



Facility Name & ID Number Apostolic Christian Timber Ridge

# 0016220 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	98	Intermediate/DD	98	35,770	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	33,832			33,832	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,832			33,832	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.58%

D. How many bed-hold days during this year were paid by the Department? 399 (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)  
None

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 10/01/1971

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: 06/30/2006 Fiscal Year: 06/30/2006

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

**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
<b>A. General Services</b>											
1	Dietary	268,342	17,346	6,072	291,760	(221)	291,539	0	291,539		1
2	Food Purchase		163,139		163,139		163,139	0	163,139		2
3	Housekeeping	70,535	13,589		84,124		84,124	0	84,124		3
4	Laundry	148,612	13,742		162,354	275	162,629	0	162,629		4
5	Heat and Other Utilities			110,486	110,486		110,486	0	110,486		5
6	Maintenance	97,574	24,617	27,003	149,194	5,395	154,589	(19,686)	134,903		6
7	Other (specify):*				0		0	0	0		7
8	<b>TOTAL General Services</b>	<b>585,063</b>	<b>232,433</b>	<b>143,561</b>	<b>961,057</b>	<b>5,449</b>	<b>966,506</b>	<b>(19,686)</b>	<b>946,820</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			1,332	1,332		1,332	0	1,332		9
10	Nursing and Medical Records	948,186	221,752	336,162	1,506,100	(15,267)	1,490,833	(10,886)	1,479,947		10
10a	Therapy	1,370,436	6,160	6,685	1,383,281	(588)	1,382,693	0	1,382,693		10a
11	Activities	246,792	9,377		256,169	(49)	256,120	0	256,120		11
12	Social Services	312,121	3,843	13,452	329,416	(24,398)	305,018	0	305,018		12
13	CNA Training		4,381		4,381	41,710	46,091	0	46,091		13
14	Program Transportation		66,414		66,414	(13,278)	53,136	(27,289)	25,847		14
15	Other (specify):* <b>Day Programming</b>	106,692	1,809		108,501	(55)	108,446	0	108,446		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,984,227</b>	<b>313,736</b>	<b>357,631</b>	<b>3,655,594</b>	<b>(11,925)</b>	<b>3,643,669</b>	<b>(38,175)</b>	<b>3,605,494</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	92,552			92,552	(122)	92,430	0	92,430		17
18	Directors Fees				0		0	0	0		18
19	Professional Services			21,092	21,092		21,092	0	21,092		19
20	Dues, Fees, Subscriptions & Promotions			19,353	19,353		19,353	(3,584)	15,769		20
21	Clerical & General Office Expenses	117,397	32,622		150,019	1,020	151,039	0	151,039		21
22	Employee Benefits & Payroll Taxes			1,011,120	1,011,120		1,011,120	(28,545)	982,575		22
23	Inservice Training & Education			6,040	6,040		6,040	0	6,040		23
24	Travel and Seminar			5,775	5,775		5,775	(3,754)	2,021		24
25	Other Admin. Staff Transportation				0		0	(1,034)	(1,034)		25
26	Insurance-Prop.Liab.Malpractice			50,809	50,809		50,809	(5,637)	45,172		26
27	Other (specify):* <b>See Schedule</b>			30,154	30,154	(17,949)	12,205	(17,290)	(5,085)		27
28	<b>TOTAL General Administration</b>	<b>209,949</b>	<b>32,622</b>	<b>1,144,343</b>	<b>1,386,914</b>	<b>(17,051)</b>	<b>1,369,863</b>	<b>(59,844)</b>	<b>1,310,019</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,779,239</b>	<b>578,791</b>	<b>1,645,535</b>	<b>6,003,565</b>	<b>(23,527)</b>	<b>5,980,038</b>	<b>(117,705)</b>	<b>5,862,333</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.

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

Facility Name &amp; ID Number

Apostolic Christian Timber Ridge

#0016220

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

## 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			160,222	160,222		160,222	(15,212)	145,010			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			0	0		0	0	0			32
33	Real Estate Taxes			0	0		0	0	0			33
34	Rent-Facility & Grounds			0	0		0	0	0			34
35	Rent-Equipment & Vehicles			6,240	6,240	(678)	5,562	0	5,562			35
36	Other (specify):* <b>Asset Management Fees</b>			46,056	46,056		46,056	(46,056)	0			36
37	<b>TOTAL Ownership</b>			212,518	212,518	(678)	211,840	(61,268)	150,572			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			0	0	13,278	13,278	(13,278)	0			38
39	Ancillary Service Centers			0	0	10,927	10,927	0	10,927			39
40	Barber and Beauty Shops			0	0		0	0	0			40
41	Coffee and Gift Shops			0	0		0	0	0			41
42	Provider Participation Fee			287,480	287,480		287,480	0	287,480			42
43	Other (specify):* <b>Facility Bulletin</b>			2,556	2,556		2,556	0	2,556			43
44	<b>TOTAL Special Cost Centers</b>	0	0	290,036	290,036	24,205	314,241	(13,278)	300,963			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,779,239	578,791	2,148,089	6,506,119	0	6,506,119	(192,251)	6,313,868			45

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

Facility Name & ID Number Apostolic Christian Timber Ridge

# 0016220

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

**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	\$ (19,686)	6	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(46,056)	36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,000)	27		18
19	Entertainment				19
20	Contributions	(7,290)	27		20
21	Owner or Key-Man Insurance	(5,637)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,584)	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	(99,998)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (192,251)		\$ 0	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 0		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (192,251)		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		\$ 13,278	14	38
39			x			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		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 13,278		47

