

Facility Name & ID Number Apostolic Christian Timber Ridge

0016220 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	33,214	256		33,470	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,214	256		33,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.57%

D. How many bed-hold days during this year were paid by the Department? 568 (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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	276,392	17,035	6,837	300,264	664	300,928	0	300,928		1
2	Food Purchase		162,387		162,387	0	162,387	0	162,387		2
3	Housekeeping	67,378	13,412		80,790	0	80,790	0	80,790		3
4	Laundry	144,738	18,602		163,340	153	163,493	0	163,493		4
5	Heat and Other Utilities			121,395	121,395	0	121,395	0	121,395		5
6	Maintenance	91,353	16,115	30,728	138,196	6,142	144,338	(20,652)	123,686		6
7	Other (specify):*				0	0	0	0	0		7
8	TOTAL General Services	579,861	227,551	158,960	966,372	6,959	973,331	(20,652)	952,679		8
	B. Health Care and Programs										
9	Medical Director			1,332	1,332	0	1,332	0	1,332		9
10	Nursing and Medical Records	1,027,868	212,684	384,723	1,625,275	(11,967)	1,613,308	(11,420)	1,601,888		10
10a	Therapy	1,343,973	5,560	9,401	1,358,934	(17,782)	1,341,152	0	1,341,152		10a
11	Activities	270,170	10,664		280,834	23	280,857	0	280,857		11
12	Social Services	326,837	2,327	14,989	344,153	(19,070)	325,083	0	325,083		12
13	CNA Training		3,545		3,545	32,787	36,332	0	36,332		13
14	Program Transportation		60,862		60,862	(16,616)	44,246	(18,528)	25,718		14
15	Other (specify):* Day Programming	92,667	1,475		94,142	(27)	94,115	0	94,115		15
16	TOTAL Health Care and Programs	3,061,515	297,117	410,445	3,769,077	(32,652)	3,736,425	(29,948)	3,706,477		16
	C. General Administration										
17	Administrative	123,706			123,706	(47)	123,659	0	123,659		17
18	Directors Fees				0	0	0	0	0		18
19	Professional Services			61,946	61,946	0	61,946	0	61,946		19
20	Dues, Fees, Subscriptions & Promotions			16,176	16,176	0	16,176	(3,385)	12,791		20
21	Clerical & General Office Expenses	95,749	37,156		132,905	642	133,547	0	133,547		21
22	Employee Benefits & Payroll Taxes			964,791	964,791	18,135	982,926	(23,157)	959,769		22
23	Inservice Training & Education			13,384	13,384	0	13,384	0	13,384		23
24	Travel and Seminar			3,435	3,435	0	3,435	(2,316)	1,119		24
25	Other Admin. Staff Transportation				0	0	0	0	0		25
26	Insurance-Prop.Liab.Malpractice			62,626	62,626	0	62,626	(9,592)	53,034		26
27	Other (specify):* See Schedule			17,478	17,478	(17,051)	427	(500)	(73)		27
28	TOTAL General Administration	219,455	37,156	1,139,836	1,396,447	1,679	1,398,126	(38,950)	1,359,176		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,860,831	561,824	1,709,241	6,131,896	(24,014)	6,107,882	(89,550)	6,018,332		29

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

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

Facility Name & ID Number

Apostolic Christian Timber Ridge

#0016220

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			185,800	185,800		185,800	(26,058)	159,742			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			5,076	5,076	(3,611)	1,465	0	1,465			35
36	Other (specify):* Asset Management Fees			53,857	53,857		53,857	(53,857)	0			36
37	TOTAL Ownership			244,733	244,733	(3,611)	241,122	(79,915)	161,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0	16,616	16,616	(16,616)	0			38
39	Ancillary Service Centers				0	11,009	11,009	0	11,009			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			288,660	288,660		288,660	0	288,660			42
43	Other (specify):* Facility Bulletin			2,109	2,109		2,109	0	2,109			43
44	TOTAL Special Cost Centers	0	0	290,769	290,769	27,625	318,394	(16,616)	301,778			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,860,831	561,824	2,244,743	6,667,398	0	6,667,398	(186,081)	6,481,317			45

