	19,606		19
20	Dues, Fees, Subscriptions & Promotions			7,564	7,564		7,564	(1,175)	6,389		20
21	Clerical & General Office Expenses	37,685	7,569	4,262	49,516		49,516		49,516		21
22	Employee Benefits & Payroll Taxes			377,655	377,655	11,029	388,684	228	388,912		22
23	Inservice Training & Education			8,002	8,002	1,237	9,239		9,239		23
24	Travel and Seminar			999	999	3,011	4,010	(3,311)	699		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,672	50,672		50,672		50,672		26
27	Other (specify):* <u>see schedule</u>			11,079	11,079	(11,029)	50	(63)	(13)		27
28	<b>TOTAL General Administration</b>	<b>121,136</b>	<b>7,569</b>	<b>480,089</b>	<b>608,794</b>	<b>4,248</b>	<b>613,042</b>	<b>(4,571)</b>	<b>608,471</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,786,331</b>	<b>150,636</b>	<b>589,996</b>	<b>2,526,963</b>		<b>2,526,963</b>	<b>(22,747)</b>	<b>2,504,216</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 RESTHAVEN

#0029892

Report Period Beginning: Jan. 1, 2004 Ending:

Dec. 31, 2004

## 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	
	<b>D. Ownership</b>											
30	Depreciation			124,241	124,241		124,241	(28,414)	95,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(13,190)	(13,190)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			124,241	124,241		124,241	(41,604)	82,637			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,587	119,333	171,920		171,920		171,920			39
40	Barber and Beauty Shops	23,369	176	1,788	25,333		25,333		25,333			40
41	Coffee and Gift Shops		1,247		1,247		1,247	(1,247)				41
42	Provider Participation Fee			27,450	27,450		27,450		27,450			42
43	Other (specify):* <a href="#">see schedule</a>		361	65,855	66,216		66,216	(65,855)	361			43
44	<b>TOTAL Special Cost Centers</b>	23,369	54,371	214,426	292,166		292,166	(67,102)	225,064			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,809,700	205,007	928,663	2,943,370		2,943,370	(131,453)	2,811,917			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,584)	2		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	(493)	30		9
10	Interest and Other Investment Income	(13,190)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(27,921)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		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	(250)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,000)	20		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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (62,676)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	<b>(sum of SUBTOTALS</b>			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (62,676)		37

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

APOSTOLIC CHRISTIAN RESTHAVEN

ID# 0029892

Report Period Beginning: Jan. 1, 2004

Ending: Dec. 31, 2004

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Out-of-state travel	\$ (3,011)	24	1
2	Apartment expense	(65,855)	43	2
3	Vending expense	(1,247)	41	3
4	Non-care vehicle expense	(300)	24	4
5	Donated food	185	2	5
6	Donated nursing supplies	105	10	6
7	Donated activities	1,093	11	7
8	Donated staff appreciation/employee relations	228	22	8
9	Donated dietary supplies	25	1	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(68,777)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN# 0029892

Report Period Beginning:

Jan. 1, 2004

Ending:

Dec. 31, 2004

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	25	0	0	0	0	0	0	0	0	0	0	25	1
2	Food Purchase	(19,399)	0	0	0	0	0	0	0	0	0	0	(19,399)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(19,374)</b>	<b>0</b>	<b>(19,374)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	105	0	0	0	0	0	0	0	0	0	0	105	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,093	0	0	0	0	0	0	0	0	0	0	1,093	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	<b>TOTAL Health Care and Programs</b>	<b>1,198</b>	<b>0</b>	<b>1,198</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(250)	0	0	0	0	0	0	0	0	0	0	(250)	19
20	Fees, Subscriptions & Promotions	(1,175)	0	0	0	0	0	0	0	0	0	0	(1,175)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	228	0	0	0	0	0	0	0	0	0	0	228	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,311)	0	0	0	0	0	0	0	0	0	0	(3,311)	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):*	(63)	0	0	0	0	0	0	0	0	0	0	(63)	27
28	<b>TOTAL General Administration</b>	<b>(4,571)</b>	<b>0</b>	<b>(4,571)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(22,747)</b>	<b>0</b>	<b>(22,747)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN# 0029892

Report Period Beginning:

Jan. 1, 2004 Ending:

Summary B

Dec. 31, 2004

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(28,414)	0	0	0	0	0	0	0	0	0	0	(28,414)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,190)	0	0	0	0	0	0	0	0	0	0	(13,190)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(41,604)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,604)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,247)	0	0	0	0	0	0	0	0	0	0	(1,247)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(65,855)	0	0	0	0	0	0	0	0	0	0	(65,855)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(67,102)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(67,102)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(131,453)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(131,453)</b>	<b>45</b>

**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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	27 Rent-land	\$ 1	Apostolic Christian Church of Elgin	100.00%	\$ 1	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ 1			\$ 1	\$ *	14

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

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2004 Ending: Dec. 31, 2004

## 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									\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN

# 0029892

Report Period Beginning: Jan. 1, 2004

Ending: Dec. 31, 2004

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

APOSTOLIC CHRISTIAN RESTHAVEN

# 0029892

Report Period Beginning:

Jan. 1, 2004 Ending:

Dec. 31, 2004

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME APOSTOLIC CHRISTIAN RESTHAVEN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0029892

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 2003 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 2003.

	(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.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,600 B. General Construction Type: Exterior 80% brick/20% cedar Frame Steel Number of Stories 1

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

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

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

Eighteen (18) congregate housing units (apartments) are attached to the nursing home. Utilities are separately metered and costs are handled separately

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number APOSTOLIC CHRISTIAN RESTHAVEN

# 0029892

Report Period Beginning:

Jan. 1, 2004 Ending: Dec. 31, 2004

**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	49	1985	1985	\$ 2,033,874	\$ 50,847	40	\$ 50,847	\$	\$ 982,660	4
5		1986	1986	10,064	252	40	252		4,660	5
6		1987	1987	67,246	1,681	40	1,681		29,417	6
7	1	1988	1988	91,817	2,295	40	2,295		37,868	7
8		1999	1999	74,929	1,873	40	1,380	(493)	8,666	8
<b>Improvement Type**</b>										
9	Land improvements		1985	24,667		15			24,667	9
10	Land improvements		1986	4,800		15			4,800	10
11	Land improvements		1989	2,069	46	15	46		2,058	11
12	Land improvements		1990	590	39	15	39		559	12
13	Land improvements		1992	3,525	235	15	235		2,938	13
14	Land improvements		1992	26,596	1,771	15	1,771		21,720	14
15	Land improvements		1997	15,126	1,008	15	1,008		7,476	15
16	Land improvements		1997	16,291	1,086	15	1,086		7,964	16
17	Land improvements-parking lot		2001	5,200	347	15	347		1,128	17
18	Land improvements-parking lot sealcoating		2001	2,095	140	15	140		455	18
19	Building improvements		1986	1,400	70	20	70		1,266	19
20	Building improvements		1987	8,669	433	20	433		7,461	20
21	Building improvements		1988	28,461	1,423	20	1,423		23,479	21
22	Building improvements		1989	500	25	20	25		392	22
23	Building improvements		1990	6,091	305	20	305		4,405	23
24	Building improvements		1991	6,846	342	20	342		4,520	24
25	Building improvements		1992	15,080	754	20	754		9,425	25
26	Building improvements		1994	885	44	20	44		458	26
27	Building improvements		1995	18,458	1,850	10	1,850		17,659	27
28	Building improvements		1996	6,987	699	10	699		6,049	28
29	Building improvements		1996	809	40	20	40		347	29
30	Building improvements		1997	1,164	116	10	116		880	30
31	Building improvements		1998	2,100	105	20	105		709	31
32	Building improvements		1998	2,029	101	20	101		665	32
33	Building improvements		1998	2,671	267	10	267		1,713	33
34	Building improvements		1999	4,500	225	20	225		1,313	34
35	Building improvements		1999	3,882	194	20	194		1,116	35
36	Building improvements		1999	389	19	20	19		109	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Building improvements	1999	\$ 310	\$ 16	20	\$ 16	\$	\$ 91	37
38	Building improvements	1999	1,325	66	20	66		380	38
39	Building improvements	1999	985	49	20	49		278	39
40	Building improvements	1999	656	33	20	33		171	40
41	Building improvements	2000	1,975	99	20	99		454	41
42	Building improvements-faucets	2001	104	5	20	5		18	42
43	Building improvements-faucets	2001	2,268	113	20	113		414	43
44	Building improvements-greasetrap	2001	3,769	188	20	188		689	44
45	Building improvements-door shades	2001	281	14	20	14		47	45
46	Building improvements-door shades	2001	281	14	20	14		46	46
47	Building improvements-damper	2001	710	36	20	36		113	47
48	Building improvements-door for PT room	2001	600	30	20	30		93	48
49	Building improvements-drapes for employee dining room	2002	653	33	20	33		93	49
50	Building improvements-drapes for residents	2002	1,307	65	20	65		179	50
51	Building improvements-electromagnetic front doors	2003	1,717	86	20	86		165	51
52	Building improvements-air conditioning	2003	3,100	155	20	155		220	52
53	Building improvements-fire dampers	2003	2,160	108	20	108		126	53
54	Building improvements-steam table restoration	2004	3,700	170	20	170		170	54
55	Building improvements-hot water coil replacement	2004	3,408	142	20	142		142	55
56	Building improvements-activity room shelving	2004	1,850	77	20	77		77	56
57	Building improvements-service door exit alarms	2004	994	25	20	25		25	57
58	Building improvements-smoke detectors with office window	2004	953	12	20	12		12	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,522,916	\$ 70,168		\$ 69,675	\$ (493)	\$ 1,223,005	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 207,021	\$ 21,147	\$ 21,147	\$	5/10/20	\$ 125,469	71
72	Current Year Purchases	45,082	2,659	2,659		5/10	2,659	72
73	Fully Depreciated Assets	195,137					195,137	73
74								74
75	TOTALS	\$ 447,240	\$ 23,806	\$ 23,806	\$		\$ 323,265	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	Van-70% care-related	1996 National Mobility	1996	\$ 23,467	\$ 2,346	\$ 2,346	\$	10	\$ 20,732	76
77										77
78										78
79										79
80	TOTALS			\$ 23,467	\$ 2,346	\$ 2,346	\$		\$ 20,732	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)	\$ 2,993,623	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,320	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,827	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (493)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,567,002	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	Apartments-1986/1990/1999	\$ 924,274	\$ 23,107	\$ 368,229	86
87	Land improvements-1986/1990/1991/1997	94,036	2,646	66,740	87
88	Equipment-1986-1999	42,662	164	42,164	88
89	Building improvements-1999-2003	19,958	998	2,996	89
90	Van-30% non-care-1996	10,058	1,006	8,884	90
91	TOTALS	\$ 1,090,988	\$ 27,921	\$ 489,013	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?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2005                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2006                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2007                      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" 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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	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	39-2	visits				2,903		2,903	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		5,030	119,333	1,410	5,030	120,743	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>personal supplies</u>	39-2					48,274		48,274	13
14	TOTAL			\$	5,030	\$ 119,333	\$ 52,587	5,030	\$ 171,920	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **Dec. 31, 2004** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 603,148	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	92,825		3
4	Supply Inventory (priced at <u>cost</u> )	19,824		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,959		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 742,756	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	100,000		12
13	Land			13
14	Buildings, at Historical Cost	3,561,184		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	523,427		16
17	Accumulated Depreciation (book methods)	(2,057,495)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	95,394		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>deposits</u>	15,435		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,237,945	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,980,701	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 49,371	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			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
<b>Other Current Liabilities(specify):</b>				
36	<u>Deferred income-advance billings</u>	184,295		36
37	<u>Accrued expenses</u>	10,245		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 379,840	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deposits-Apartments</u>	183,600		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 183,600	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 563,440	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,417,261	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,980,701	\$	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,341,335</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,341,335</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>75,926</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>75,926</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,417,261</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **APOSTOLIC CHRISTIAN RESTHAVEN**# **0029892**Report Period Beginning: **Jan. 1, 2004**Ending: **Dec. 31, 2004**

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,599,435	1
2	Discounts and Allowances for all Levels	(137,722)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,461,713</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,500	6
7	Oxygen	122	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,622</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	2,955	13
14	Non-Patient Meals	7,607	14
15	Telephone, Television and Radio	89	15
16	Rental of Facility Space		16
17	Sale of Drugs	127,070	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 137,721</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	231,380	24
25	Interest and Other Investment Income***	13,190	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 244,570</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See schedule	173,670	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 173,670</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,019,296</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	588,972	31
32	Health Care	1,329,197	32
33	General Administration	608,794	33
<b>B. Capital Expense</b>			
34	Ownership	124,241	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	264,716	35
36	Provider Participation Fee	27,450	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,943,370</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>75,926</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 75,926</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **APOSTOLIC CHRISTIAN RESTHAVEN**

# **0029892**

Report Period Beginning: **Jan. 1, 2004**

Ending:

**Dec. 31, 2004**

**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	1,924	2,106	\$ 56,856	\$ 27.00	1
2	Assistant Director of Nursing	2,010	2,185	48,696	22.29	2
3	Registered Nurses	13,949	14,913	343,707	23.05	3
4	Licensed Practical Nurses	5,723	6,467	125,826	19.46	4
5	Nurse Aides & Orderlies	46,178	49,828	590,478	11.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,864	2,115	26,937	12.74	8
9	Activity Director	1,721	1,900	26,000	13.68	9
10	Activity Assistants	3,320	3,582	34,292	9.57	10
11	Social Service Workers	1,882	2,045	24,942	12.20	11
12	Dietician	2,098	2,197	43,732	19.91	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,612	18,234	188,546	10.34	15
16	Dishwashers					16
17	Maintenance Workers	3,051	3,287	51,749	15.74	17
18	Housekeepers	5,612	6,214	55,668	8.96	18
19	Laundry	2,891	3,181	34,830	10.95	19
20	Administrator	1,950	2,102	83,451	39.70	20
21	Assistant Administrator					21
22	Other Administrative	1,210	1,295	12,936	9.99	22
23	Office Manager					23
24	Clerical	2,875	3,132	37,685	12.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>barber/beauty</u>	1,517	1,709	23,369	13.67	33
34	TOTAL (lines 1 - 33)	116,387	126,492	\$ 1,809,700 *	\$ 14.31	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	6	2,000	9-3	36
37	Medical Records Consultant	13	783	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	4,500	10-3	39
40	Physical Therapy Consultant	53	2,930	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,668	11-3	44
45	Social Service Consultant	24	1,535	12-3	45
46	Other(specify)	138	1,654	40-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	354	\$ 15,070		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$		50	
51	Licensed Practical Nurses			51	
52	Nurse Aides	190	4,015	10-3	52
53	TOTAL (lines 50 - 52)	190	\$ 4,015		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
David Stieglitz	Administrator	0	\$ 83,451	Workers' Compensation Insurance	\$ 49,858	IDPH License Fee	\$ 750		
				Unemployment Compensation Insurance	(1,881)	Advertising: Employee Recruitment	1,735		
				FICA Taxes	133,830	Health Care Worker Background Check	97		
				Employee Health Insurance	143,174	(Indicate # of checks performed <u>20</u> )			
				Employee Meals	0	City restaurant license	140		
				Illinois Municipal Retirement Fund (IMRF)*	0	Association dues	3,047		
				Life insurance	1,161	Chamber of commerce	175		
				Pension expense	49,904	Publications/bulk mail license	266		
				Employee health services	1,609	Newsletter	1,000		
				Employee relations-see attached schedule	11,029	Buying group/notary/CLIA lab fees	354		
				Employee relations-donated goods adjustment	228	Less: Public Relations Expense	(175)		
						Non-allowable advertising	(1,000)		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,451	TOTAL (agree to Schedule V, line 22, col.8)		\$ 388,912	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,389
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 699
C. Professional Services			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount	
Borhart Spellmeyer & Company	CPA	\$ 9,463				Out-of-State Travel	\$ 2,429		
Paychex, Inc.	Payroll services	4,540							
Wagner Office Solutions	Office equipment service	1,007				In-State Travel			
MCC Technology	Computer network support	1,600				Vehicle expense	999		
Gardner & White	Form 5500 fpr EBP	410							
Achieve Healthcare	Medical software support	2,334				Seminar Expense			
						Less out-of-state travel	(2,429)		
Steffen, Kelly & Steffen	Attorney-collections	250				Less non-care vehicle expense	(300)		
Wessels & Pautsch	Attorney-labor	252				Entertainment Expense	( )		
						(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 19,856	TOTAL		\$			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2001					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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 2,165; AAHSA 747
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,271 Line 39
- (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. \$ 27,450  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 0 Has any meal income been offset against related costs? no Indicate the amount. \$ 0
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? yes  
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? 0
  - 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? yes
  - 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? no  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a 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? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.

APOSTOLIC CHRISTIAN RESTHAVEN  
SCHEDULE XVII SUPPORTING SCHEDULES  
2004 COST REPORT  
FACILITY #0029892

PAGE 19, SCHEDULE XVII

OTHER REVENUE, LINE 28

<u>ACCOUNT</u>		
8023	VENDING INCOME (NOTE: VENDING EXPENSE IS ALREADY ALREADY ADJUSTED OUT OF SCH. V, LINE 41)	1,892
6902	ACTIVITY	918
802	COOKBOOKS	882
8050	APARTMENTS	167,431
6911/8026	MISCELLANEOUS	<u>2,547</u>
		<u><u>173,670</u></u>

APOSTOLIC CHRISTIAN RESTHAVEN  
 SCHEDULE V SUPPORTING SCHEDULES  
 RECLASSIFICATION ENTRIES  
 2004 COST REPORT  
 FACILITY #0029892

Pages 3 and 4, Schedule V.

	<u>Cost Center</u>	<u>Expense Category</u>	<u>Line #</u>	<u>Reclassification</u>
1	General Administration Health Care and Programs	Inservice training Nurse aide training	23-3 13-3	4,248 (4,248)
	- to reclassify expenses (A/C 7044) not related to nurse aides' training.			
2	General Administration General Administration	Employee benefits Other	22-3 27-3	11,029 (11,029)
	- to reclassify employee benefits consistent with 1989 IDPA adjustments (A/C 7911).			
3	General Administration General Administration	Travel & seminars Inservice training	24-3 23-3	2,429 (2,429)
	- to reclassify out-of-state travel & seminar cost for 10/23-10/28/04 AAHSA annual meeting in Nashville, TN (see A/C 7853).			
4	General Administration General Administration	Travel & seminars Inservice training	24-3 23-3	582 (582)
	- to reclassify out-of-state travel & seminar cost for 8/9-8/11/2004 AmeriNet Central meeting in Warrendale, PA (see A/C 7529).			

<b><u>C. General Administration</u></b>	<b><u>7841</u></b>	<b><u>7911</u></b>	<b><u>7850</u></b>	
<b><u>Other expenses, Line 27</u></b>	<b><u>Volunteer</u></b>	<b><u>Employee</u></b>	<b><u>Misc.</u></b>	<b><u>Total</u></b>
	<b><u>Expense</u></b>	<b><u>Relations</u></b>	<b><u>Expense</u></b>	
Volunteer expense	-			
Plants, flowers		227		
Staff Christmas gifts		3,184		
Staff appreciation gifts, certificates, luncheon, cards, lunches, plants, awards		2,000		
Staff appreciation dinner		631		
Gifts for years of service anniversaries		800		
Christmas dinner		1,200		
Employee assistance program		2,025		
Other employee relations		962		
Rent-land			1	
Stop payment charge on 2 checks			49	
Column 4 total	-	11,029	50	11,079
<b>Reclassifications:</b>				
Employee benefits to Line 22	-	(11,029)	-	(11,029)
Column 6 reclassified total	-	-	50	50
<b>Adjustments:</b>				
Volunteer expense	-			-
Sales tax		(63)		(63)
Column 8 adjusted total	-	(63)	50	(13)

<b><u>E. Special Cost Centers</u></b>	<b><u>8540</u></b>	<b><u>8530</u></b>	<b><u>8508</u></b>	
<b><u>Other expenses, Line 43</u></b>	<b><u>Apartment</u></b>	<b><u>Multi-</u></b>	<b><u>Misc.</u></b>	<b><u>Total</u></b>
	<b><u>Expense</u></b>	<b><u>Purpose Rm.</u></b>	<b><u>Expense</u></b>	
Apartment expense	65,855			65,855
Multi-purpose room expense		361		361
Miscellaneous expense			-	-
Column 4 total	65,855	361	-	66,216
<b>Reclassifications-none</b>				
Column 6 reclassified total	65,855	361	-	66,216
<b>Adjustments:</b>				
Apartment expense	(65,855)	-	-	(65,855)
Column 8 adjusted total	-	361	-	361

APOSTOLIC CHRISTIAN RESTHAVEN  
SCHEDULE V SUPPORTING SCHEDULES  
TRAINING AND EDUCATION  
2004 COST REPORT  
FACILITY #0029892

PAGE 3, SCHEDULE V., LINE NO.

<u>Account</u>	<u>Account name</u>	<u>13</u> Nurse Aide Training	<u>23</u> Inservice Training & Education	<u>24</u> Travel & Seminar
7044	Nursing education	4,248		
7191	Social service education		570	
7230	Activities education		505	
7269	Hairdresser education (not classified on this line)			
7529	Dietary education		1,304	
7614	Maintenance education		13	
7820	Vehicle expense			999
7853	Administrative education		3,270	
7926	Employee Hiring and Training		2,340	
Column 4 total		4,248	8,002	999
Reclassifications:				
	Nursing education to Inservice	(4,248)	4,248	
	AAHSA annual conference to Travel & Seminar		(2,429)	2,429
	AmeriNet Central Meeting to Travel & Seminar		(582)	582
			-	-
Column 6 reclassified total		-	9,239	4,010
Adjustments: Out-of-state travel				(3,011)
Adjustments: Non-care vehicle expense				(300)
Column 8 adjusted total		-	9,239	699

Total

---

13,249
-
-
-

---

13,249
(3,011)
<u>(300)</u>

---

9,938

INDICATES INPUT CELL

Cost Report		Current				Accum
Page 12A care-related assets		Cost	book depr	SL depr	Adjust	depr
Building						
Land improvements						
Building improvements						
Line 70 totals		2,522,916	70,168	69,675	(493)	1,223,005
Page 13 care-related assets						
Equipment						
Line 75 totals		447,240	23,806	23,806		323,265
Van-care		33,525	3,352			29,616
Van-non-care		(10,058)	(1,006)		-	(8,884)
Line 80 totals		23,467	2,346	2,346	-	20,732
Equipment totals		470,707	26,152	26,152	-	343,997
Column 2 totals		2,993,623	96,320	95,827	(493)	1,567,002
	Line #	81	82	83	84	85

**FROM DEPRECIATION SCHEDULES-CARE-RELATED ASSETS**

BLDG		2,277,929	56,948			1,064,751
LIMP		100,959	4,674			73,765
BIMP		144,028	8,546			85,969
		<u>2,522,916</u>	<u>70,168</u>			<u>1,224,485</u>
ALL OTHER EQUIP		447,240	23,806			323,265
VAN-70% CARE	70.00%	23,467	2,346			20,732
VAN-30% NON-CARE	30.00%	10,058	1,006			8,884
TOTAL VAN		33,525	3,352			29,616
FEQP		480,765	27,158			352,881
		3,003,681	97,326			1,577,366
LESS 30% VAN NON-CARE		(10,058)	(1,006)			(8,884)
		<u>2,993,623</u>	<u>96,320</u>			<u>1,568,482</u>
Difference from cost report		-	-			(1,480)

Cost Report						
Page 13 Non-care assets						
Apartments		924,274	23,107			368,229
Land improvements		94,036	2,646			66,740
Equipment		42,662	164			42,164
Building improvements		19,958	998			2,996
		1,080,930	26,915	-	-	480,129
Van-non-care		10,058	1,006	-	-	8,884
Line 91		1,090,988	27,921	-	-	489,013

**FROM DEPRECIATION SCHEDULES-NON-CARE ASSETS**

BIMP		19,958	998			2,995
BLDG		924,274	23,107			368,229
FEQP		42,662	164			42,164
LIMP		94,036	2,646			66,741
		1,080,930	26,915			480,129
ADD 30% VAN NON-CARE		10,058	1,006			8,884
		<u>1,090,988</u>	<u>27,921</u>			<u>489,013</u>
Difference from cost report		-	-			-

**TOTALS CARE AND NON-CARE ASSETS**

Totals from cost report		4,084,611	124,241	95,827	(493)	2,056,015
TOTALS FROM DEPRECIATION SCH		4,084,611	124,241	-	-	2,057,495
Total diff from cost report		-	-	95,827	(493)	(1,480)

**Cost report roof adjustment to depreciation per IDPA:**

2002		(493)	(493)
2003		(493)	(493)
2004		(493)	(493)

(1,479)

Rounding

(1)

Total diff from cost report

(1,480)