



Facility Name & ID Number Apostolic Christian Resthaven

# 0029892 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 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	<u>50</u>	Skilled (SNF)	<u>50</u>	<u>18,250</u>	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	<u>50</u>	TOTALS	<u>50</u>	<u>18,250</u>	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	<u>4,038</u>	<u>4,434</u>		<u>8,472</u>	8
9	SNF/PED					9
10	ICF	<u>2,626</u>	<u>6,782</u>		<u>9,408</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,664</u>	<u>11,216</u>		<u>17,880</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.97%

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, haircare, 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

ACCRAUAL  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: 01/01/2007 Ending: 12/31/2007

**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
	<b>A. General Services</b>										
1	Dietary	241,688	13,768	992	256,448		256,448	(13,058)	243,390		1
2	Food Purchase		112,022		112,022		112,022	(6,468)	105,554		2
3	Housekeeping	54,525	10,170		64,695		64,695		64,695		3
4	Laundry	36,739	7,241	236	44,216		44,216		44,216		4
5	Heat and Other Utilities			64,015	64,015		64,015		64,015		5
6	Maintenance	44,477	8,869	24,365	77,711		77,711		77,711		6
7	Other (specify):* <b>waste removal</b>			4,857	4,857		4,857		4,857		7
8	<b>TOTAL General Services</b>	<b>377,429</b>	<b>152,070</b>	<b>94,465</b>	<b>623,964</b>		<b>623,964</b>	<b>(19,526)</b>	<b>604,438</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,289,743	43,347	807	1,333,897		1,333,897		1,333,897		10
10a	Therapy		2	855	857		857		857		10a
11	Activities	53,856	6,571	772	61,199		61,199	(71)	61,128		11
12	Social Services	24,893	83	2,049	27,025		27,025		27,025		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,368,492</b>	<b>50,003</b>	<b>6,483</b>	<b>1,424,978</b>		<b>1,424,978</b>	<b>(71)</b>	<b>1,424,907</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	93,924			93,924		93,924		93,924		17
18	Directors Fees										18
19	Professional Services			20,998	20,998		20,998	(3,044)	17,954		19
20	Dues, Fees, Subscriptions & Promotions			6,613	6,613		6,613	(275)	6,338		20
21	Clerical & General Office Expenses	71,713	7,604	4,253	83,570		83,570	(183)	83,387		21
22	Employee Benefits & Payroll Taxes			419,405	419,405		419,405		419,405		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,320	12,320		12,320	(3,071)	9,249		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,968	29,968		29,968		29,968		26
27	Other (specify):* <b>misc. exp. / vol. exp.</b>			2,931	2,931		2,931	(1,599)	1,332		27
28	<b>TOTAL General Administration</b>	<b>165,637</b>	<b>7,604</b>	<b>496,488</b>	<b>669,729</b>		<b>669,729</b>	<b>(8,172)</b>	<b>661,557</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,911,558</b>	<b>209,677</b>	<b>597,436</b>	<b>2,718,671</b>		<b>2,718,671</b>	<b>(27,769)</b>	<b>2,690,902</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Apostolic Christian Resthaven #0029892 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			126,121	126,121	126,121	(30,121)	96,000			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			126,121	126,121	126,121	(30,121)	96,000			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		24,639	79,155	103,794	103,794		103,794			39
40	Barber and Beauty Shops	8,573	225	11,916	20,714	20,714		20,714			40
41	Coffee and Gift Shops		1,674		1,674	1,674	(1,674)				41
42	Provider Participation Fee			27,375	27,375	27,375		27,375			42
43	Other (specify):* <b>apartment &amp; mpr</b>		276	84,957	85,233	85,233	(85,233)				43
44	<b>TOTAL Special Cost Centers</b>	8,573	26,814	203,403	238,790	238,790	(86,907)	151,883			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,920,131	236,491	926,960	3,083,582	3,083,582	(144,797)	2,938,785			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: 01/01/2007

Ending: 12/31/2007

**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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,468)	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	(71)	11		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(29,628)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(275)	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	(3,044)	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	(104,818)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (144,797)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (144,797)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