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

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	BHF USE ONLY	
1	Day Care	\$ (20,652)	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	(53,857)	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				18
19	Entertainment				19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance	(9,592)	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	(3,385)	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	(98,095)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,081)		\$ 0	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)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (186,081)		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		\$ 16,616	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 16,616		47

BHF USE ONLY

48		49		50		51		52	
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Apostolic Christian Timber Ridge

ID# 0016220

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset day draining transportation income	\$ (11,420)	10	1
2	Offset day draining transportation income	(18,528)	14	2
3	Out-of-state Travel (Administrative Staff)	0	25	3
4	Depreciation of non-care vehicles	(26,058)	30	4
5	Offset medically necessary transportation income	(16,616)	38	5
6	Benefits allocated to day programming	(23,157)	22	6
7	Out-of-state Travel (In-service Training & Education)	0	24	7
8	Out-of-state Travel (Board of Directors)	(2,316)	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	Total	(98,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	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	(20,652)	0	0	0	0	0	0	0	0	0	0	(20,652)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,652)	0	(20,652)	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	(11,420)	0	0	0	0	0	0	0	0	0	0	(11,420)	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	(18,528)	0	0	0	0	0	0	0	0	0	0	(18,528)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(29,948)	0	(29,948)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,385)	0	0	0	0	0	0	0	0	0	0	(3,385)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(23,157)	0	0	0	0	0	0	0	0	0	0	(23,157)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,316)	0	0	0	0	0	0	0	0	0	0	(2,316)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,592)	0	0	0	0	0	0	0	0	0	0	(9,592)	26
27	Other (specify):*	(500)	0	0	0	0	0	0	0	0	0	0	(500)	27
28	TOTAL General Administration	(38,950)	0	(38,950)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(89,550)	0	(89,550)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Timber Ridge # 0016220 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(26,058)	0	0	0	0	0	0	0	0	0	0	(26,058) 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):*	(53,857)	0	0	0	0	0	0	0	0	0	0	(53,857) 36
37	TOTAL Ownership	(79,915)	0	(79,915) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	(16,616)	0	0	0	0	0	0	0	0	0	0	(16,616) 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	TOTAL Special Cost Centers	(16,616)	0	(16,616) 44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(186,081)	0	(186,081) 45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<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</u>		<u>Services for the</u>
				<u>Services</u>		<u>Developmentally</u>
						<u>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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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: 07/01/2006 Ending: 06/30/2007

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	Director	Director	0.00		0.5			\$		1
2	Roger Aberle	Director	Director	0.00	498	0.5		Travel	1,495	line 24; col.3	2
3	Dan Schumacher	Chairman	Director	0.00		0.5					3
4	Jerry Christensen	Director	Director	0.00		0.5					4
5	Ron Hodel	Director	Director	0.00		0.5					5
6	Roger Beutel	Director	Director	0.00		0.5					6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	132	0.5		Travel	393	line 24; col.3	7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Stan Virkler	Vice-Chairman	Director	0.00	148	0.5		Travel	444	line 24; col.3	9
10	Warren Zahner	Director	Director	0.00	126	0.5		Travel	377	line 24; col.3	10
11											11
12											12
13								TOTAL	\$ 2,709		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: 07/01/2006

Ending: 6/30/2007

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

Facility Name & ID Number

Apostolic Christian Timber Ridge

0016220

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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		8	9	10									
					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	Original				Balance
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					\$	0	\$	0	\$	0	9						
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	0	\$	0	\$	0	14						
15	TOTALS (line 9+line14)					\$	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 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 2007 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.