Apostolic Christian Timber Ridge

ID# 0016220

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Offset day draining transportation income	\$ (10,886)	10	1
2	Offset day draining transportation income	(27,289)	14	2
3	Out-of-state Travel (Administrative Staff)	(1,034)	25	3
4	Depreciation of non-care vehicles	(15,212)	30	4
5	Offset medically necessary transportation income	(13,278)	38	5
6	Benefits allocated to day programming	(28,545)	22	6
7	Out-of-state Travel (In-service Training & Education)	(1,034)	24	7
8	Out-of-state Travel (Board of Directors)	(2,720)	24	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(99,998)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(19,686)	0	0	0	0	0	0	0	0	0	0	(19,686)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(19,686)</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>(19,686)</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	(10,886)	0	0	0	0	0	0	0	0	0	0	(10,886)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(27,289)	0	0	0	0	0	0	0	0	0	0	(27,289)	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>(38,175)</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>(38,175)</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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,584)	0	0	0	0	0	0	0	0	0	0	(3,584)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(28,545)	0	0	0	0	0	0	0	0	0	0	(28,545)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,754)	0	0	0	0	0	0	0	0	0	0	(3,754)	24
25	Other Admin. Staff Transportation	(1,034)	0	0	0	0	0	0	0	0	0	0	(1,034)	25
26	Insurance-Prop.Liab.Malpractice	(5,637)	0	0	0	0	0	0	0	0	0	0	(5,637)	26
27	Other (specify):*	(17,290)	0	0	0	0	0	0	0	0	0	0	(17,290)	27
28	<b>TOTAL General Administration</b>	<b>(59,844)</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>(59,844)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(117,705)</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>(117,705)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	(15,212)	0	0	0	0	0	0	0	0	0	0	(15,212) 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):*	(46,056)	0	0	0	0	0	0	0	0	0	0	(46,056) 36
37	<b>TOTAL Ownership</b>	<b>(61,268)</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>(61,268) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	(13,278)	0	0	0	0	0	0	0	0	0	0	(13,278) 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(13,278)</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>(13,278) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(192,251)</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>(192,251) 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
<u>Apostolic Christian Home for the Handicapped, Inc.</u>	<u>100%</u>	<u>Oakwood Estate</u>	<u>Morton</u>	<u>Community</u>	<u>Morton</u>	<u>Residential</u>
		<u>Linden Estate</u>	<u>Morton</u>	<u>Residential Services</u>		<u>Services for the Disabled</u>

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

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

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

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

Facility Name & ID Number      Apostolic Christian Timber Ridge      #      0016220      Report Period Beginning:      07/01/2005      Ending:      06/30/2006

## 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	John Knobloch	Chairman	Director	0.00		0.5			\$	1
2	Roger Aberle	Director	Director	0.00	226	0.5		Travel	680	line 24; col.3
3	Dan Schumacher	Director	Director	0.00		0.5				3
4	Jerry Christensen	Vice-Chairman	Director	0.00		0.5				4
5	Ron Hodel	Director	Director	0.00		0.5				5
6	Jerry Kieser	Director	Director	0.00		0.5				6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	272	0.5		Travel	818	line 24; col.3
8	Cleve Klopfenstein	Director	Director	0.00		0.5				8
9	Stan Virkler	Director	Director	0.00	292	0.5		Travel	879	line 24; col.3
10	Warren Zahner	Director	Director	0.00	380	0.5		Travel	1,161	line 24; col.3
11										11
12										12
13								TOTAL	\$ 3,538	13

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

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

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

**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
		YES	NO				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		
<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>					\$	0	\$	0	\$	0	9
<b>B. Non-Facility Related*</b>												
10											10	
11											11	
12											12	
13											13	
14	<b>TOTAL Non-Facility Related</b>					\$	0	\$	0	\$	0	14
15	<b>TOTALS (line 9+line14)</b>					\$	0	\$	0	\$	0	15

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

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, 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 2005 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	0 3																								
4. Real Estate Tax accrual used for 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	0 7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
<b>FOR BHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

**NOTES:**

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Apostolic Christian Timber Ridge COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0016220

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 2005 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 2005.

(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>		\$ <u>0.00</u>	\$ <u>0.00</u>

**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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,135 B. General Construction Type: Exterior Brick Frame Fireproof Building 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

Oakwood Estate (IDPA #0033712) is located adjacent to this property.

Type of business: Nursing Home (ICF/DD-16)

Square footage: Land - 91,781 sq ft; Building - 7,140 sq ft

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	<u>Nursing Home</u>	<u>1,345,699</u>	<u>1969</u>	<u>\$ 54,397</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>1,345,699</u>		<u>\$ 54,397</u>	<u>3</u>