## Apostolic Christian Resthaven

ID# 0029892

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Out-of-state travel	\$ (2,890)	24	1
2	Apartment expense	(84,933)	43	2
3	Vending expense	(1,674)	41	3
4	Non-care vehicle expense	(181)	24	4
5	Non-patient meals (wage-related costs)	(13,058)	1	5
6	Multi-purpose room expense	(276)	43	6
7	Volunteer expenses and dinner	(1,599)	27	7
8	Miscellaneous non-operating expense	(24)	43	8
9	Newsletters	(183)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(104,818)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(13,058)	0	0	0	0	0	0	0	0	0	0	(13,058)	1
2	Food Purchase	(6,468)	0	0	0	0	0	0	0	0	0	0	(6,468)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(19,526)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(19,526)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	<b>TOTAL Health Care and Programs</b>	<b>(71)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(71)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,044)	0	0	0	0	0	0	0	0	0	0	(3,044)	19
20	Fees, Subscriptions & Promotions	(275)	0	0	0	0	0	0	0	0	0	0	(275)	20
21	Clerical & General Office Expenses	(183)	0	0	0	0	0	0	0	0	0	0	(183)	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	(3,071)	0	0	0	0	0	0	0	0	0	0	(3,071)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,599)	0	0	0	0	0	0	0	0	0	0	(1,599)	27
28	<b>TOTAL General Administration</b>	<b>(8,172)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,172)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(27,769)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,769)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2007 Ending:

Summary B

12/31/2007

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	(30,121)	0	0	0	0	0	0	0	0	0	0	(30,121)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(30,121)</b>	<b>0</b>	<b>(30,121)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,674)	0	0	0	0	0	0	0	0	0	0	(1,674)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(85,233)	0	0	0	0	0	0	0	0	0	0	(85,233)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(86,907)</b>	<b>0</b>	<b>(86,907)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(144,797)</b>	<b>0</b>	<b>(144,797)</b>	<b>45</b>									

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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: 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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

\* 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: 01/01/2007 Ending: 12/31/2007

## 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									\$		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: 01/01/2007

Ending: 2/31/2007

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Resthaven COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0029892

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Resthaven

# 0029892 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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:

01/01/2007 Ending: 12/31/2007

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1985	1985	\$ 2,025,975	\$ 50,649	40	\$ 50,649		\$ 1,130,814	4
5			1986	1986	10,064	252	40	252		5,414	5
6			1987	1987	67,246	1,681	40	1,681		34,461	6
7	1		1988	1988	91,817	2,295	40	2,295		44,758	7
8			1999	1999	74,929	1,873	40	1,380	(493)	12,807	8
		<b>Improvement Type**</b>									
9		Land improvements - general land improvements		1985	24,667		15			24,667	9
10		Land improvements - general land improvements		1986	4,800		15			4,800	10
11		Land improvements - general land improvements		1989	2,069		15			2,069	11
12		Land improvements - general land improvements		1990	590		15			590	12
13		Land improvements - parking lot seal coating		1992	3,525	117	15	117		3,525	13
14		Land improvements - court yard		1992	26,596	1,330	15	1,330		26,595	14
15		Land improvements - front court yard		1997	15,126	1,008	15	1,008		10,502	15
16		Land improvements - black topping		1997	16,291	1,086	15	1,086		11,222	16
17		Land improvements - parking lot		2001	5,200	347	15	347		2,167	17
18		Land improvements - parking lot seal coating		2001	2,095	140	15	140		873	18
19		Land improvements - sidewalk to parking lot		2005	5,315	354	15	354		856	19
20		Building improvements - general building improvements		1987	8,669	325	20	325		8,654	20
21		Building improvements - general building improvements		1988	28,461	1,423	20	1,423		27,748	21
22		Building improvements - general building improvements		1989	500	25	20	25		467	22
23		Building improvements - general building improvements		1990	6,091	305	20	305		5,317	23
24		Building improvements - general building improvements		1991	6,846	342	20	342		5,548	24
25		Building improvements - air conditioner		1992	13,749	688	20	688		10,652	25
26		Building improvements - light fixtures		1992	1,331	67	20	67		1,035	26
27		Building improvements - rpz plumbing valve		1994	885	44	20	44		591	27
28		Building improvements - curtains		1995	1,944		10			1,944	28
29		Building improvements - carpeting music room		1995	1,332		10			1,332	29
30		Building improvements - drapes		1995	2,989		10			2,989	30
31		Building improvements - carpet on walls		1995	6,262		10			6,262	31
32		Building improvements - wallpaper		1995	3,703		10			3,703	32
33		Building improvements - drapes		1995	884		10			884	33
34		Building improvements - carpeting office		1995	1,344		10			1,344	34
35		Building improvements - wallpaper and drapes		1996	540		10			540	35
36		Building improvements - drapes in lobby		1996	412		10			411	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

