

Facility Name & ID Number Apostolic Christian Resthaven

0029892 Report Period Beginning: Jan. 1, 2006 Ending: Dec. 31, 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 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	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	3,116	5,647		8,763	8
9	SNF/PED					9
10	ICF	2,851	6,400		9,251	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,967	12,047		18,014	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.71%

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, 2006 Ending: Dec. 31, 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
A. General Services											
1	Dietary	240,543	12,860		253,403		253,403	(9,968)	243,435		1
2	Food Purchase		103,769		103,769		103,769	(4,820)	98,949		2
3	Housekeeping	61,811	8,663		70,474		70,474		70,474		3
4	Laundry	38,231	4,644		42,875	150	43,025		43,025		4
5	Heat and Other Utilities			60,990	60,990		60,990		60,990		5
6	Maintenance	43,548	201	37,710	81,459		81,459		81,459		6
7	Other (specify):* waste removal			3,944	3,944		3,944		3,944		7
8	TOTAL General Services	384,133	130,137	102,644	616,914	150	617,064	(14,788)	602,276		8
B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,315,711	42,210	822	1,358,743		1,358,743	(20)	1,358,723		10
10a	Therapy		37	1,083	1,120		1,120		1,120		10a
11	Activities	62,454	5,825	760	69,039		69,039	(51)	68,988		11
12	Social Services	23,547	298	2,060	25,905		25,905		25,905		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,401,712	48,370	6,725	1,456,807		1,456,807	(71)	1,456,736		16
C. General Administration											
17	Administrative	86,709			86,709		86,709		86,709		17
18	Directors Fees										18
19	Professional Services			16,530	16,530		16,530	(500)	16,030		19
20	Dues, Fees, Subscriptions & Promotions			7,989	7,989		7,989	(175)	7,814		20
21	Clerical & General Office Expenses	63,195	7,329	4,192	74,716		74,716		74,716		21
22	Employee Benefits & Payroll Taxes			441,959	441,959		441,959		441,959		22
23	Inservice Training & Education			300	300		300		300		23
24	Travel and Seminar			16,203	16,203		16,203	(3,831)	12,372		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,602	30,602		30,602		30,602		26
27	Other (specify):* miscellaneous			1,254	1,254	(151)	1,103		1,103		27
28	TOTAL General Administration	149,904	7,329	519,029	676,262	(151)	676,111	(4,506)	671,605		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,935,749	185,836	628,398	2,749,983	(1)	2,749,982	(19,365)	2,730,617		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, 2006 Ending:

Dec. 31, 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	
	D. Ownership											
30	Depreciation			126,291	126,291		126,291	(29,432)	96,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1	1	(1)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			126,291	126,291	1	126,292	(29,433)	96,859			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,562	85,226	108,788		108,788		108,788			39
40	Barber and Beauty Shops	23,888	462	1,339	25,689		25,689		25,689			40
41	Coffee and Gift Shops		1,618		1,618		1,618	(1,618)				41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):* apartment & mpr		1,502	68,230	69,732		69,732	(69,732)				43
44	TOTAL Special Cost Centers	23,888	27,144	182,170	233,202		233,202	(71,350)	161,852			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,959,637	212,980	936,859	3,109,476		3,109,476	(120,148)	2,989,328			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, 2006

Ending:

Dec. 31, 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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,820)	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	(51)	11		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(28,383)	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	(500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,148)		\$	30

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

		1	2	
		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))	\$ (120,148)		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

BHF USE ONLY						
48		49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Apostolic Christian Resthaven

ID# 0029892

Report Period Beginning: Jan. 1, 2006

Ending: Dec. 31, 2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Out-of-state travel	\$ (3,520)	24	1
2	Apartment expense	(68,215)	43	2
3	Vending expense	(1,618)	41	3
4	Non-care vehicle expense	(311)	24	4
5	Non-patient meals (wage-related costs)	(9,968)	1	5
6	Dental consultant	(20)	10	6
7	Multi-purpose room expense	(1,502)	43	7
8	Rent on land paid to related party	(1)	34	8
9	Other non-operating expenses	(15)	43	9
10	Deprec on old van reclassified to Non-Care Assets	(556)	30	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(85,726)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2006

Ending:

Dec. 31, 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)	
	A. General Services													
1	Dietary	(9,968)	0	0	0	0	0	0	0	0	0	0	(9,968)	1
2	Food Purchase	(4,820)	0	0	0	0	0	0	0	0	0	0	(4,820)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,788)	0	0	0	0	0	0	0	0	0	0	(14,788)	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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(51)	0	0	0	0	0	0	0	0	0	0	(51)	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	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	(500)	0	0	0	0	0	0	0	0	0	0	(500)	19
20	Fees, Subscriptions & Promotions	(175)	0	0	0	0	0	0	0	0	0	0	(175)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,831)	0	0	0	0	0	0	0	0	0	0	(3,831)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,506)	0	0	0	0	0	0	0	0	0	0	(4,506)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,365)	0	0	0	0	0	0	0	0	0	0	(19,365)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2006 Ending:

Dec. 31, 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)
	D. Ownership												
30	Depreciation	(29,432)	0	0	0	0	0	0	0	0	0	0	(29,432) 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	(1)	0	0	0	0	0	0	0	0	0	0	(1) 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	(29,433)	0	0	0	0	0	0	0	0	0	0	(29,433) 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	(1,618)	0	0	0	0	0	0	0	0	0	0	(1,618) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(69,732)	0	0	0	0	0	0	0	0	0	0	(69,732) 43
44	TOTAL Special Cost Centers	(71,350)	0	0	0	0	0	0	0	0	0	0	(71,350) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(120,148)	0	0	0	0	0	0	0	0	0	0	(120,148) 45

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2006 Ending: Dec. 31, 2006

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)	
	V	27 Rent - land	\$ 1	Apostolic Christian Church of Elgin	100.00%	\$ 1	\$	1
	V							2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$ 1			\$ 1	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven # 0029892 Report Period Beginning: Jan. 1, 2006 Ending: Dec. 31, 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									\$	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, 2006 Ending: Dec. 31, 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	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 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).		\$	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. (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>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">FOR BHF USE ONLY</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>		FOR BHF USE ONLY		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																										
FOR BHF USE ONLY																											
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Resthaver COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0029892

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(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 direct 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 hom (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 20C 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: 22,600 B. General Construction Type: Exterior 80% brick/20% cedar Frame steel Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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)
Eighteen (18) congregate housing units (apartments) are attached to the nursing home. Utilities are separately metered and costs are handled separately.