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2005 Ending: 06/30/2006**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	44		1971	\$ 650,091	\$ 16,252	40	\$ 16,252		\$ 558,687	4
5	54		1978	1,006,746	25,169	40	25,169		726,099	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	3--Original Storage Building		1974	8,047	201	40	201		6,614	9
10	4--Second Floor Storage		1975	281	7	40	7		221	10
11	5--Balcony Storage		1976	289	7	40	7		220	11
12	6--Tub & Water Heater		1976	448	11	40	11		342	12
13	19--New Addition Phase 2		1979	47,854	1,196	40	1,196		33,257	13
14	7--Additional Storage Building Phase 1		1981	4,660	117	40	117		2,971	14
15	21--Activity Room/ TVs		1981	1,265	32	40	32		817	15
16	8--Additional Storage Building Phase 2		1982	21,495	537	40	537		13,166	16
17	22--Front Entrance		1982	8,046	201	40	201		4,997	17
18	9--Electrical Upgrade		1983	126	3	40	3		74	18
19	23--Security System & Energy Saver		1983	9,724	243	40	243		5,800	19
20	24--Courtyard Foyer		1984	6,477	162	40	162		3,704	20
21	10--Garage Extension		1985	842	21	40	21		462	21
22	25--Nursing Foyer		1985	24,285	607	40	607		13,291	22
23	26--Upkeep (Windows,Furnace,Fixtures)		1986	9,877	247	40	247		5,162	23
24	27--North End & East Wing		1987	26,990	675	40	675		13,442	24
25	1--3 stall garage		1988	22,885	572	40	572		10,584	25
26	28--1988 Additions		1988	27,441	686	40	686		12,991	26
27	29--1989 Additions		1989	48,259	1,206	40	1,206		21,659	27
28	30--1990 Additions		1990	60,923	1,523	40	1,523		25,842	28
29	31--1991 Additions		1991	11,832	296	40	296		4,728	29
30	32--1992 Additions		1992	14,999	375	40	375		5,624	30
31	33--1994 Additions		1994	31,810	795	40	795		10,361	31
32	34--1995 Additions		1995	32,834	821	40	821		9,887	32
33	35--1996 Additions		1996	6,371	159	40	159		1,762	33
34	36--1997 Additions		1997	23,216	580	40	580		5,847	34
35	2--Garage Door for Van		1998	667	44	15	44		363	35
36	37--1998 Additions		1998	6,263	157	40	157		1,423	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

## STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

## 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	38--1999 Additions	1999	\$ 17,738	\$ 443	40	\$ 443	\$	\$ 3,594		37
38	39--Air Conditioner	2000	1,882	47	40	47		306		38
39	40--Heat Pump	2000	3,100	78	40	78		504		39
40	41--Automatic Rear Door	2000	1,773	44	40	44		288		40
41	42--Power Panels/Generator	2000	14,000	350	40	350		2,275		41
42	43--Office Window to Lobby	2000	1,057	26	40	26		172		42
43	44--Exhaust Fan in Womens N Bathroom	2000	580	14	40	14		94		43
44	45--Dining Room Remodeling	2000	10,565	264	40	264		1,717		44
45	46--Fire Alarm Relay	2000	2,400	60	40	60		390		45
46	47--Remodel Bathrooms	2000	22,147	554	40	554		3,599		46
47	48--Water Coolers at both ends	2000	2,701	68	40	68		439		47
48	49--Roof Repairs	2000	1,133	28	40	28		184		48
49	471--Garage Lights	2001	1,400	93	15	93		513		49
50	472--OT/PT Decorating	2001	1,111	74	15	74		407		50
51	473--Slab Jacking	2001	1,312	87	15	87		481		51
52	474--Roof Replacement	2001	21,380	1,425	15	1,425		7,839		52
53	475--Roof Replacement	2001	16,779	1,119	15	1,119		6,152		53
54	476--Lobby Carpet and Redecorating	2001	11,774	785	15	785		4,317		54
55	477--Dining Room Remodeling	2001	3,308	221	15	221		1,213		55
56	478--Additional QMRP office (bv activities)	2001	2,393	160	15	160		877		56
57	479--Pipe Insulation	2001	2,613	174	15	174		958		57
58	480--North Resident Renovation	2001	4,632	309	15	309		1,698		58
59	481--Activity Room Remodeling	2001	1,903	127	15	127		698		59
60	482--Sourth Whirlpool Room	2001	2,676	178	15	178		981		60
61	483--Hand Rails	2001	2,844	190	15	190		1,043		61
62	484--South Living Remodeling	2001	5,107	341	15	341		1,873		62
63	537--Garage Door	2002	594	40	15	40		178		63
64	538--Key pad entrv for south end	2002	2,500	167	15	167		750		64
65	540--Water heater plumbing	2002	706	47	15	47		212		65
66	541--Water heaters	2002	8,482	565	15	565		2,545		66
67	542--Lighting - small office in lobby	2002	545	36	15	36		163		67
68	545--Air conditioner - south living room	2002	3,196	213	15	213		959		68
69	575--Roof on large garage	2003	8,941	596	15	596		2,086		69
70	TOTAL (lines 4 thru 69)		\$ 2,298,312	\$ 61,825		\$ 61,825	\$ 0	\$ 1,549,902		70

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

## STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,298,312	\$ 61,825		\$ 61,825	\$	\$ 1,549,902	1
2	576--Garage door on small garage	2003	647	43	15	43		151	2
3	613--Plumb and insulate water lines	2004	7,274	485	15	485		1,212	3
4	614--Flooring for Corridors	2004	23,007	1,534	15	1,534		3,834	4
5	616--Air Conditioner	2004	1,259	84	15	84		210	5
6	617--Courtvard Carpet	2004	981	65	15	65		164	6
7	618--Heat Pump & Blower	2004	4,885	326	15	326		814	7
8	619--Electrical for Fuel tanks	2004	1,686	112	15	112		281	8
9	620--Heat pump	2004	3,980	265	15	265		663	9
10	621--Foot valve for Hopper	2004	637	42	15	42		106	10
11	622--Bathroom partitions	2004	3,176	212	15	212		529	11
12	623--Air conditioner south wing	2004	1,181	79	15	79		197	12
13	276--Fully Depreciated Assets	1971	104,543	0	20	0		104,543	13
14	277--Gravel Driveway	1974	1,220	0	20	0		1,220	14
15	278--Gravel Driveway	1974	500	0	20	0		500	15
16	279--Chain Link Fence	1976	3,440	0	20	0		3,440	16
17	280--Road Prep for New addition	1976	5,769	0	20	0		5,769	17
18	281--Bar-B-Que Pit	1981	277	0	20	0		277	18
19	282--Electric & Water to Picnic Area	1981	783	0	20	0		783	19
20	283--Chain Link Fence	1982	38	0	20	0		38	20
21	284--Chain Link Fence	1983	5,843	0	20	0		5,843	21
22	285--Ornamental Fence	1985	565	0	20	0		565	22
23	286--South Patio	1985	1,008	0	20	0		1,008	23
24	287--Resurfacing Driveway	1986	22,000	550	20	550		22,000	24
25	288--Irrigation System & Landscaping	1990	2,585	129	20	129		2,195	25
26	289--South Patio Sod & Lighting	1990	1,408	70	20	70		1,186	26
27	290--Pole Light	1993	975	49	20	49		729	27
28	291--Asphalt Parking Lot & Driveway	1993	5,530	276	20	276		4,145	28
29	292--Landscape Courtvard	1993	3,954	198	20	198		2,785	29
30	293--Sewer Repair	1994	6,700	335	20	335		4,355	30
31	294--Tile Drain	1995	721	36	20	36		432	31
32	295--Asphalt Patching	1995	1,290	65	20	65		751	32
33	296--Excavate & Asphalt Drive	1997	15,136	757	20	757		7,568	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,531,309	\$ 67,537		\$ 67,537	\$ 0	\$ 1,728,195	34

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

## STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 2,531,309	\$ 67,537		\$ 67,537	\$	\$ 1,728,195		1
2	297--Asphalt South Drive	1997 39,261	1,963	20	1,963		17,667		2
3	298--Install Parking Lot Light Poles	1998 4,000	200	20	200		1,500		3
4	299--Repair Asphalt	1998 3,500	175	20	175		1,313		4
5	511--Blacktop Ramp at Rear Entrance	2000 770	77	10	77		424		5
6	512--Landscape Drive Entrance	2000 1,447	96	15	96		531		6
7	513--Landscape around Timber Ridge	2000 1,230	82	15	82		451		7
8	564--Sidewalk/entry apron	2001 11,816	788	15	788		3,545		8
9	647--Catch Basin & Tile @ South Drive	2003 3,344	223	15	223		557		9
10	648--Garage Door Opener	2004 720	48	15	48		72		10
11	649--Canopy Lighting	2004 788	53	15	53		79		11
12	650--MPR Remodel	2004 14,256	950	15	950		1,426		12
13	651--North Living Room Floor	2004 4,649	310	15	310		465		13
14	652--North Snack Room Remodeling	2004 1,452	97	15	97		145		14
15	653--Office Remodeling	2004 1,447	96	15	96		145		15
16	654--South Snack Room Refrigerator	2004 469	67	7	67		101		16
17	655--South Snack Room Remodeling	2004 9,127	608	15	608		913		17
18	656--Speech Room Floor	2004 641	43	15	43		64		18
19	680--Driveway Repavement	2004 50,323	3,355	15	3,355		5,032		19
20	681--Concrete to Picnic Area	2004 9,858	657	15	657		986		20
21	682--Concrete Pad for Dumpster	2004 806	54	15	54		81		21
22	692--Concrete leveling	2005 2,830	94	15	94		94		22
23	693--Sprinkler heads - bathroom closet	2005 1,082	36	15	36		36		23
24	695--Cabinets and Countertops	2005 680	23	15	23		23		24
25	706--Phone system	2005 1,756	59	15	59		59		25
26	707--Electronic Door repairs	2005 3,245	108	15	108		108		26
27	714--Bathroom remodeling 400 wing	2005 10,579	353	15	353		353		27
28	716--Bathroom remodel - 500 wing	2005 13,305	444	15	444		444		28
29	721--Laundry room remodel	2005 5,261	175	15	175		175		29
30	724--Door locks-South End	2005 687	23	15	23		23		30
31	735--North sick room	2005 3,557	119	15	119		119		31
32	740--Kitchen piping	2005 875	29	15	29		29		32
33	755--Kami's office	2005 287	10	15	10		10		33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 2,735,357	\$ 78,952		\$ 78,952	\$ 0	\$ 1,765,165		34

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

Facility Name & ID Number Apostolic Christian Timber Ridge

# 0016220

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12C, Carried Forward</b>	\$ 2,735,357	\$ 78,952		\$ 78,952	\$	\$ 1,765,165		1
2	757--M. room sound system	2005 2,611	87	15	87		87		2
3	697--Iron Fence for Rear Courtyard	2005 22,888	763	15	763		763		3
4	759--New driveway at Bus Garage	2005 5,130	171	15	171		171		4
5	762--North Courtyard Landscaping	2005 910	30	15	30		30		5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 2,766,896	\$ 80,003		\$ 80,003	\$ 0	\$ 1,766,216		34

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

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	\$ 399,926	\$ 42,435	\$ 42,435	\$ 0	10	\$ 191,116	71
72	Current Year Purchases	162,297	13,928	13,928	0	6	13,928	72
73	Fully Depreciated Assets	599,838	8,644	8,644	0	9	599,838	73
74	Disposed Assets	1,290	0	0	0	10	1,290	74
75	TOTALS	\$ 1,163,351	\$ 65,007	\$ 65,007	\$ 0		\$ 806,172	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

	1	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)	\$ 3,984,644	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,010	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,010	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,572,388	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Fully depreciated vehicles	\$ 181,973	\$ 0	\$ 181,973	86
87	Capitalized repairs	8,568	976	2,696	87
88	Vehicle Equipment	39,217	6,856	24,252	88
89	Vehicles	67,603	7,380	12,462	89
90	Disposed Assets	37,561	0	37,561	90
91	TOTALS	\$ 334,922	\$ 15,212	\$ 258,944	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.	_____/2007	\$ _____
13.	_____/2008	\$ _____
14.	_____/2009	\$ _____

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: \$ 5,562 Description: Food pump, oxygen concentrator  
(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	<b>TOTAL</b>		\$	\$	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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$ 0
2	Books and Supplies		1,164		3,834
3	Classroom Wages (a)		4,454		20,171
4	Clinical Wages (b)		2,227		33,660
5	In-House Trainer Wages (c)		1,726		26,082
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$	9,571	\$ 74,176	\$ 0 \$ 83,747
10	SUM OF line 9, col. 1 and 2 (e)	\$	83,747		

- (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	39
2. From other facilities (f)	8
DROP-OUTS	
1. From this facility	17
2. From other facilities (f)	3
<b>TOTAL TRAINED</b>	<b>67</b>

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number    Apostolic Christian Timber Ridge

#    0016220

Report Period Beginning:    07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of    06/30/2006

(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	\$ 336,379	\$ 338,379	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0 )	774,604	1,060,315	3
4	Supply Inventory (priced at )	25,792	32,600	4
5	Short-Term Investments	4,098,760	4,098,760	5
6	Prepaid Insurance	24,495	37,277	6
7	Other Prepaid Expenses	6,779	5,172	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Employees &amp; other related parties</b>	26,881	30,366	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,293,690	\$ 5,602,869	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,397	262,033	13
14	Buildings, at Historical Cost	2,425,668	3,691,272	14
15	Leasehold Improvements, at Historical Cost	341,226	520,895	15
16	Equipment, at Historical Cost	1,459,422	2,098,292	16
17	Accumulated Depreciation (book methods)	(2,792,475)	(3,797,886)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,122	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,122)	20
21	Restricted Funds	4,322,538	4,322,538	21
22	Other Long-Term Assets (spec Cash Value of Life In:	22,030	22,030	22
23	Other(specify): <b>Investment in other facilities</b>	3,352,146	0	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,184,952	\$ 7,119,174	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,478,642	\$ 12,722,043	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 151,196	\$ 169,383	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	355,971	465,292	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	109,049	205,053	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 616,216	\$ 839,728	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	<b>Capital Lease</b>	29,009	29,009	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 29,009	\$ 29,009	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 645,225	\$ 868,737	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 13,833,417	\$ 11,853,306	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 14,478,642	\$ 12,722,043	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>13,556,018</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>13,556,018</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>352,462</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>Cost to Market Adjustment on Investments</b>	<b>(75,063)</b>	<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>277,399</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>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>13,833,417</b>	<b>24</b> *

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

Facility Name &amp; ID Number Apostolic Christian Timber Ridge

# 0016220

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,818,890	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,818,890	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	73,073	10
11	CNA Training Reimbursements	42,000	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,368	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,752	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 131,193	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,095,525	24
25	Interest and Other Investment Income***	405,512	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,501,037	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See attached schedule	407,461	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 407,461	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,858,581	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	961,057	31
32	Health Care	3,655,594	32
33	General Administration	1,386,914	33
<b>B. Capital Expense</b>			
34	Ownership	212,518	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,556	35
36	Provider Participation Fee	287,480	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,506,119	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	352,462	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 352,462	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Apostolic Christian Timber Ridge**# **0016220**Report Period Beginning: **07/01/2005**Ending: **06/30/2006****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	1,944	2,040	\$ 68,412	\$ 33.54	1
2	Assistant Director of Nursing	4,761	5,018	139,851	27.87	2
3	Registered Nurses	15,026	16,388	362,155	22.10	3
4	Licensed Practical Nurses	17,779	19,740	370,693	18.78	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,824	2,080	38,182	18.36	9
10	Activity Assistants	19,091	20,241	210,876	10.42	10
11	Social Service Workers	1,944	2,080	34,462	16.57	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	41,176	19.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,217	23,067	226,633	9.82	15
16	Dishwashers					16
17	Maintenance Workers	5,155	5,889	97,797	16.61	17
18	Housekeepers	7,336	7,813	72,006	9.22	18
19	Laundry	11,925	13,450	149,246	11.10	19
20	Administrator	1,628	1,892	92,552	48.92	20
21	Assistant Administrator	1,143	1,327	43,728	32.95	21
22	Other Administrative					22
23	Office Manager	1,074	1,322	29,165	22.06	23
24	Clerical	3,119	3,850	48,303	12.55	24
25	Vocational Instruction	2,500	2,826	45,571	16.13	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,194	10,348	161,974	15.65	28
29	Resident Services Coordinator	1,848	2,080	50,092	24.08	29
30	Habilitation Aides (DD Homes)	104,335	111,779	1,179,021	10.55	30
31	Medical Records	288	288	5,049	17.53	31
32	Other Health Care OT/PT, Speech	12,619	14,205	206,071	14.51	32
33	Other(specify) Day Program	7,356	8,235	106,224	12.90	33
34	TOTAL (lines 1 - 33)	254,986	278,038	\$ 3,779,239 *	\$ 13.59	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	145	\$ 6,072	1-3	35
36	Medical Director	flat fee	1,332	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	1,243	10-3	39
40	Physical Therapy Consultant	59	3,356	10a-3	40
41	Occupational Therapy Consultant	59	3,329	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	102	7,654	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	39	3,123	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	404	\$ 26,109		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	526	\$ 17,839	10-3	50
51	Licensed Practical Nurses	2,599	81,078	10-3	51
52	Certified Nurse Assistants/Aides	12,409	236,002	10a-3	52
53	TOTAL (lines 50 - 52)	15,534	\$ 334,919		53





Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220Report Period Beginning: 07/01/2005Ending: 06/30/2006**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. Illinois Health Care Association - \$5,140
- (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? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 85,257 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 287,480  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 19,109 Has any meal income been offset against related costs? No Indicate the amount. \$ n/a
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No, they have been adjusted out  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 13,278  
c. What percent of all travel expense relates to transportation of nurses and patients? 90%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 73,073**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Heinold-Banwart, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. n/a
- (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 Timber Ridge  
 FYE 06/30/2006 #0016220  
 Sub schedules

Schedule V - Costs Center Expenses		
Lines	Description	Amount
43	Facility Bulletin / Newsletter	2,556
36	Investment Management Fees	45,760
36	Interest Expense	296
27	Dental costs	10,927
27	Charitable Contributions	7,290
27	Fines & Penalties	10,000
27	Miscellaneous	(5,085)
	Other Expenses	<u>71,744</u>

Schedule V - Reclassifications			
Lines	Description	Increase	Decrease
6	Communication equipment rental	678	
35	Communication equipment rental		678
11	Donated labor	6	
1	Donated labor	20	
4	Donated labor	275	
6	Donated labor	5,075	
21	Donated labor	1,020	
10	Donated labor	55	
10a	Donated labor	520	
12	Donated labor	51	
27	Donated labor		7,022
38	Medically necessary transportation	13,278	
14	Medically necessary transportation		13,278
13	Nurse aid trainer wages	41,710	
1	Nurse aid trainer wages		241
6	Nurse aid trainer wages		358
10	Nurse aid trainer wages	15,322	
10a	Nurse aid trainer wages	1,108	
11	Nurse aid trainer wages	55	
12	Nurse aid trainer wages	24,449	
15	Nurse aid trainer wages	55	
17	Nurse aid trainer wages	122	
39	Dental costs	10,927	
27	Dental costs		10,927
		<u>73,615</u>	<u>73,615</u>

Schedule V, Line 39 - Ancillary Service Centers		
Dental costs for 124 visits		<u>\$ 10,927</u>

Schedule VI B - Non-paid workers			
Lines	Description	Amount	
31	Donated Labor	\$ 7,022	
	Department	Time in Hours	Time in Dollars
	Activities	1.00	6
	Kitchen	3.75	20
	Laundry	50.00	275
	Maintenance	507.50	5,075
	Nursing	5.50	55
	PT/OT	94.50	520
	Social Service Programs	9.25	51
	Office	185.50	1,020
	Totals	<u>857.00</u>	<u>\$ 7,022</u>

Schedule VII - Compensation Received From Other Nursing Home:	
Roger Aberle - \$226 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Stan Virkler - \$292 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Keith Pflum - \$272 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Warren Zahner - \$380 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets	
Investment in Related Entities	<u>22,030</u>

Sch. XVII - Income Statement, Line 28; Other Revenue	
Developmental training	397,005
Farm Income	950
Gain on Sale of Assets	1,135
Insurance Income	1,518
Miscellaneous	1,485
Employee Meals	5,368
	<u>407,461</u>

Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	352,462
Income from related parties	(160,369)
Estimated excess for year, Form 990, p.1, line 18	<u>192,093</u>

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Column 1, Row 45	3,779,239
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(3,779,239)
Variance	<u>-</u>

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	3,779,239
Add Prior Year PTO Accrual at 06/30/05	168,668
Less Current Year PTO Accrual at 06/30/06	(178,775)
Less: Section 125 Wages not applicable to FICA taxes	(178,602)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$9,945 x 6.2%/7.65%)	(8,060)
Add: Miscellaneous Wages	18,497
Add: ACCS Wages	203,635
Add: wages included in employee meal calculation	11,379
Cash basis salaries	3,815,980
FICA rate	7.650%
Calculated FICA	291,922
FICA per Sch XIX	<u>291,922</u>
Unknown variance	<u>0</u>

Sch. XX - General Information		
12. Nurse Aide Trainer Wages:		
	Administrator	122
	Therapy / PT / OT	1,108
	Activities Director	55
	Day Program	55
	Head Cook	241
	Maintenance	358
	Nursing	15,322
	Soc. Serv. / QMRP	<u>24,449</u>
		<u>41,710</u>

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

16. Out of State Travel	
	<b>Administration</b>
	Matthew Steffen, Business Manager
	<u>1,034</u>
	<u>1,034</u>
	<b>Board of Directors</b>
	Stan Virkler
	Roger Aberle
	Warren Zahner
	<u>1,161</u>
	<u>2,720</u>

Nursing	
	<u>-</u>

**Cell:** A5  
**Comment:** Done  
2004

**Cell:** F5  
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2004

**Cell:** F7  
**Comment:** Done  
2004

**Cell:** J11  
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2004

**Cell:** F19  
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**Comment:** Done  
2004

**Cell:** A45  
**Comment:** Done  
2004

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Oakwood Estate, Morton, IL	#0033712
Linden Estate, Morton, IL	#0039305

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

John Knobloch, Chairman  
Jerry Christensen, Vice Chairman  
Keith Pflum, Secretary/ Treasurer  
Ron Hodel, Director  
Jerry Kieser, Director (term ended 03/18/2006)  
Cleve Klopfenstein, Director  
Daniel Schumacher, Director  
Roger Aberle, Director (term began 03/18/2006)  
Stan Virkler, Director  
Warren Zahner, Director

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

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

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

	Pioneer Park	PARC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	2	1								
Miles per trip	40	40	40								
Gas/Depreciation Price per Mile	\$0.85	\$0.95	\$0.55								
Hours per trip	1 1/4	1 1/4	1 1/4								
Attendant Wages	\$8.50	\$8.50									
Driver Wages	\$12.75	\$12.75	\$10.50								
Gas & Depreciation	\$ 34.00	\$ 38.00	\$ 22.00	\$ 94.00	\$ 166.00	58.16%	42,500.68	(15,212.00)	27,289.00	14	Sch. VI Ln. 29
Depreciation					\$ -			15,212.00	15,212.00	Sch XI (F)	Sch. VI Ln. 29
Driver Wages	\$ 15.94	\$ 15.94	\$ 13.13	\$ 45.01	\$ 76.89	26.94%	19,686.01		19,686.00	6	Sch. VI Ln. 1
Attendant Wages	\$ 10.63	\$ 10.63	\$ -	\$ 21.26	\$ 42.52	14.90%	10,886.32		10,886.00	10	Sch. VI Ln. 29
Total	\$ 60.57	\$ 64.57	\$ 35.13	\$ 160.27	\$ 285.41		73,073.00		73,073.00		

**Cell:** I14

**Comment:** msteffen:  
from transportation income

**AIDE CLASSES**

**APOSTOLIC CHRISTIAN TIMBER RIDGE\_#0016220**

From: 07/01/2005 to 06/30/2006

**CLASS DATE**

	TR				OE				LE				CILA								
	# of Students	Hrs	Wages	OJT HRS	# of Students	Hrs	Wages	OJT HRS	# of Students	Hrs	Wages	OJT HRS	# of Students	Hrs	Wages	OJT HRS					
completed	47	39	1,560	\$ 13,260.00	3120	\$ 26,520.00	3	120	\$ 1,020.00	240	\$ 2,040.00	160	\$ 1,360.00	3	120	\$ 1,020.00	240	\$ 2,040.00			
still enrolled, not complete	24	18	289	\$ 2,456.50	578	\$ 4,913.00	2	37	\$ 314.50	74	\$ 629.00	6	\$ 51.00	3	27	\$ 229.50	54	\$ 459.00			
dropouts	20	17	262	\$ 2,227.00	524	\$ 4,454.00	1	11	\$ 93.50	22	\$ 187.00	0	\$ -	2	6	\$ 51.00	12	\$ 102.00			
			\$ -	\$ -	0	\$ -		\$ -	0	\$ -		\$ -		\$ -	0	\$ -		\$ -			
<b>Total</b>	<b>2515</b>	<b>74</b>	<b>2111</b>	<b>\$ 17,943.50</b>	<b>4222</b>	<b>\$ 35,887.00</b>	<b>6</b>	<b>168</b>	<b>\$ 1,428.00</b>	<b>336</b>	<b>\$ 2,856.00</b>	<b>3</b>	<b>83</b>	<b>\$ 705.50</b>	<b>166</b>	<b>\$ 1,411.00</b>	<b>8</b>	<b>153</b>	<b>\$ 1,300.50</b>	<b>306</b>	<b>\$ 2,601.00</b>

**TRAINER WAGES**

Classification	Hours	Hourly Rate	Wages	Hours/Class	# of Classes	WAGES				Hours											
						TR	OE	LE	CILA	TR	OE	LE	CILA								
Aggression Management - 1,2,3	12q	30	\$ 16.80	\$ 504.00	6	5	423.04	33.67	16.63	30.66	25.18	2.00	0.99	1.83							
Nutrition	1	15	\$ 19.14	\$ 287.10	3	5	240.98	19.18	9.47	17.47	12.59	1.00	0.50	0.91							
Nursing 1 class	10	20	\$ 22.98	\$ 459.60	4	5	385.77	30.70	15.17	27.96	16.79	1.34	0.66	1.22							
ISP Development	12q	16	\$ 17.01	\$ 272.16	4	4	228.44	18.18	8.98	16.56	13.43	1.07	0.53	0.97							
On the Job Trainer - RN	10	894	\$ 19.49	\$ 17,419.19			14,621.04	1,163.59	574.87	1,059.70	750.18	59.70	29.50	54.37							
Maintenance - Gary Flinn, RN	6	18	\$ 23.69	\$ 426.42	3	6	357.92	28.48	14.07	25.94	15.11	1.20	0.59	1.10							
Environmental Safety	15	4	\$ 18.09	\$ 65.12	0.6	6	54.66	4.35	2.15	3.96	3.02	0.24	0.12	0.22							
Community Integration	11	4	\$ 18.08	\$ 65.02	0.6	6	54.57	4.34	2.15	3.96	3.02	0.24	0.12	0.22							
Community Integration	12r	4	\$ 20.45	\$ 73.62	0.6	6	61.79	4.92	2.43	4.48	3.02	0.24	0.12	0.22							
Community Integration	12r	4	\$ 12.34	\$ 44.42	0.6	6	37.29	2.97	1.47	2.70	3.02	0.24	0.12	0.22							
Community Integration	12r	4	\$ 16.96	\$ 61.06	0.6	6	51.25	4.08	2.01	3.71	3.02	0.24	0.12	0.22							
CPR	10a	48	\$ 10.15	\$ 487.20	3	16	408.94	32.54	16.08	29.64	40.29	3.21	1.58	2.92							
First Aide	10a	18	\$ 10.15	\$ 182.70	2	9	153.35	12.20	6.03	11.11	15.11	1.20	0.59	1.10							
Body Mechanics / Eating & Food Safety	10ot	15	\$ 19.34	\$ 275.10	3	5	230.01	18.38	9.08	16.74	12.59	1.00	0.50	0.91							
Introduction to DD / Human Rights	12r	40	\$ 23.68	\$ 947.20	8	5	795.05	63.27	31.26	57.62	33.57	2.67	1.32	2.43							
Great Counseling	12r	5	\$ 23.68	\$ 118.40	1	5	99.38	7.91	3.91	7.20											
Nursing 2 class	10	12	\$ 31.33	\$ 375.96	3	4	315.57	25.11	12.41	22.87	10.07	0.80	0.40	0.73							
Sign Language	10s	10	\$ 15.64	\$ 156.40	2	5	131.28	10.45	5.16	9.51	8.39	0.67	0.33	0.61							
Human Interaction	10s	14	\$ 15.64	\$ 218.96	3.5	4	183.79	14.63	7.23	13.32	11.75	0.94	0.46	0.85							
Mission & Social Serv. Dir. - Jodi Anlik	12m	14	\$ 16.15	\$ 226.10	3.5	4	189.78	15.10	7.46	13.75	11.75	0.94	0.46	0.85							
Abuse/Neglect/Etc.	17	6	\$ 24.27	\$ 145.62	3	2	122.23	9.73	4.81	8.86	5.04	0.40	0.20	0.37							
Abuse/Neglect/Etc.	12ojt	1933	\$ 13.91	\$ 26,881.08			22,563.00	1,795.63	887.13	1,635.31	1,622.07	129.09	63.78	117.56							
On the Job Trainer - Aide																					
<b>OE</b>																					
RSD - Evie Mogler	12r	0	\$ 20.45	\$ -		6															
Administrator - Helen Schuon	17	0	\$ 24.27	\$ -		2															
<b>LE</b>																					
RSD - Rob Mooney	12r	0	\$ 16.96	\$ -		6															
<b>CILA</b>																					
RSD - Sherry Parnham	12r	0	\$ 12.34	\$ -		6															
<b>Total trainer wages</b>		<b>3125.25</b>		<b>\$ 49,692.42</b>			<b>41,710.02</b>	<b>3,319.41</b>	<b>1,639.95</b>	<b>3,023.04</b>	<b>2,619.02</b>	<b>208.43</b>	<b>102.97</b>	<b>189.82</b>							

	TR	OE	LE	CILA
<b>Drop-Outs</b>				
Number from this Facility	17	1	0	2
Clinical Wages	\$ 4,454.00	\$ 22.00	\$ -	\$ 102.00
Classroom Wages	\$ 2,227.00	\$ 94.00	\$ -	\$ 51.00
In-House Trainer Wages	\$ 1,726.00	\$ 177.00	\$ -	\$ 40.00
<b>Completed</b>				
Number from this Facility	57	5	3	6
Clinical Wages	\$ 15,717.00	\$ 1,335.00	\$ 706.00	\$ 1,250.00
Classroom Wages	\$ 31,433.00	\$ 314.00	\$ 1,411.00	\$ 2,499.00
In-House Trainer Wages	\$ 24,356.00	\$ 591.00	\$ 1,093.00	\$ 1,936.00

Schedule V	Line	TR Change	OE Change	LE Change	CILA Change
Dietary	1	(241.00)	(19.00)	(9.00)	(17.00)
Maintenance	6	(358.00)	(28.00)	(14.00)	(26.00)
Nursing	10	(15,322.00)	(1,219.00)	(602.00)	(1,111.00)
Therapy	10a	(562.00)	(45.00)	(22.00)	(41.00)
OT/PT	10ot	(231.00)	(18.00)	(9.00)	(17.00)
Activities	11	(55.00)	(4.00)	(2.00)	(4.00)
RSD	12r	(1,045.00)	(83.00)	(41.00)	(78.00)
QMRPs	12q	(651.00)	(52.00)	(26.00)	(47.00)
MSSD	12m	(190.00)	(15.00)	(7.00)	(14.00)
Training Wages	13	41,710.00	3,319.00	1,640.00	3,023.00
Day Program	15	(55.00)	(4.00)	(2.00)	(4.00)
Administrator	17	(122.00)	(10.00)	(5.00)	(9.00)
OJT	12ojt	(22,563.00)	(1,796.00)	(887.00)	(1,635.00)
Speech	10s	(315.00)	(25.00)	(12.00)	(23.00)
Adjustment	12	-	(1.00)	(2.00)	1.00