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<a href="#">Building improvements - carpeting lobby</a>	1996	\$ 5,853	\$	10	\$	\$	\$ 5,853	37
38	<a href="#">Building improvements - sound system lobby</a>	1996	809	40	20	40		470	38
39	<a href="#">Building improvements - drapes in lobby</a>	1996	182		10			181	39
40	<a href="#">Building improvements - code alert</a>	1997	1,164	49	10	49		1,162	40
41	<a href="#">Building improvements - patio door</a>	1998	2,100	105	20	105		1,024	41
42	<a href="#">Building improvements - automatic door</a>	1998	2,029	101	20	101		971	42
43	<a href="#">Building improvements - carpeting music room</a>	1998	2,671	267	10	267		2,515	43
44	<a href="#">Building improvements - kitchen air conditioner</a>	1999	4,500	225	20	225		1,988	44
45	<a href="#">Building improvements - kitchen air conditioner</a>	1999	3,882	194	20	194		1,699	45
46	<a href="#">Building improvements - cabinets</a>	1999	389	19	20	19		169	46
47	<a href="#">Building improvements - cabinets and parts</a>	1999	310	16	20	16		137	47
48	<a href="#">Building improvements - carpeting two offices</a>	1999	1,325	66	20	66		579	48
49	<a href="#">Building improvements - kitchen air conditioner wiring</a>	1999	985	49	20	49		426	49
50	<a href="#">Building improvements - dining room blinds</a>	1999	656	33	20	33		269	50
51	<a href="#">Building improvements - garbage disposal</a>	2000	1,975	99	20	99		749	51
52	<a href="#">Building improvements - faucets</a>	2001	104	5	20	5		34	52
53	<a href="#">Building improvements - faucets</a>	2001	2,268	113	20	113		755	53
54	<a href="#">Building improvements - grease trap</a>	2001	3,769	188	20	188		1,256	54
55	<a href="#">Building improvements - door shades</a>	2001	281	14	20	14		89	55
56	<a href="#">Building improvements - door shades</a>	2001	281	14	20	14		88	56
57	<a href="#">Building improvements - damper</a>	2001	710	36	20	36		219	57
58	<a href="#">Building improvements - door for pt room</a>	2001	600	30	20	30		183	58
59	<a href="#">Building improvements - drapes employee dining room</a>	2002	653	33	20	33		191	59
60	<a href="#">Building improvements - drapes resident rooms</a>	2002	1,307	65	20	65		376	60
61	<a href="#">Building improvements - electromagnetic front doors</a>	2003	1,717	86	20	86		422	61
62	<a href="#">Building improvements - air conditioning</a>	2003	3,100	155	20	155		685	62
63	<a href="#">Building improvements - fire dampers</a>	2003	2,160	108	20	108		450	63
64	<a href="#">Building improvements - steam table restoration</a>	2004	3,700	185	20	185		725	64
65	<a href="#">Building improvements - hot water coil replacement</a>	2004	3,408	170	20	170		653	65
66	<a href="#">Building improvements - activity room shelving</a>	2004	1,850	93	20	93		354	66
67	<a href="#">Building improvements - exit door alarms at service entrance</a>	2004	994	50	20	50		174	67
68	<a href="#">Building improvements - smoke detectors with office window</a>	2004	953	48	20	48		155	68
69	<a href="#">Building improvements - hot water heaters</a>	2005	8,650	433	20	433		1,261	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,527,582	\$ 67,440		\$ 66,947	\$ (493)	\$ 1,421,803	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,527,582	\$ 67,440		\$ 66,947	\$ (493)	\$ 1,421,803	1
2	Building improvements - wiring for doors	2005	15	1	20	1		2	2
3	Building improvements - fire doors	2005	3,215	161	20	161		375	3
4	Building improvements - 3 wings security door systems	2005	6,600	330	20	330		715	4
5	Building improvements - duct detectors	2005	1,167	58	20	58		121	5
6	Building improvements - smoke dampers	2005	4,607	230	20	230		480	6
7	Building improvements - smoke detectors	2005	5,159	258	20	258		516	7
8	Building improvements - RN station cabinets and counters	2006	12,126	808	15	808		1,280	8
9	Building improvements - a/c condenser for kitchen	2006	2,800	187	15	187		280	9
10	Building improvements - RN station carpeting	2006	3,700	740	5	740		925	10
11	Building improvements - replace windows	2005	23,921	598	40	598		1,595	11
12	Building improvements - replace windows	2005	5,045	126	40	126		326	12
13	Building improvements - replace windows	2006	24,955	624	40	624		832	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,620,892	\$ 71,561		\$ 71,068	\$ (493)	\$ 1,429,250	34

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	\$ 192,629	\$ 21,299	\$ 21,299	\$	5/10/12/15	\$ 106,366	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	272,326					272,326	73
74								74
75	TOTALS	\$ 464,955	\$ 21,299	\$ 21,299	\$		\$ 378,692	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	\$ 3,633	\$ 3,633	\$	10	\$ 6,055	76
77										77
78										78
79										79
80	TOTALS			\$ 36,327	\$ 3,633	\$ 3,633	\$		\$ 6,055	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)	\$ 3,122,174	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,493	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,000	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)	\$ 1,813,997	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 - 1986/1991/1999/2006	\$ 929,473	\$ 23,237	\$ 437,722	86
87	Land improvements - 86/90/91/97	94,036	2,646	74,680	87
88	Equipment - 1986-1999/2006	42,726	705	40,478	88
89	Building improvements -99-03/06/07	24,787	1,483	6,645	89
90	Van - 30% non-care related - 2006	15,569	1,557	2,595	90
91	TOTALS	\$ 1,106,591	\$ 29,628	\$ 562,120	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

**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 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><u>SEE ATTACHMENT ON PAGE 27</u></p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-2	visits				3,538		3,538	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		6,109	79,155	2,849	6,109	82,004	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					18,252		18,252	13
14	<b>TOTAL</b>			\$	6,109	\$ 79,155	\$ 24,639	6,109	\$ 103,794	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven# 0029892Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 47,930	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 60,000 )	277,774		3
4	Supply Inventory (priced at cost )	16,157		4
5	Short-Term Investments	431,954		5
6	Prepaid Insurance	21,074		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 794,889	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,000		12
13	Land			13
14	Buildings, at Historical Cost	3,669,188		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	559,577		16
17	Accumulated Depreciation (book methods)	(2,379,075)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	157,441		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>capital in risk retention grp</u>	57,725		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,066,856	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,861,745	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 210,059	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,639		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	2,328		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Accrued expenses</u>	10,387		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 378,413	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deposits - apartments</u>	77,700		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 77,700	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 456,113	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,405,632	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,861,745	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,396,050	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,396,050	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	9,582	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 9,582</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 2,405,632</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven# 002982Report Period Beginning: 01/01/2007Ending: 12/31/2007**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,030,083	1
2	Discounts and Allowances for all Levels	(373,206)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,656,877</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,075	6
7	Oxygen	392	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,467</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	3,322	13
14	Non-Patient Meals	3,647	14
15	Telephone, Television and Radio	62	15
16	Rental of Facility Space		16
17	Sale of Drugs	80,693	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 87,724</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	100,616	24
25	Interest and Other Investment Income***	47,849	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 148,465</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other revenues - see schedule</b>	<b>196,631</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 196,631</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,093,164</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	623,964	31
32	Health Care	1,424,978	32
33	General Administration	669,729	33
<b>B. Capital Expense</b>			
34	Ownership	126,121	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	211,415	35
36	Provider Participation Fee	27,375	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,083,582</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>9,582</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 9,582</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

**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	1,684	1,872	\$ 56,646	\$ 30.26	1
2	Assistant Director of Nursing	1,882	2,082	52,549	25.24	2
3	Registered Nurses	16,671	17,742	382,420	21.55	3
4	Licensed Practical Nurses	5,844	6,438	131,513	20.43	4
5	CNAs & Orderlies	49,134	52,615	621,167	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,919	2,088	30,993	14.84	8
9	Activity Director	1,842	2,002	25,187	12.58	9
10	Activity Assistants	2,425	2,597	28,669	11.04	10
11	Social Service Workers	1,594	1,759	24,893	14.15	11
12	Dietician	1,878	2,182	46,877	21.48	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,543	18,171	181,753	10.00	15
16	Dishwashers					16
17	Maintenance Workers	1,951	2,180	44,477	20.40	17
18	Housekeepers	6,023	6,581	54,525	8.29	18
19	Laundry	2,865	3,247	36,739	11.31	19
20	Administrator	1,847	2,088	93,924	44.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,007	4,481	71,713	16.00	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	1,227	1,358	14,455	10.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>barber / beauty</u>	434	581	8,573	14.76	33
34	TOTAL (lines 1 - 33)	119,770	130,064	\$ 1,907,073 *	\$ 14.66	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	23	\$ 992	1-3	35
36	Medical Director	6	2,000	9-3	36
37	Medical Records Consultant	13	807	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	13	855	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	772	11-3	44
45	Social Service Consultant	24	2,049	12-3	45
46	Other(specify) <u>Beautician</u>	794	11,916	40-3	46
47	<u>Laundry</u>	31	236	4-3	47
48					48
49	TOTAL (lines 35 - 48)	920	\$ 19,627		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



Facility Name & ID Number Apostolic Christian Resthaven

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Life Services Network 2,169; AAHSA 828
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,692 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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? no Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? no  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$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>		
80501	Apartment Income	\$ 192,571
8023	Vending Income	1,510
6902	Activity Income	1,163
8020	Cookbook Sales	884
8026/6911	Miscellaneous Non-Operating Income	<u>503</u>
		<u>\$ 196,631</u>

NOTES:

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

Page 20, Schedule XVIII, Line 34 Reconciliation

Total Wages Reported on Page 20, Line 34	\$ 1,907,073
Dietary Wages Allocated to Non-Patient Meals as per Adjustment on Page 5A	<u>13,058</u>
Total Salary / Wages Reported on Page 4, Column 1	<u>\$ 1,920,131</u>

Page 3, Schedule V, Line 7, Other

Expenses related to removal of general waste	<u>\$ 4,857</u>
--	-----------------

Page 3, Schedule V, Line 27, Other Expense

	Other Expenses
Volunteer Expense	\$ 1,599
Retire Old Copier	1,331
Restocking Fee	<u>1</u>
Column 4 Total	\$ 2,931
Reclassifications	
Volunteer Expense on Page 5A Non-Allowable Expenses	<u>(1,599)</u>
Column 8 Adjusted Total	<u>\$ 1,332</u>

Page 4, Schedule V, Line 43, Other Expense

	Other Expenses
Apartment Expense	\$ 84,933
Other Non-Operating	24
MPR Expense	<u>276</u>
Column 4 Total	85,233
Page 5A - Non-Allowable Expenses	
Apartment Expense	(84,933)
Other Non-Operating	(24)
MPR Expense	<u>(276)</u>
Column 8 Adjusted Total	<u>\$ -</u>

Page 21, Schedule XIX, Section D, Employee Relations

1	Gifts for Sympathy / Get Well	\$	475
2	Christmas Dinner		1,333
3	Christmas Gifts		4,612
4	Staff Appreciation Dinner		708
5	Anniversary Gifts for Years of Service		880
6	Employee Assistance Program		2,025
7	Other		4,038
8	Staff Appreciation Awards		200
9	Donated Items		<u>280</u>
		\$	<u>14,551</u>

Page 21, Schedule XIX, Schedule D, Pension Expense

Pension Costs for Owners	\$	-
Pension Costs for Related Parties		-
Pension Costs for All Other Employees		<u>53,072</u>
	\$	<u>53,072</u>

Note - 53 employees were covered under the pension plan for year 2007.

**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 19 nurse assistants leave employment during 2007 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 October 20-25, 2007, David Stieglitz, Administrator, attended the American Association of Homes and Services for the Aging Annual Meeting held in Orlando, Florida. This convention included topics related to employee recruitment and retention, regulatory compliance, the future of long term care, and board management.

On October 2 & 3, 2007, Nina Dubman, RD, attended a food show sponsored by Gordon Food Service in Grand Rapids, Michigan. The food show was an opportunity to learn about new food products being made available for long-term care.

Nina Dubman also attended the Amerinet Member West Conference in San Diego, California, from May 14-17, 2007. This conference included topics related to nutritional services in long-term care.

**2007 Board of Directors and Officers**

Glen Pfeifer, President	37W951 McKee Road, Batavia, IL 60510
David Martin, Vice President	24107 W. Grant Highway, Marengo, IL 60152
David Jepson, Treasurer	229 Nelson Parkway, Cherry Valley, IL 61016
Roger Weiss, Secretary	804 Elm Street, Hampshire, IL 60140
Robert Schambach	251 Brookside Drive, Elgin, IL 60123
Jeff Kellenberger	11N528 Muirhead Road, Elgin, IL 60124
Robert Cox	709 Linden Avenue, Elgin, IL 60120