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

Jan. 1, 2006 Ending: Dec. 31, 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	49	1985	1985	\$ 2,025,975	\$ 50,671	40	\$ 50,671		\$ 1,080,165	4
5		1986	1986	10,064	252	40	252		5,162	5
6		1987	1987	67,246	1,681	40	1,681		32,780	6
7	1	1988	1988	91,817	2,295	40	2,295		42,460	7
8		1999	1999	74,929	1,873	40	1,380	(493)	11,427	8
Improvement Type**										
9	Land improvements - general land improvement		1985	24,667		15			24,667	9
10	Land improvements - general land improvement		1986	4,800		15			4,800	10
11	Land improvements - general land improvement		1989	2,069	11	15	11		2,069	11
12	Land improvements - general land improvement		1990	590	4	15	4		590	12
13	Land improvements - parking lot sealcoating		1992	3,525	235	15	235		3,408	13
14	Land improvements - court yard		1992	26,596	1,773	15	1,773		25,265	14
15	Land improvements - front court yard		1997	15,126	1,008	15	1,008		9,494	15
16	Land improvements - black topping		1997	16,291	1,086	15	1,086		10,136	16
17	Land improvements - parking lot		2001	5,200	347	15	347		1,821	17
18	Land improvements - parking lot sealcoating		2001	2,095	140	15	140		734	18
19	Land improvements - sidewalk to parking lot		2005	5,315	354	15	354		502	19
20	Building improvements - general building improvement		1987	8,669	445	20	445		8,329	20
21	Building improvements - general building improvement		1988	28,461	1,423	20	1,423		26,325	21
22	Building improvements - general building improvement		1989	500	25	20	25		442	22
23	Building improvements - general building improvement		1990	6,091	305	20	305		5,013	23
24	Building improvements - general building improvement		1991	6,846	342	20	342		5,206	24
25	Building improvements - air conditioner and light fixture		1992	15,080	754	20	754		10,933	25
26	Building improvements - plumbing RPZ valve		1994	885	44	20	44		547	26
27	Building improvements - carpeting, curtains, drapes		1995	18,458	6	10	6		18,458	27
28	Building improvements - carpeting, curtains, drapes		1996	6,987	238	10	238		6,984	28
29	Building improvements - sound system in lobby		1996	809	40	20	40		429	29
30	Building improvements - code alert		1997	1,164	116	10	116		1,114	30
31	Building improvements - patio door		1998	2,100	105	20	105		919	31
32	Building improvements - automatic door		1998	2,029	102	20	102		869	32
33	Building improvements - music room carpeting		1998	2,671	267	10	267		2,248	33
34	Building improvements - kitchen air conditioner		1999	4,500	225	20	225		1,763	34
35	Building improvements - kitchen air conditioner		1999	3,882	194	20	194		1,505	35
36	Building improvements - cabinets		1999	389	20	20	20		149	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, 2006 Ending: Dec. 31, 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	Building improvements - cabinets	1999	\$ 310	\$ 16	20	\$ 16	\$	\$ 122	37
38	Building improvements - carpeting in 2 offices	1999	1,325	66	20	66		513	38
39	Building improvements - kitchen air conditioner wiring	1999	985	49	20	49		377	39
40	Building improvements - dining room blind	1999	656	33	20	33		236	40
41	Building improvements - garbage disposal	2000	1,975	99	20	99		651	41
42	Building improvements - faucets	2001	104	5	20	5		29	42
43	Building improvements - faucets	2001	2,268	113	20	113		642	43
44	Building improvements - greasetrap	2001	3,769	189	20	189		1,067	44
45	Building improvements - door shades	2001	281	14	20	14		75	45
46	Building improvements - door shades	2001	281	14	20	14		74	46
47	Building improvements - damper	2001	710	36	20	36		184	47
48	Building improvements - door for PT Room	2001	600	30	20	30		153	48
49	Building improvements - drapes for employee dining room	2002	653	33	20	33		158	49
50	Building improvements - drapes for residents	2002	1,307	65	20	65		310	50
51	Building improvements - electromagnetic front doors	2003	1,717	86	20	86		336	51
52	Building improvements - air conditioning	2003	3,100	155	20	155		530	52
53	Building improvements - fire dampers	2003	2,160	108	20	108		342	53
54	Building improvements - steam table restoration	2004	3,700	185	20	185		540	54
55	Building improvements - hot water coil replacement	2004	3,408	170	20	170		483	55
56	Building improvements - activity room shelving	2004	1,850	93	20	93		262	56
57	Building improvements - service door exit alarms	2004	994	50	20	50		124	57
58	Building improvements - smoke detectors for office shutter	2004	953	48	20	48		107	58
59	Building improvements - replace hot water heaters	2005	8,650	433	15	433		829	59
60	Building improvements - fire doors	2005	3,230	161	40	161		215	60
61	Building improvements - three wings security door systems	2005	6,600	330	20	330		385	61
62	Building improvements - duct detectors	2005	1,167	58	20	58		63	62
63	Building improvements - smoke damper	2005	4,607	230	20	230		250	63
64	Building improvements - smoke detector	2005	5,158	258	20	258		258	64
65	Building improvements - RN station cabinets & countertop	2006	12,127	472	15	472		472	65
66	Building improvements - kitchen a/c condensor	2006	2,800	93	15	93		93	66
67	Building improvements - RN station carpeting	2006	3,700	185	5	185		185	67
68	Building improvements - replace windows	2005	28,966	724	40	724		1,196	68
69	Building improvements - replace windows	2006	24,955	208	40	208		208	69
70	TOTAL (lines 4 thru 69)		\$ 2,620,892	\$ 71,190		\$ 70,697	\$ (493)	\$ 1,358,182	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	\$ 244,669	\$ 23,374	\$ 23,374	\$	5/10/20	\$ 144,355	71
72	Current Year Purchases	8,945	366	366		10/12/15	366	72
73	Fully Depreciated Assets	221,363					221,363	73
74								74
75	TOTALS	\$ 474,977	\$ 23,740	\$ 23,740	\$		\$ 366,084	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 - care related use	2006 Ford E350 Van	2006	\$ 36,327	\$ 2,422	\$ 2,422	\$	10	\$ 2,422	76
77										77
78										78
79										79
80	TOTALS			\$ 36,327	\$ 2,422	\$ 2,422	\$		\$ 2,422	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,132,196	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,352	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,859	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)	\$ 1,726,688	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 - 1986/1990/1999/2006	\$ 929,473	\$ 23,150	\$ 414,486	86
87	Land improvements - 86/90/91/97	94,036	2,646	72,034	87
88	Equipment - 1986-1999/2006	42,726	380	39,773	88
89	Building improvements - 99-03/2006	21,669	1,169	5,162	89
90	Van - 30% non-care related - 2006	15,569	1,594	1,038	90
91	TOTALS	\$ 1,103,473	\$ 28,939	\$ 532,493	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.	_____/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: \$ _____ 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?</p> <p style="text-align: right;"> <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				4,838		4,838	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		6,752	85,226	2,603	6,752	87,829	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					16,121		16,121	13
14	TOTAL			\$	6,752	\$ 85,226	\$ 23,562	6,752	\$ 108,788	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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2006

Ending:

Dec. 31, 2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Dec. 31, 2006

(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	\$ 26,235	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	397,840		3
4	Supply Inventory (priced at cost)	20,098		4
5	Short-Term Investments	280,000		5
6	Prepaid Insurance	20,960		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)	\$ 745,133	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,666,069		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	569,599		16
17	Accumulated Depreciation (book methods)	(2,261,644)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	67,573		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>capital in risk retention grp</u>	43,970		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,085,567	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,830,700	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 192,522	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,573		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	2,227		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued expenses</u>	12,628		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 356,950	\$	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>	77,700		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 77,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 434,650	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,396,050	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,830,700	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,458,488	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,458,488	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,438)	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)	\$ (62,438)	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)	\$ 2,396,050	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning: Jan. 1, 2006

Ending: Dec. 31, 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,817,305	1
2	Discounts and Allowances for all Levels	(237,494)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,579,811	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,350	6
7	Oxygen	30	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,380	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	3,386	13
14	Non-Patient Meals	4,790	14
15	Telephone, Television and Radio	61	15
16	Rental of Facility Space		16
17	Sale of Drugs	103,207	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)	\$ 111,444	23
D. Non-Operating Revenue			
24	Contributions	134,676	24
25	Interest and Other Investment Income***	16,046	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 150,722	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other revenues - see schedule	201,681	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 201,681	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,047,038	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	616,914	31
32	Health Care	1,456,807	32
33	General Administration	676,262	33
B. Capital Expense			
34	Ownership	126,291	34
C. Ancillary Expense			
35	Special Cost Centers	205,827	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)*	\$ 3,109,476	40
41	Income before Income Taxes (line 30 minus line 40)**	(62,438)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (62,438)	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, 2006**Ending: **Dec. 31, 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	1,782	1,957	\$ 56,641	\$ 28.94	1
2	Assistant Director of Nursing	1,999	2,188	49,729	22.73	2
3	Registered Nurses	15,113	16,379	397,374	24.26	3
4	Licensed Practical Nurses	5,184	5,650	116,476	20.62	4
5	CNAs & Orderlies	49,578	53,603	654,952	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,713	2,002	26,899	13.44	8
9	Activity Director	1,505	1,695	24,255	14.31	9
10	Activity Assistants	3,580	3,917	38,199	9.75	10
11	Social Service Workers	1,608	1,743	23,547	13.51	11
12	Dietician	1,929	2,117	44,788	21.16	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,768	18,465	185,787	10.06	15
16	Dishwashers					16
17	Maintenance Workers	2,012	2,223	43,548	19.59	17
18	Housekeepers	5,859	6,439	61,811	9.60	18
19	Laundry	2,929	3,347	38,231	11.42	19
20	Administrator	1,833	2,081	86,709	41.67	20
21	Assistant Administrator					21
22	Other Administrative	1,191	1,301	13,640	10.48	22
23	Office Manager					23
24	Clerical	3,866	4,172	63,195	15.15	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	1,445	1,633	23,888	14.63	33
34	TOTAL (lines 1 - 33)	119,894	130,912	\$ 1,949,669 *	\$ 14.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	6	2,000	9-3	36
37	Medical Records Consultant	13	802	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	19	1,083	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	760	11-3	44
45	Social Service Consultant	24	2,060	12-3	45
46	Other(specify) beautician	89	1,339	40-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	167	\$ 8,044		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			52
53	TOTAL (lines 50 - 52)	\$		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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
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 2,165; AAHSA 788
- (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. \$ 27,597 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. _____
- (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 \$5,000, 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

<u>Account</u>		
8023	Vending Income	\$ 1,928
6902	Activity Income	990
8020	Cookbooks	496
8050	Apartment Income	194,147
8026	Miscellaneous Income - Non Operating	4,120
		<hr/>
		\$ 201,681
		<hr/> <hr/>

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	<u>\$ 3,944</u>
----------------------------------------------	-----------------

Page 20, Schedule XVIII, Line 34 Reconciliation

Total Wages Reported on Page 20, Line 34	\$ 1,949,669
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Dietary Wages Allocated to Non-Patient Meals as per Adjustment on Page 5A	<u>9,968</u>
---------------------------------------------------------------------------	--------------

Total Salary / Wages Reported on Page 4, Column 1	<u>\$ 1,959,637</u>
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Page 3, Schedule V, Column 5, Reclassification Entries

<u>Cost Center</u>	<u>Expense Category</u>	<u>Line #</u>	<u>Amount</u>
1) General Services	Laundry	4-3	\$ 150
General Administration	Other	27-3	\$ (150)

to reclassify laundry help.

2) Ownership	Rent-Facility & Grounds	34-3	\$ 1
General Administration	Other	27-3	\$ (1)

to reclassify rent on land paid to related party

Page 3, Schedule V, Line 27, Other Expense

	Miscell. Expense
Bank Service Charge	\$ 5
Rent On Land	1
Laundry Help	150
Retire Old Nurses' Station	1,063
DVD For AC Homes Meeting	5
Stop Payment Fee On Check	30
Column 4 Total	<u>1,254</u>
Reclassifications:	
Rent on Land Paid to Related Party to Line 34	(1)
Laundry Help To Line 4	<u>(150)</u>
Column 6 Reclassified Total	<u>1,103</u>
Column 8 Adjusted Total	<u><u>\$ 1,103</u></u>

Page 4, Schedule V, Line 43, Other Expense

	Apartment Expense	Multi-Purpose Room Exp.	Miscellaneous Expense	Total
Apartment Expense	\$ 68,215	\$ -	\$ -	\$ 68,215
Other Non-Operating Expense	-	-	15	15
Multi-Purpose Room Expense	-	1,502	-	1,502
Column 4 Total	<u>68,215</u>	<u>1,502</u>	<u>15</u>	<u>69,732</u>
Adjustments:				
Apartment Expense	(68,215)	-	-	(68,215)
Other Non-Operating Expense	-	-	(15)	(15)
Multi-Purpose Room Expense	-	(1,502)	-	(1,502)
Column 8 Adjusted Total	<u><u>\$ -</u></u>	<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	\$	227
2	Christmas Dinner		1,500
3	Christmas Gifts		2,420
4	Staff Appreciation Dinner		886
5	Anniversary Gifts for Years of Service		640
6	Employee Assistance Program		2,025
7	Other		3,516
8	Staff Appreciation Awards		2,000
9	Donated Items		848
			<u>848</u>
		\$	<u>14,062</u>

Page 21, Schedule XIX, Section D, Pension Expense

Pension Costs for Owners	\$	-
Pension Costs for Related Parties		-
Pension Costs for All Other Employees		54,757
		<u>54,757</u>
	\$	<u>54,757</u>

Note - 58 employees were covered under the pension plan for year 2006.

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 25 nurse assistants leave employment during 2006 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 5-8, 2006, David Stieglitz, Administrator, attended the American Association of Homes and Services for the Aging Annual Meeting held in San Francisco, California. This convention included topics related to employee recruitment and retention, regulatory compliance, the future of long term care and board management.

From August 5-9, 2006, Nina Dubman, Registered Dietician, attended an AmeriNet Central (group purchasing organization) seminar in Pittsburgh, Pennsylvania.

2006 Board of Directors and Officers

Don Heiniger, President	38W644 Arrowmaker Pass, Elgin, IL 60124
Bob Cox, Vice President	709 Linden Avenue, Elgin, IL 60120
Glen Pfeifer, Secretary	37W951 McKee Road, Batavia, IL 60510
Dave Martin, Treasurer	24107 W. Grant Highway, Marengo, IL 60152
Jeff Kellenberger	11N528 Muirhead Road, Elgin, IL 60124
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Dave Jepson	229 Nelson Parkway, Cherry Valley, IL 61016