\$ **0** **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	_____	10
	2005	_____	11
	2006	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2006	\$ _____	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

Facility Name & ID Number Apostolic Christian Timber Ridge

0016220

Report Period Beginning:

07/01/2006 Ending:

06/30/2007

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 grounds (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 Use	2 Square Feet	3 Year Acquired	4 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	TOTALS	1,345,699		\$ 54,397	3

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220

Report Period Beginning:

07/01/2006 Ending: 06/30/2007**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	\$	\$ 574,939	4
5	54		1978	1,006,746	25,169	40	25,169		751,267	5
6										6
7										7
8										8
	Improvement Type**									
9	3--Original Storage Building		1974	8,047	201		201		6,815	9
10	4--Second Floor Storage		1975	281	7		7		228	10
11	5--Balcony Storage		1976	289	7		7		228	11
12	6--Tub & Water Heater		1976	448	11		11		353	12
13	19--New Addition Phase 2		1979	47,854	1,196		1,196		34,453	13
14	7--Additional Storage Building Phase 1		1981	4,660	117		117		3,088	14
15	21--Activity Room/ TVs		1981	1,265	32		32		849	15
16	8--Additional Storage Building Phase 2		1982	21,495	537		537		13,704	16
17	22--Front Entrance		1982	8,046	201		201		5,198	17
18	9--Electrical Upgrade		1983	126	3		3		77	18
19	23--Security System & Energy Saver		1983	9,724	243		243		6,043	19
20	24--Courtyard Foyer		1984	6,477	162		162		3,866	20
21	10--Garage Extension		1985	842	21		21		483	21
22	25--Nursing Foyer		1985	24,285	607		607		13,898	22
23	26--Upkeep (Windows,Furnace,Fixtures)		1986	9,877	247		247		5,409	23
24	27--North End & East Wing		1987	26,990	675		675		14,117	24
25	1--3 stall garage		1988	22,885	572		572		11,156	25
26	28--1988 Additions		1988	27,441	686		686		13,677	26
27	29--1989 Additions		1989	48,259	1,206		1,206		22,866	27
28	30--1990 Additions		1990	60,923	1,523		1,523		27,365	28
29	31--1991 Additions		1991	11,832	296		296		5,023	29
30	32--1992 Additions		1992	14,999	375		375		5,999	30
31	33--1994 Additions		1994	31,810	795		795		11,156	31
32	34--1995 Additions		1995	32,834	821		821		10,707	32
33	35--1996 Additions		1996	6,371	159		159		1,921	33
34	36--1997 Additions		1997	23,216	580		580		6,427	34
35	2--Garage Door for Van		1998	667	44		44		407	35
36	37--1998 Additions		1998	6,263	157		157		1,579	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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:

07/01/2006 Ending: 06/30/2007**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	<u>38--1999 Additions</u>	1999	\$ 17,738	\$ 443	40	\$ 443	\$	\$ 4,038	37
38	<u>39--Air Conditioner</u>	2000	1,882	47	40	47		353	38
39	<u>40--Heat Pump</u>	2000	3,100	78	40	78		582	39
40	<u>41--Automatic Rear Door</u>	2000	1,773	44	40	44		332	40
41	<u>42--Power Panels/Generator</u>	2000	14,000	350	40	350		2,625	41
42	<u>43--Office Window to Lobby</u>	2000	1,057	26	40	26		198	42
43	<u>44--Exhaust Fan in Womens N Bathroom</u>	2000	580	14	40	14		108	43
44	<u>45--Dining Room Remodeling</u>	2000	10,565	264	40	264		1,981	44
45	<u>46--Fire Alarm Relay</u>	2000	2,400	60	40	60		450	45
46	<u>47--Remodel Bathrooms</u>	2000	22,147	554	40	554		4,153	46
47	<u>48--Water Coolers at both ends</u>	2000	2,701	68	40	68		507	47
48	<u>49--Roof Repairs</u>	2000	1,133	28	40	28		212	48
49	<u>471--Garage Lights</u>	2001	1,400	93	15	93		607	49
50	<u>472--OT/PT Decorating</u>	2001	1,111	74	15	74		482	50
51	<u>473--Slab Jacking</u>	2001	1,312	87	15	87		569	51
52	<u>474--Roof Replacement</u>	2001	21,380	1,425	15	1,425		9,265	52
53	<u>475--Roof Replacement</u>	2001	16,779	1,119	15	1,119		7,271	53
54	<u>476--Lobby Carpet and Redecorating</u>	2001	11,774	785	15	785		5,102	54
55	<u>477--Dining Room Remodeling</u>	2001	3,308	221	15	221		1,433	55
56	<u>478--Additional OMRP office (by activities)</u>	2001	2,393	160	15	160		1,037	56
57	<u>479--Pipe Insulation</u>	2001	2,613	174	15	174		1,132	57
58	<u>480--North Resident Renovation</u>	2001	4,632	309	15	309		2,007	58
59	<u>481--Activity Room Remodeling</u>	2001	1,903	127	15	127		825	59
60	<u>482--Sourth Whirlpool Room</u>	2001	2,676	178	15	178		1,160	60
61	<u>483--Hand Rails</u>	2001	2,844	190	15	190		1,232	61
62	<u>484--South Living Remodeling</u>	2001	5,107	341	15	341		2,213	62
63	<u>537--Garage Door</u>	2002	594	40	15	40		218	63
64	<u>538--Key pad entry for south end</u>	2002	2,500	167	15	167		917	64
65	<u>540--Water heater plumbing</u>	2002	706	47	15	47		259	65
66	<u>541--Water heaters</u>	2002	8,482	565	15	565		3,110	66
67	<u>542--Lighting - small office in lobby</u>	2002	545	36	15	36		200	67
68	<u>545--Air conditioner - south living room</u>	2002	3,196	213	15	213		1,172	68
69	<u>575--Roof on large garage</u>	2003	8,941	596	15	596		2,682	69
70	TOTAL (lines 4 thru 69)		\$ 2,298,312	\$ 61,825		\$ 61,825	\$ 0	\$ 1,611,730	70

**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:

07/01/2006 Ending: 06/30/2007**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,298,312	\$ 61,825		\$ 61,825	\$	\$ 1,611,730	1
2	576--Garage door on small garage	2003	647	43	15	43		194	2
3	613--Plumb and insulate water lines	2004	7,274	485	15	485		1,697	3
4	614--Flooring for Corridors	2004	23,007	1,534	15	1,534		5,368	4
5	616--Air Conditioner	2004	1,259	84	15	84		294	5
6	617--Courtyard Carpet	2004	981	65	15	65		229	6
7	618--Heat Pump & Blower	2004	4,885	326	15	326		1,140	7
8	619--Electrical for Fuel tanks	2004	1,686	112	15	112		393	8
9	620--Heat pump	2004	3,980	265	15	265		929	9
10	621--Foot valve for Hopper	2004	637	42	15	42		149	10
11	622--Bathroom partitions	2004	3,176	212	15	212		741	11
12	623--Air conditioner south wing	2004	1,181	79	15	79		276	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	0	20	0		22,000	24
25	288--Irrigation System & Landscaping	1990	2,585	129	20	129		2,324	25
26	289--South Patio Sod & Lighting	1990	1,408	70	20	70		1,256	26
27	290--Pole Light	1993	975	49	20	49		777	27
28	291--Asphalt Parking Lot & Driveway	1993	5,530	276	20	276		4,421	28
29	292--Landscape Courtyard	1993	3,954	198	20	198		2,983	29
30	293--Sewer Repair	1994	6,700	335	20	335		4,690	30
31	294--Tile Drain	1995	721	36	20	36		468	31
32	295--Asphalt Patching	1995	1,290	65	20	65		816	32
33	296--Excavate & Asphalt Drive	1997	15,136	757	20	757		8,325	33
34	TOTAL (lines 1 thru 33)		\$ 2,531,309	\$ 66,987		\$ 66,987	\$ 0	\$ 1,795,186	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:

07/01/2006 Ending: 06/30/2007**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,531,309	\$ 66,987		\$ 66,987	\$	\$ 1,795,186	1
2	297--Asphalt South Drive	1997	39,261	1,963	20	1,963		19,630	2
3	298--Install Parking Lot Light Poles	1998	4,000	200	20	200		1,700	3
4	299--Repair Asphalt	1998	3,500	175	20	175		1,488	4
5	511--Blacktop Ramp at Rear Entrance	2000	770	77	10	77		501	5
6	512--Landscape Drive Entrance	2000	1,447	96	15	96		627	6
7	513--Landscape around Timber Ridge	2000	1,230	82	15	82		533	7
8	564--Sidewalk/entry apron	2001	11,816	788	15	788		4,333	8
9	647--Catch Basin & Tile @ South Drive	2003	3,344	223	15	223		780	9
10	648--Garage Door Opener	2004	720	48	15	48		120	10
11	649--Canopy Lighting	2004	788	53	15	53		131	11
12	650--MPR Remodel	2004	14,256	950	15	950		2,376	12
13	651--North Living Room Floor	2004	4,649	310	15	310		775	13
14	652--North Snack Room Remodeling	2004	1,452	97	15	97		242	14
15	653--Office Remodeling	2004	1,447	96	15	96		241	15
16	654--South Snack Room Refrigerator	2004	469	67	7	67		168	16
17	655--South Snack Room Remodeling	2004	9,127	608	15	608		1,521	17
18	656--Speech Room Floor	2004	641	43	15	43		107	18
19	680--Driveway Repavement	2004	50,323	3,355	15	3,355		8,387	19
20	681--Concrete to Picnic Area	2004	9,858	657	15	657		1,643	20
21	682--Concrete Pad for Dumpster	2004	806	54	15	54		134	21
22	692--Concrete leveling	2005	2,830	189	15	189		283	22
23	693--Sprinkler heads - bathroom closet	2005	1,082	72	15	72		108	23
24	695--Cabinets and Countertops	2005	680	45	15	45		68	24
25	706--Phone system	2005	1,756	117	15	117		176	25
26	707--Electronic Door repairs	2005	3,245	216	15	216		325	26
27	714--Bathroom remodeling 400 wing	2005	10,579	705	15	705		1,058	27
28	716--Bathroom remodel - 500 wing	2005	13,305	887	15	887		1,331	28
29	721--Laundry room remodel	2005	5,261	351	15	351		526	29
30	724--Door locks-South End	2005	687	46	15	46		69	30
31	735--North sick room	2005	3,557	237	15	237		356	31
32	740--Kitchen piping	2005	875	58	15	58		88	32
33	755--OT/PT office	2005	287	19	15	19		29	33
34	TOTAL (lines 1 thru 33)		\$ 2,735,357	\$ 79,871		\$ 79,871	\$ 0	\$ 1,845,040	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,735,357	\$ 79,871		\$ 79,871	\$	\$ 1,845,040	1
2	757--M. room sound system	2005	2,611	174	15	174		261	2
3	697--Iron Fence for Rear Courtyard	2005	22,888	1,526	15	1,526		2,289	3
4	759--New driveway at Bus Garage	2005	5,130	342	15	342		513	4
5	762--North Courtyard Landscaping	2005	910	61	15	61		91	5
6	801--Garage Doors - 4	2006	5,000	167	15	167		167	6
7	804--Bus Garage Renovations	2006	6,500	217	15	217		217	7
8	791--North Snack Room Remodeling	2006	5,476	183	15	183		183	8
9	796--Office Moves	2006	2,556	85	15	85		85	9
10	809--PT Outlet	2006	658	22	15	22		22	10
11	811--Floor and Cabinets	2006	22,292	743	15	743		743	11
12	814--North Treatment Room - Plumbing	2006	1,825	61	15	61		61	12
13	821--Office Move	2006	11,808	394	15	394		394	13
14	826--Damper - Heat and Air Conditioning	2006	61	2	15	2		2	14
15	831--Donated - New Concrete Sidewalk	2006	1,385	46	15	46		46	15
16	832--Landscaping - Donations	2006	600	20	15	20		20	16
17	833--2 Donated Wheelchairs and Dynavox	2006	1,000	33	15	33		33	17
18	836--Contributions - Landscaping - Time and Labor	2006	2,010	67	15	67		67	18
19	837--Contributions - Labor for N. Treatment Room	2006	39	1	15	1		1	19
20	786--Courtyard Landscaping	2006	9,283	309	15	309		309	20
21	790--Front Courtyard - Sidewalk	2006	1,950	65	15	65		65	21
22	824--Light Poles	2006	954	32	15	32		32	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,840,293	\$ 84,421		\$ 84,421	\$ 0	\$ 1,850,641	34

