

Facility Name & ID Number Apostolic Christian Resthaven

0029892 Report Period Beginning: Jan. 1, 2005 Ending: Dec. 31, 2005

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	18,250	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	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
		8	SNF	1,605		
9	SNF/PED				9	
10	ICF	1,679	7,709	9,388	10	
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	3,284	14,385	17,669	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.82%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) meals, hair care, housekeeping 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, 2005 Ending: Dec. 31, 2005

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	241,259	13,532		254,791		254,791	(11,615)	243,176		1
2	Food Purchase		100,701		100,701		100,701	(5,561)	95,140		2
3	Housekeeping	58,474	9,511		67,985		67,985		67,985		3
4	Laundry	34,780	5,578		40,358	548	40,906		40,906		4
5	Heat and Other Utilities			61,804	61,804		61,804		61,804		5
6	Maintenance	46,329	2	26,940	73,271		73,271	50	73,321		6
7	Other (specify):* waste removal			5,153	5,153		5,153		5,153		7
8	TOTAL General Services	380,842	129,324	93,897	604,063	548	604,611	(17,126)	587,485		8
	B. Health Care and Programs										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,283,666	11,037	7,627	1,302,330		1,302,330	85	1,302,415		10
10a	Therapy		12	3,013	3,025		3,025		3,025		10a
11	Activities	65,535	5,363	752	71,650		71,650	487	72,137		11
12	Social Services	23,865	123	1,298	25,286		25,286		25,286		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,373,066	16,535	14,690	1,404,291		1,404,291	572	1,404,863		16
	C. General Administration										
17	Administrative	87,754			87,754		87,754		87,754		17
18	Directors Fees										18
19	Professional Services			21,482	21,482		21,482		21,482		19
20	Dues, Fees, Subscriptions & Promotions			6,591	6,591	200	6,791	(975)	5,816		20
21	Clerical & General Office Expenses	58,580	7,407	4,227	70,214		70,214	190	70,404		21
22	Employee Benefits & Payroll Taxes			397,521	397,521		397,521	434	397,955		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,075	14,075	(200)	13,875	(3,507)	10,368		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,193	38,193		38,193		38,193		26
27	Other (specify):* miscell & volunteer			4,723	4,723	(548)	4,175	(1,169)	3,006		27
28	TOTAL General Administration	146,334	7,407	486,812	640,553	(548)	640,005	(5,027)	634,978		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,900,242	153,266	595,399	2,648,907		2,648,907	(21,581)	2,627,326		29

*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, 2005

Ending:

Dec. 31, 2005

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			125,415	125,415		125,415	(28,414)	97,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			125,415	125,415		125,415	(28,414)	97,001			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,627	156,347	201,974		201,974		201,974			39
40	Barber and Beauty Shops	22,487	339	1,140	23,966		23,966		23,966			40
41	Coffee and Gift Shops		945		945		945	(945)				41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):* apartment & mpr		350	72,152	72,502		72,502	(72,502)				43
44	TOTAL Special Cost Centers	22,487	47,261	257,014	326,762		326,762	(73,447)	253,315			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,922,729	200,527	977,828	3,101,084		3,101,084	(123,442)	2,977,642			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

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning:

Jan. 1, 2005

Ending:

Dec. 31, 2005

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	(5,576)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	11		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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(800)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,028)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (35,028)		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.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Apostolic Christian Resthaven

ID# 0029892

Report Period Beginning: Jan. 1, 2005

Ending: Dec. 31, 2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Out-of-state travel	\$ (3,069)	24	1
2	Apartment expense	(72,152)	43	2
3	Vending expense	(945)	41	3
4	Non-care vehicle expense	(438)	24	4
5	Donated food	15	2	5
6	Donated nursing supplies	85	10	6
7	Donated activities	550	11	7
8	Donated maintenance	50	6	8
9	Donated volunteer dinner food	159	27	9
10	Donated dietary supplies	163	1	10
11	Donated office supplies	190	21	11
12	Donated staff appr/employee relations	434	22	12
13	Non-Patient Meals (Wage-Related Costs)	(11,778)	1	13
14	Volunteer Expense	(1,328)	27	14
15	Multipurpose Room Expense	(350)	43	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(88,414)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2005

Ending:

Dec. 31, 2005

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	(11,615)	0	0	0	0	0	0	0	0	0	0	(11,615)	1
2	Food Purchase	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	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	50	0	0	0	0	0	0	0	0	0	0	50	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,126)	0	0	0	0	0	0	0	0	0	0	(17,126)	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	85	0	0	0	0	0	0	0	0	0	0	85	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	487	0	0	0	0	0	0	0	0	0	0	487	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	572	0	0	0	0	0	0	0	0	0	0	572	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(975)	0	0	0	0	0	0	0	0	0	0	(975)	20
21	Clerical & General Office Expenses	190	0	0	0	0	0	0	0	0	0	0	190	21
22	Employee Benefits & Payroll Taxes	434	0	0	0	0	0	0	0	0	0	0	434	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,507)	0	0	0	0	0	0	0	0	0	0	(3,507)	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):*	(1,169)	0	0	0	0	0	0	0	0	0	0	(1,169)	27
28	TOTAL General Administration	(5,027)	0	0	0	0	0	0	0	0	0	0	(5,027)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,581)	0	0	0	0	0	0	0	0	0	0	(21,581)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2005 Ending:

Dec. 31, 2005

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	(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	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	(28,414)	0	0	0	0	0	0	0	0	0	0	(28,414) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(945)	0	0	0	0	0	0	0	0	0	0	(945) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(72,502)	0	0	0	0	0	0	0	0	0	0	(72,502) 43
44	TOTAL Special Cost Centers	(73,447)	0	0	0	0	0	0	0	0	0	0	(73,447) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(123,442)	0	0	0	0	0	0	0	0	0	0	(123,442) 45

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2005 Ending: Dec. 31, 2005

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
Apostolic Christian Church of Elgin	100%					

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	27 Rent-land	\$ 3	Apostolic Christian Church of Elgin	100.00%	\$ 3	\$	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		\$ 3			\$ 3	\$ *	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, 2005 Ending: Dec. 31, 2005

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, 2005 Ending: Dec. 31, 2005

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2004 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 2005 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:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2004 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2000	8																						
2001	9																						
2002	10																						
2003	11																						
2004	12																						
FOR OHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2004 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Resthaver COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0029892

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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 Allocation:

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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2005 Ending: Dec. 31, 2005

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	\$ 2,028,074	\$ 50,750	40	\$ 50,750		\$ 1,030,582	4
5		1986	1986	10,064	252	40	252		4,910	5
6		1987	1987	67,246	1,681	40	1,681		31,099	6
7	1	1988	1988	91,817	2,295	40	2,295		40,165	7
8		1999	1999	74,929	1,873	40	1,380	(493)	10,046	8
Improvement Type**										
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		15			2,058	11
12	Land improvements		1990	590	26	15	26		586	12
13	Land improvements		1992	3,525	235	15	235		3,173	13
14	Land improvements		1992	26,596	1,773	15	1,773		23,492	14
15	Land improvements		1997	15,126	1,008	15	1,008		8,486	15
16	Land improvements		1997	16,291	1,086	15	1,086		9,050	16
17	Land improvements-parking lot		2001	5,200	347	15	347		1,474	17
18	Land improvements-parking lot sealcoating		2001	2,095	140	15	140		594	18
19	Building improvements		1986	1,400	70	20	70		1,336	19
20	Building improvements		1987	8,669	434	20	434		7,896	20
21	Building improvements		1988	28,461	1,423	20	1,423		24,902	21
22	Building improvements		1989	500	25	20	25		417	22
23	Building improvements		1990	6,091	305	20	305		4,708	23
24	Building improvements		1991	6,846	342	20	342		4,863	24
25	Building improvements		1992	15,080	754	20	754		10,179	25
26	Building improvements		1994	885	44	20	44		503	26
27	Building improvements		1995	18,458	801	10	801		18,452	27
28	Building improvements		1996	6,987	699	10	699		6,747	28
29	Building improvements		1996	809	40	20	40		388	29
30	Building improvements		1997	1,164	116	10	116		998	30
31	Building improvements		1998	2,100	105	20	105		814	31
32	Building improvements		1998	2,029	102	20	102		768	32
33	Building improvements		1998	2,671	267	10	267		1,980	33
34	Building improvements		1999	4,500	225	20	225		1,538	34
35	Building improvements		1999	3,882	194	20	194		1,310	35
36	Building improvements		1999	389	20	20	20		130	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2005 Ending: Dec. 31, 2005**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	\$	\$ 106		37
38	Building improvements	1999	1,325	66	20	66		447		38
39	Building improvements	1999	985	49	20	49		328		39
40	Building improvements	1999	656	33	20	33		203		40
41	Building improvements	2000	1,975	99	20	99		552		41
42	Building improvements-faucets	2001	104	5	20	5		24		42
43	Building improvements-faucets	2001	2,268	113	20	113		529		43
44	Building improvements-greasetrap	2001	3,769	188	20	188		879		44
45	Building improvements-door shades	2001	281	14	20	14		61		45
46	Building improvements-door shades	2001	281	14	20	14		60		46
47	Building improvements-damper	2001	710	36	20	36		148		47
48	Building improvements-door for PT room	2001	600	30	20	30		123		48
49	Building improvements-drapes for employee dining room	2002	653	33	20	33		125		49
50	Building improvements-drapes for residents	2002	1,307	65	20	65		245		50
51	Building improvements-electromagnetic front doors	2003	1,717	86	20	86		250		51
52	Building improvements-air conditioning	2003	3,100	155	20	155		375		52
53	Building improvements-fire dampers	2003	2,160	108	20	108		234		53
54	Building improvements-steam table restoration	2004	3,700	185	20	185		355		54
55	Building improvements-hot water coil replacement	2004	3,408	170	20	170		312		55
56	Building improvements-activity room shelving	2004	1,850	93	20	93		170		56
57	Building improvements-service door exit alarms	2004	994	50	20	50		75		57
58	Building improvements-smoke detectors with office window	2004	953	48	20	48		60		58
59	Land improvements-cement sidewalk to parking lot	2005	5,315	148	15	148		148		59
60	Building improvements-replace windows	2005	28,966	472	40	472		472		60
61	Building improvements-hot water heaters replaced	2005	8,650	396	20	396		396		61
62	Building improvements-fire doors	2005	3,230	54	20	54		54		62
63	Building improvements-3 wings security door systems	2005	6,600	55	20	55		55		63
64	Building improvements-duct detectors	2005	1,167	5	20	5		5		64
65	Building improvements-smoke damper	2005	4,607	19	20	19		19		65
66	Building improvements-smoke detector	2005	5,158		20					66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,580,809	\$ 70,237		\$ 69,744	\$ (493)	\$ 1,289,921		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	\$ 227,535	\$ 23,252	\$ 23,252	\$	5/10/20	\$ 126,812	71
72	Current Year Purchases	24,624	1,659	1,659		5/10	1,659	72
73	Fully Depreciated Assets	213,873					213,873	73
74								74
75	TOTALS	\$ 466,032	\$ 24,911	\$ 24,911	\$		\$ 342,344	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	\$		\$ 23,078	76
77										77
78										78
79										79
80	TOTALS			\$ 23,467	\$ 2,346	\$ 2,346	\$		\$ 23,078	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,070,308	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,001	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)	\$ 1,655,343	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	\$ 391,335	86
87	Land improvements-86/90/91/97	94,036	2,646	69,388	87
88	Equipment-1986-1999	42,662	164	42,329	88
89	Building improvements-1999-2003	19,958	998	3,993	89
90	Van-30% non-care related - 1996	10,058	1,006	9,891	90
91	TOTALS	\$ 1,090,988	\$ 27,921	\$ 516,936	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	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> </u> /2006	\$ <u> </u>
13.	<u> </u> /2007	\$ <u> </u>
14.	<u> </u> /2008	\$ <u> </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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. CLASSROOM PORTION:</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 CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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				3,747		3,747	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		6,152	156,347	1,391	6,152	157,738	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					40,489		40,489	13
14	TOTAL			\$	6,152	\$ 156,347	\$ 45,627	6,152	\$ 201,974	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2005

Ending:

Dec. 31, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Dec. 31, 2005

(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	\$ 151,794	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	216,409		3
4	Supply Inventory (priced at cost)	20,824		4
5	Short-Term Investments	400,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 789,027	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,619,077		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	542,219		16
17	Accumulated Depreciation (book methods)	(2,174,252)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	130,846		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>capital in risk retention grp</u>	27,497		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,145,387	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,934,414	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,305	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,118		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	2,050		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred income-advance billings</u>	169,942		36
37	<u>Accrued expenses</u>	5,611		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,026	\$	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	<u>Deposits-apartments</u>	108,900		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 108,900	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 475,926	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,458,488	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,934,414	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,417,261	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,417,261	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	41,227	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 41,227	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)	\$ 2,458,488	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2005

Page 19
Ending: Dec. 31, 2005

VII. 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	\$ 2,696,941	1
2	Discounts and Allowances for all Levels	(100,202)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,596,739	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,025	6
7	Oxygen	235	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,260	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,630	13
14	Non-Patient Meals	4,576	14
15	Telephone, Television and Radio	80	15
16	Rental of Facility Space		16
17	Sale of Drugs	172,546	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 180,832	23
D. Non-Operating Revenue			
24	Contributions	159,521	24
25	Interest and Other Investment Income***	16,725	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 176,246	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See schedule</u>	187,234	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 187,234	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,142,311	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	604,063	31
32	Health Care	1,404,291	32
33	General Administration	640,553	33
B. Capital Expense			
34	Ownership	125,415	34
C. Ancillary Expense			
35	Special Cost Centers	299,387	35
36	Provider Participation Fee	27,375	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,101,084	40
41	Income before Income Taxes (line 30 minus line 40)**	41,227	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 41,227	43

* 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, 2005**Ending: **Dec. 31, 2005**

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	2,106	2,125	\$ 59,675	\$ 28.08	1
2	Assistant Director of Nursing	2,025	2,195	49,333	22.48	2
3	Registered Nurses	15,137	16,403	384,331	23.43	3
4	Licensed Practical Nurses	2,743	3,198	109,093	34.11	4
5	CNAs & Orderlies	50,918	54,799	647,647	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,354	1,543	20,263	13.13	8
9	Activity Director	1,705	1,903	26,792	14.08	9
10	Activity Assistants	3,623	3,960	38,743	9.78	10
11	Social Service Workers	1,606	1,783	23,865	13.38	11
12	Dietician	1,912	2,128	46,432	21.82	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,580	18,276	194,827	10.66	15
16	Dishwashers					16
17	Maintenance Workers	2,434	2,713	46,329	17.08	17
18	Housekeepers	5,568	6,231	58,474	9.38	18
19	Laundry	2,745	3,163	34,780	11.00	19
20	Administrator	1,862	2,105	87,754	41.69	20
21	Assistant Administrator					21
22	Other Administrative	1,214	1,309	13,324	10.18	22
23	Office Manager					23
24	Clerical	3,883	4,198	58,580	13.95	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) barber/beauty	1,442	1,596	22,487	14.09	33
34	TOTAL (lines 1 - 33)	118,857	129,628	\$ 1,922,729 *	\$ 14.83	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	19	1,130	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	3,750	10-3	39
40	Physical Therapy Consultant	42	3,013	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	752	11-3	44
45	Social Service Consultant	19	1,298	12-3	45
46	Other(specify) beautician	76	1,140	40-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 13,083		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$		50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	127	2,747	10-3	52
53	TOTAL (lines 50 - 52)	127	\$ 2,747		53

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 2,219; AAHSA 750
- (3) Did the nursing home make political contributions or payments to a political 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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,502 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 during this cost report period. \$ 27,375
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, 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 benefit: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 19, Schedule XVII, Line 28, Other Revenue

Account

8023 Vending Income	\$	1,503
6902 Activity Income		731
8020 Cookbooks		1,066
8050 Apartment Income		181,495
8026 Miscellaneous Income		<u>2,439</u>
	\$	<u>187,234</u>

NOTES:

Vending Expense is already adjusted out of Sch. V, Line 41
Apartment Expense is already adjusted out of Sch. V, Line 43
Other Revenues, as detailed above, have not been offset against expenses
on Schedule V

Page 3, Schedule V, Line 7, Other

Expenses related to removal of general waste

\$ 5,153

Page 3, Schedule V, Column 5, Reclassification Entries

<u>Cost Center</u>	<u>Expense Category</u>	<u>Line #</u>	<u>Reclass</u>
1 General Administration	Dues, Fees, Subsc.	20-3	200
General Administration	Inservice Training	24-3	(200)

to reclassify the cost of Healthcare Worker background checks (a/c 7926)

2 General Services	Laundry	4-3	548
General Administration	Other	27-3	(548)

to reclassify non-employee laundry help.

Page 3, Schedule V, Line 27, Other Expense

	<u>Volunteer Expense</u>	<u>Miscell. Expense</u>	<u>Total</u>
Volunteer expense	1,169		1,169
Rent - land		3	3
Laundry - non-employee help		548	548
Retire windows in Accum Depr		2,973	2,973
Stop payment fee on check		30	30
Column 4 total	<u>1,169</u>	<u>3,554</u>	<u>4,723</u>
Reclassifications:			
Laundry help to Line 4		(548)	(548)
Column 6 total	<u>1,169</u>	<u>3,006</u>	<u>4,175</u>
Adjustments:			
Volunteer exp. - donated items	159		159
Disallow volunteer expense	(1,328)		(1,328)
Column 8 Adjusted Total	<u><u>-</u></u>	<u><u>3,006</u></u>	<u><u>3,006</u></u>

Page 4, Schedule V, Line 43, Other Expense

	<u>Apartment Expense</u>	<u>Multi-Purpose Room Exp.</u>	<u>Total</u>
Apartment expense	72,152		72,152
Multi-purpose room expense		350	350
Column 4 total	<u>72,152</u>	<u>350</u>	<u>72,502</u>
Adjustments:			
Apartment expense	(72,152)		(72,152)
Multi-purpose room expense		(350)	(350)
Column 8 Adjusted Total	<u><u>-</u></u>	<u><u>-</u></u>	<u><u>-</u></u>

Page 21, Schedule XIX, Section D, Employee Relations

1	Gifts for Sympathy / Get Well	\$ 159
2	Christmas Dinner	1,490
3	Christmas Gifts	3,587
4	Staff Appreciation Dinner	605
5	Anniversary Gifts for Years of Service	785
6	Employee Assistance Program	2,025
7	Other	3,138
8	Staff Appreciation Awards	<u>1,900</u>
		<u>\$ 13,689</u>

Page 21, Schedule XIX, Section D, Pension Expense

Pension Costs for Owners	\$ -
Pension Costs for Related Parties	-
Pension Costs for All Other Employees	<u>55,343</u>
	<u>\$ 55,343</u>

Note - 54 employees were covered under the pension plan for year 2005.

Attachment to Schedule XIII

Nurse assistants were not trained in Basic Nurse Assistant courses during this report period due to our policy to hire nursing assistants who are currently enrolled in a Basic Nurse Assistant Training program or are already listed on the Illinois Nurse Assistant Registry. Our facility had 16 nurse assistants leave employment during 2005 and all replacements met the above requirement.

Attachment to Schedule XX, General Information #14

A portion of the building consists of 19 independent congregate living units. Costs are allocated to this portion of the building on the basis of square footage, exact costs (if able to be determined) and provider estimates of service costs.

Attachment to Schedule XX, General Information #16a

There are costs included for out-of-state travel in the cost report. On November 5-10 2005, David Stieglitz, Administrator, attended the American Association of Homes and Services for the Aging Annual Meeting held in San Antonio, Texas. This convention included topics related to employee recruitment and retention, regulatory compliance, the future of long term care and board management.

On March 30-April 1, 2005, Nina Dubman, Registered Dietician, attended a Food Director Magazine seminar in Philadelphia, Pennsylvania, as an award recipient. On March 18, 2005, Ms. Dubman attended the Hoosier Chapter Meeting of ASHFSA (American Society of Healthcare Food Service Administrators) in Indianapolis, Indiana, and on August 7-10, 2005, she attended the Amerinet Central group purchasing organization's meeting in Orlando, Florida.

2005 Board of Directors and Officers

Don Heiniger, President	38W644 Arrowmaker Pass, Elgin, IL 60123
Bob Cox, Vice-President	709 Linden Avenue, Elgin, IL 60120
Glen Pfeifer, Secretary	37W951 McKee Road, Batavia, IL 60150
Dave Martin, Treasurer	24107 W. Grant Highway, Marengo, IL 60152
Dave Jepson	229 Nelson Parkway, Cherry Valley, IL 61016
Roger Weiss	804 Elm Street, Hampshire, IL 60140
Mark Wewetzer	8709 South Rood Road, Kingston, IL 60145