**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	\$ 547,698	\$ 68,654	\$ 68,654	\$ 0	9	\$ 260,025	71
72	Current Year Purchases	141,641	5,809	5,809	0	7	5,809	72
73	Fully Depreciated Assets	614,364	855	855	0	9	614,364	73
74	Disposed Assets		0	0	0			74
75	TOTALS	\$ 1,303,703	\$ 75,318	\$ 75,318	\$ 0		\$ 880,198	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 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)	\$ 4,198,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,739	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,739	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)	\$ 2,730,839	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	\$ 144,412	\$ 0	\$ 144,412	86
87	Capitalized repairs	17,721	2,522	7,232	87
88	Vehicle Equipment	18,044	2,610	11,797	88
89	Vehicles	157,122	20,926	46,440	89
90	Disposed Assets	37,561	0	37,561	90
91	TOTALS	\$ 374,860	\$ 26,058	\$ 247,442	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

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: \$ 1,465 Description: Food pump & Oxygen concentrators

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		1,284	1,593	2,877	
3	Classroom Wages (a)		4,760	11,968	16,728	
4	Clinical Wages (b)		2,380	23,936	26,316	
5	In-House Trainer Wages (c)		1,813	18,233	20,046	
6	Transportation				0	
7	Contractual Payments				0	
8	CNA Competency Tests				0	
9	TOTALS	\$	10,237	\$ 55,730	\$ 0	\$ 65,967
10	SUM OF line 9, col. 1 and 2 (e)	\$	65,967			

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	31
2. From other facilities (f)	13
DROP-OUTS	
1. From this facility	25
2. From other facilities (f)	3
TOTAL TRAINED	72

- (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.

- (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.

Facility Name & ID Number **Apostolic Christian Timber Ridge**

0016220

Report Period Beginning: **07/01/2006**

Ending:

06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2007**

(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	\$ 576,649	\$ 579,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (4,000))	828,369	1,190,699	3
4	Supply Inventory (priced at)	18,792	25,600	4
5	Short-Term Investments	3,610,474	3,610,474	5
6	Prepaid Insurance	8,186	14,526	6
7	Other Prepaid Expenses	1,144	3,314	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employees & other related parties	339,694	342,306	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,383,308	\$ 5,766,566	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,397	262,033	13
14	Buildings, at Historical Cost	2,486,878	3,763,342	14
15	Leasehold Improvements, at Historical Cost	353,413	531,852	15
16	Equipment, at Historical Cost	1,581,817	2,238,025	16
17	Accumulated Depreciation (book methods)	(2,885,887)	(3,967,784)	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	4,803,856	4,803,856	21
22	Other Long-Term Assets (specify: Cash Value of Life Insurance)	36,270	36,270	22
23	Other(specify): Investment in other facilities	3,514,901	3,514,901	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,945,645	\$ 11,182,495	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,328,953	\$ 16,949,061	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 121,357	\$ 140,586	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,917	456,678	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,602	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	146,720	190,000	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 601,994	\$ 788,866	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	Capital Lease	23,547	23,547	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 23,547	\$ 23,547	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 625,541	\$ 812,413	46
47	TOTAL EQUITY(page 18, line 24)	\$ 14,703,412	\$ 16,136,648	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,328,953	\$ 16,949,061	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,827,095	1
2	Restatements (describe):		2
3	Cost to Market Adjustment for Prior Year per Auditors	(10,138)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,816,957	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	886,455	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)	\$ 886,455	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 14,703,412	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,838,868	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,838,868	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	76,658	10
11	CNA Training Reimbursements	95,234	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,117	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,160	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 184,169	23
	D. Non-Operating Revenue		
24	Contributions	1,332,638	24
25	Interest and Other Investment Income***	751,295	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,083,933	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	446,883	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 446,883	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,553,853	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	966,372	31
32	Health Care	3,769,077	32
33	General Administration	1,396,447	33
	B. Capital Expense		
34	Ownership	244,733	34
	C. Ancillary Expense		
35	Special Cost Centers	2,109	35
36	Provider Participation Fee	288,660	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,667,398	40
41	Income before Income Taxes (line 30 minus line 40)**	886,455	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 886,455	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:

07/01/2006

Ending:

06/30/2007

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	1,904	2,080	\$ 68,101	\$ 32.74	1
2	Assistant Director of Nursing	5,174	5,460	143,242	26.23	2
3	Registered Nurses	17,308	18,880	444,859	23.56	3
4	Licensed Practical Nurses	16,556	18,300	358,909	19.61	4
5	CNAs & Orderlies	0	0	0		5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,949	3,354	59,717	17.80	9
10	Activity Assistants	19,644	20,986	213,641	10.18	10
11	Social Service Workers	2,094	2,304	36,522	15.85	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	2,784	3,184	48,423	15.21	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,748	22,241	228,035	10.25	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	4,639	5,600	90,710	16.20	17
18	Housekeepers	7,053	7,635	67,920	8.90	18
19	Laundry	11,490	13,292	145,215	10.92	19
20	Administrator	1,339	1,659	75,433	45.47	20
21	Assistant Administrator	1,135	1,327	48,273	36.38	21
22	Other Administrative	0	0	0		22
23	Office Manager	1,066	1,322	20,672	15.64	23
24	Clerical	3,490	4,137	53,987	13.05	24
25	Vocational Instruction	2,120	2,420	38,459	15.89	25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	9,212	10,149	171,046	16.85	28
29	Resident Services Coordinator	1,880	2,080	52,139	25.07	29
30	Habilitation Aides (DD Homes)	101,343	109,699	1,164,949	10.62	30
31	Medical Records	2,163	2,259	28,896	12.79	31
32	Other Health C: OT/PT & Speech T	12,019	13,627	202,059	14.83	32
33	Other(specify) <u>Day Program</u>	6,595	7,220	99,624	13.80	33
34	TOTAL (lines 1 - 33)	254,705	279,215	\$ 3,860,831 *	\$ 13.83	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	154	\$ 6,837	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	555	10-3	39
40	Physical Therapy Consultant	41	2,277	10-3	40
41	Occupational Therapy Consultant	52	2,964	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	116	8,125	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	42	3,389	12-3	46
47	<u>Psychiatrist</u>	46	3,475	12-3	47
48					48
49	TOTAL (lines 35 - 48)	451	\$ 28,954		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	910	\$ 30,620	10-3	50
51	Licensed Practical Nurses	2,059	56,347	10-3	51
52	Certified Nurse Assistants/Aides	14,799	297,201	10a-3	52
53	TOTAL (lines 50 - 52)	17,768	\$ 384,168		53

Facility Name & ID Number Apostolic Christian Timber Ridge# 0016220Report Period Beginning: 07/01/2006Ending: 06/30/2007**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 Healthcare Association - \$5,139
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,977 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 288,660
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 benefits on Schedule V. \$ 14,598 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. \$ 16,616
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. \$ 76,658
- (17) Has an audit been performed by an independent certified public accounting firm? _____
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees