

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0023952

Facility Name: Apostolic Christian Restmor

Address: 935 East Jefferson Street Morton 61550
 Number City Zip Code

County: Tazewell

Telephone Number: 309-266-7141 **Fax #** 309-266-7877

HFS ID Number: _____

Date of Initial License for Current Owners: April 1978

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501-c-3</u>	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	_____
	<input type="checkbox"/> Limited Liability Co.	_____
	<input type="checkbox"/> Trust	_____
	<input type="checkbox"/> Other	_____

In the event there are further questions about this report, please contact:
Name: Michael Kaiser **Telephone Number:** 309-266-7141

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2007 to 12-31-2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>John Kelley</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Restmor# 0023952 Report Period Beginning: 1-1-2007 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 _____

	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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>26</u>	Sheltered Care (SC)	<u>26</u>	<u>9,490</u>	5
6		ICF/DD 16 or Less			6
7	<u>146</u>	TOTALS	<u>146</u>	<u>53,290</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>6,521</u>	<u>18,924</u>	<u>3,593</u>	<u>29,038</u>	8
9	SNF/PED					9
10	ICF	<u>1,291</u>	<u>8,166</u>		<u>9,457</u>	10
11	ICF/DD					11
12	SC		<u>5,106</u>		<u>5,106</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,812</u>	<u>32,196</u>	<u>3,593</u>	<u>43,601</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.82%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Meals on WheelsF. 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 4/1/1978

J. Was the facility purchased or leased after January 1, 1978?

YES Date 4/1/1978 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 26 and days of care provided 3,593Medicare Intermediary Wisconsin Physicians Insurance Co

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2007 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
	A. General Services										
1	Dietary	301,278	44,868	153,167	499,313		499,313		499,313		1
2	Food Purchase		280,142		280,142	(9,030)	271,112	(16,559)	254,553		2
3	Housekeeping	132,028	42,093		174,121		174,121		174,121		3
4	Laundry	90,317	9,883		100,200		100,200		100,200		4
5	Heat and Other Utilities			154,282	154,282		154,282		154,282		5
6	Maintenance	134,640	20,326	174,491	329,457		329,457	3,395	332,852		6
7	Other (specify):*			23,329	23,329		23,329		23,329		7
8	TOTAL General Services	658,263	397,312	505,269	1,560,844	(9,030)	1,551,814	(13,164)	1,538,650		8
	B. Health Care and Programs										
9	Medical Director			6,755	6,755		6,755		6,755		9
10	Nursing and Medical Records	2,959,734	226,493	5,339	3,191,566	(3,994)	3,187,572		3,187,572		10
10a	Therapy			271,429	271,429		271,429		271,429		10a
11	Activities	127,779			127,779		127,779	(478)	127,301		11
12	Social Services	172,620			172,620		172,620		172,620		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,260,133	226,493	283,523	3,770,149	(3,994)	3,766,155	(478)	3,765,677		16
	C. General Administration										
17	Administrative	192,032			192,032		192,032	(30,300)	161,732		17
18	Directors Fees										18
19	Professional Services			55,693	55,693		55,693	(20,348)	35,345		19
20	Dues, Fees, Subscriptions & Promotions			37,463	37,463	1,490	38,953	(22,623)	16,330		20
21	Clerical & General Office Expenses	215,670	23,386	55,213	294,269	(21,272)	272,997	(12,289)	260,708		21
22	Employee Benefits & Payroll Taxes			1,068,135	1,068,135	7,540	1,075,675	(23,318)	1,052,357		22
23	Inservice Training & Education										23
24	Travel and Seminar			33,557	33,557		33,557	(16,612)	16,945		24
25	Other Admin. Staff Transportation			10,849	10,849		10,849	(7,407)	3,442		25
26	Insurance-Prop.Liab.Malpractice			103,685	103,685		103,685		103,685		26
27	Other (specify):*										27
28	TOTAL General Administration	407,702	23,386	1,364,595	1,795,683	(12,242)	1,783,441	(132,897)	1,650,544		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,326,098	647,191	2,153,387	7,126,676	(25,266)	7,101,410	(146,539)	6,954,871		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 Restmor #0023952 Report Period Beginning: 1-1-2007 Ending: 12-31-2007

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			110,133	110,133		110,133	(3,030)	107,103		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					25,266	25,266		25,266		35
36	Other (specify):*										36
37	TOTAL Ownership			110,133	110,133	25,266	135,399	(3,030)	132,369		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		215,263	23,376	238,639		238,639		238,639		39
40	Barber and Beauty Shops	26,460		3,287	29,747		29,747		29,747		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			67,690	67,690		67,690	(1,990)	65,700		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	26,460	215,263	94,353	336,076		336,076	(1,990)	334,086		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,352,558	862,454	2,357,873	7,572,885		7,572,885	(151,559)	7,421,326		45

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

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning: 1-1-2007

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	(1,468)	2		4
5	Telephone, TV & Radio in Resident Rooms	(631)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,030)	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				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	(5,101)	20		17
18	Fines and Penalties	(1,175)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,473)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,522)	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		6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,400)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (45,400)		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.			\$		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)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Apostolic Christian Restmor

ID# 0023952

Report Period Beginning: 1-1-2007

Ending: 12-31-2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non Allowable Seminar	\$ (7,860)	24	1
2	Employee Meal Income	(9,030)	22	2
3	Misc Expense	(3,292)	21	3
4	Misc Income	(7,191)	21	4
5	Auto Expense	(7,407)	25	5
6	Billing Service	(2,450)	19	6
7	Meals on Wheels	(13,546)	2	7
8	Sunshine Cart Income	(478)	11	8
9	congregate Living Management Fee	(30,300)	17	9
10	Non Allowable Travel	(8,752)	24	10
11	Other Meal income	(1,545)	2	11
12	Pension Interest Inocme	(14,288)	22	12
13	IDPA filing fee	(500)	19	13
14	Jewel Technologies	(925)	19	14
15	Deferred Maintenance	3,395	6	15
16	Late Fee	(1,990)	42	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	(106,159)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor# 0023952

Report Period Beginning:

1-1-2007

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16,559)	0	0	0	0	0	0	0	0	0	0	(16,559)	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	3,395	0	0	0	0	0	0	0	0	0	0	3,395	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,164)	0	0	0	0	0	0	0	0	0	0	(13,164)	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	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	(478)	0	0	0	0	0	0	0	0	0	0	(478)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(478)	0	0	0	0	0	0	0	0	0	0	(478)	16
	C. General Administration													
17	Administrative	(30,300)	0	0	0	0	0	0	0	0	0	0	(30,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,348)	0	0	0	0	0	0	0	0	0	0	(20,348)	19
20	Fees, Subscriptions & Promotions	(22,623)	0	0	0	0	0	0	0	0	0	0	(22,623)	20
21	Clerical & General Office Expenses	(12,289)	0	0	0	0	0	0	0	0	0	0	(12,289)	21
22	Employee Benefits & Payroll Taxes	(23,318)	0	0	0	0	0	0	0	0	0	0	(23,318)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16,612)	0	0	0	0	0	0	0	0	0	0	(16,612)	24
25	Other Admin. Staff Transportation	(7,407)	0	0	0	0	0	0	0	0	0	0	(7,407)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(132,897)	0	0	0	0	0	0	0	0	0	0	(132,897)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(146,539)	0	0	0	0	0	0	0	0	0	0	(146,539)	29

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning:

1-1-2007 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	(3,030)	0	0	0	0	0	0	0	0	0	0	(3,030)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,030)	0	(3,030)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(1,990)	0	0	0	0	0	0	0	0	0	0	(1,990)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,990)	0	(1,990)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(151,559)	0	(151,559)	45									

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning:

1-1-2007

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
	0					
Steve Roeschley, Director	0					
John Zimmerman, Director	0					
Howard Getz, Director	0					
Jim Ritthaler, Director	0					
Marty Rollins, Director	0					
Joe Zimmerman, Director	0					

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 Restmor # 0023952 Report Period Beginning: 1-1-2007 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	NONE								\$	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.

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning: 1-1-2007

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										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	Morton community Bank		X	New Facility			\$	\$ 4,802,300		\$ None	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 4,802,300		\$	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$	\$ 4,802,300		\$	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.)

Facility Name & ID Number Apostolic Christian Restmor# 0023952 Report Period Beginning: 1-1-2007 Ending: 12-31-2007

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 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.			\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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 Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0023952

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>_____</u>	\$ <u>_____</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 Restmor# 0023952 Report Period Beginning:1-1-2007 Ending: 12-31-2007**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 56,000 B. General Construction Type: Exterior brick Frame Steel Number of Stories 1C. 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).

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

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>217,800</u>	<u>1978</u>	<u>\$ 125,000</u>	<u>1</u>
2	<u>cong Living</u>	<u>45 acres</u>	<u>1991-2005</u>	<u>675,396</u>	<u>2</u>
3	TOTALS	#VALUE!		\$ 800,396	3

Facility Name & ID Number Apostolic Christian Restmor# 0023952

Report Period Beginning:

1-1-2007

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			1961		\$ 315,426	\$ 5,626	25	\$	\$ (5,626)	\$ 315,426	4
5			1962		59,373		25			59,373	5
6			1965		324,445		25			324,445	6
7			1971		2,813		20			2,813	7
8			1976		112,250		20			112,250	8
		Improvement Type**									
9			1978		15,000		20			15,000	9
10			1979		7,888		20			7,888	10
11			1980		50,819		16			50,819	11
12			1981		90,107		16			90,107	12
13			1982		96,603		18			96,603	13
14			1983		39,124		16			39,124	14
15			1984		243,503		16			243,503	15
16			1986		660,199	17,578	20		(17,578)	660,199	16
17			1986		18,532		18			18,532	17
18			1987		122,666		20			122,666	18
19			1987		27,395		20			27,395	19
20			1988		85,020		15			85,020	20
21			1989		46,665		15			46,665	21
22			1990		7,131		8--20	81	81	6,925	22
23			1991		38,812		10--15			38,812	23
24			1992		55,156		5--10			55,156	24
25			1993		46,959		10			46,959	25
26			1994		3,462		10			3,462	26
27			1995		64,958		10--15	4,163	4,163	53,521	27
28		Locking System	1996		12,447		15	830	830	9,959	28
29		Roof Repairs	1996		2,500		5			2,500	29
30		Water Heater	1996		7,066		10			7,066	30
31		Sink	1996		3,148		15	210	210	2,519	31
32		Carpet	1996		1,824		10			1,824	32
33		Quick Channels	1996		585		10			585	33
34		Oxygen Control Manager	1996		5,301		12	442	442	5,229	34
35		Room Closets	1996		44,000		20	2,200	2,200	25,667	35
36											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

Facility Name & ID Number Apostolic Christian Restmor# 0023952

Report Period Beginning:

1-1-2007

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	Ventilator Remodeling	1996	\$ 34,281	\$	15	\$ 2,285	\$ 2,285	\$ 26,660	37
38	Carpeting	1996	20,762		10			20,762	38
39	Sewer Repair	1996	5,534		15	369	369	4,212	39
40	Roofing Repair	1996	2,950		5			2,950	40
41	Wallpaper Drapes	1996	5,409		15	361	361	4,120	41
42	Dining Room Door	1997	1,658		15	111	111	1,201	42
43	Electric Installed for A/C	1997	2,300		20	115	115	1,227	43
44	Floor Covering Therapy	1997	656		10	36	36	656	44
45	Fire Alarm System	1998	15,800		12	1,317	1,317	13,169	45
46	Conference Room carpet	1998	1,112		10	111	111	1,074	46
47	Shower Repairs	1998	1,524		15	102	102	976	47
48	A/C Compressor	1998	6,485		8			6,485	48
49	Pharmacy Building Improvements	1998	2,503		15	167	167	1,517	49
50	Broom Closet	1998	700		15	47	47	426	50
51	Ceiling Tile	1999	1,600		10	160	160	1,440	51
52	Pharmacy Building Improvements	1999	8,585		15	572	572	5,101	52
53	Door Alarm	1999	6,075		7			6,075	53
54	Bulletin Boards	1999	5,669		10	567	567	5,008	54
55	Wallcovering Room 117	1999	889		10	89	89	779	55
56	Nursing Office	1999	4,401		10	440	440	3,777	56
57	Computer Cables	1999	11,475		7			11,475	57
58	Blinds	1999	605		10	61	61	508	58
59	Break Room Carpet	1999	1,515		7			1,515	59
60	Marketing Office Electric	1999	2,768		15	185	185	1,603	60
61	Thin Trees	1999	1,765		5			1,765	61
62	Mulch	1999	1,300		3			1,300	62
63	Exchange Oil Tanks	1999	15,833		15	1,056	1,056	9,063	63
64	Roof Repair	2000	4,365		2			4,365	64
65	Dining Room Floor	2000	2,788		4			2,788	65
66	Vestibule Alarm	2000	4,618		4			4,618	66
67	Bathroom Floor Covering	2000	1,229		4			1,229	67
68	Air Duct for Telephone	2000	3,160		4			3,160	68
69	Med Room A/C	2000	5,483		5			5,483	69
70	TOTAL (lines 4 thru 69)		\$ 2,796,974	\$ 23,204		\$ 16,077	\$ (7,127)	\$ 2,734,499	70

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

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning:

1-1-2007

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	Totals from Page 12A, Carried Forward		\$ 2,796,974	\$ 23,204		\$ 16,077	\$ (7,127)	\$ 2,734,499	1
2	Dining Room Compressor	2000	4,348		5			4,348	2
3	Trees	2001	3,500		20	175	175	1,079	3
4	New Sidewalk	2001	2,920		10	292	292	1,801	4
5	Sealcoating	2003	4,130		2			4,130	5
6	Corridor Doors	2005	3,510		15	234	234	566	6
7	Roof Repair	2006	4,300		2	2,150	2,150	4,121	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,819,682	\$ 23,204		\$ 18,928	\$ (4,276)	\$ 2,750,544	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	\$ 1,725,080	\$ 64,999	\$ 64,999	\$	2--15	\$ 1,463,007	71
72	Current Year Purchases	266,848	20,603	20,603		4--15	20,603	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,991,928	\$ 85,602	\$ 85,602	\$		\$ 1,483,610	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	Patient Transportation	Bus, 1996 Dodge Van	1990, 1996	\$ 60,654	\$	\$	\$		\$ 60,654	76
77	Staff	Chevy Venture Van	1998	24,913					24,913	77
78	Patient Transportation	Chrysler Minivan	2006	3,980	1,327	1,327		3	2,101	78
79	Facility Operation	Machinery & Equipment		14,719		1,246	1,246		11,213	79
80	TOTALS			\$ 104,266	\$ 1,327	\$ 2,573	\$ 1,246		\$ 98,881	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)	\$ 5,716,272	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,133	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,030)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,333,035	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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	TOTAL		\$ _____	\$ _____	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>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)	
TOTAL TRAINED	

- (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	10a	hrs	\$ 0		\$ 17,625	\$		\$ 17,625	1
2	Licensed Speech and Language Development Therapist	10a	hrs	0		48,451			48,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			25,435			25,435	4
5	Physician Care	39	visits			400			400	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts			215,263			215,263	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab					22,976			22,976	13
14	TOTAL			\$		\$ 330,150	\$		\$ 330,150	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 Restmor # 0023952 Report Period Beginning: 1-1-2007 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 521,260	\$	1
2	Cash-Patient Deposits	7,790		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	748,377		3
4	Supply Inventory (priced at)	53,288		4
5	Short-Term Investments	1,872,549		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	63,672		7
8	Accounts Receivable (owners or related parties)	32,169		8
9	Other(specify): <u>security deposits</u>	74,902		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,374,007	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	857,443		13
14	Buildings, at Historical Cost	2,182,754		14
15	Leasehold Improvements, at Historical Cost	997,289		15
16	Equipment, at Historical Cost	2,096,195		16
17	Accumulated Depreciation (book methods)	(4,879,495)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	15,127,143		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,381,329	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,755,336	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 175,640	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,790		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,864		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,432		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Pension</u>	255,034		36
37	<u>Accrued PTO</u>	329,379		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 960,139	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,802,301		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,802,301	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,762,440	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,992,896	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,755,336	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,812,539	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,812,539	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,180,357	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)	\$ 2,180,357	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,992,896	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Restmor

0023952

Report Period Beginning: 1-1-2007

Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,561,487	1
2	Discounts and Allowances for all Levels	(842,898)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,718,589	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	607,856	6
7	Oxygen	43,140	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 650,996	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35,295	13
14	Non-Patient Meals	12,043	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	170,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	230,881	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 448,751	23
D. Non-Operating Revenue			
24	Contributions	1,763,270	24
25	Interest and Other Investment Income***	104,530	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,867,800	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		36,806	28
28a	<u>cong living management fee</u>	30,300	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 67,106	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,753,242	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,560,844	31
32	Health Care	3,770,149	32
33	General Administration	1,795,683	33
B. Capital Expense			
34	Ownership	110,133	34
C. Ancillary Expense			
35	Special Cost Centers	270,376	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,572,885	40
41	Income before Income Taxes (line 30 minus line 40)**	2,180,357	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,180,357	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Restmor

0023952

Report Period Beginning:

1-1-2007

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	1,928	2,080	\$ 68,793	\$ 33.07	1
2	Assistant Director of Nursing	4,542	5,072	137,103	27.03	2
3	Registered Nurses	29,787	32,056	763,360	23.81	3
4	Licensed Practical Nurses	14,768	16,040	324,976	20.26	4
5	CNAs & Orderlies	106,599	115,604	1,370,808	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,632	2,939	39,353	13.39	8
9	Activity Director	1,822	2,080	38,856	18.68	9
10	Activity Assistants	10,764	11,602	88,923	7.66	10
11	Social Service Workers	5,469	5,855	100,663	17.19	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,189	29,719	13.58	13
14	Head Cook	4,883	5,363	62,906	11.73	14
15	Cook Helpers/Assistants	15,941	16,576	208,653	12.59	15
16	Dishwashers					16
17	Maintenance Workers	6,070	6,636	134,640	20.29	17
18	Housekeepers	10,669	11,728	132,028	11.26	18
19	Laundry	8,811	9,660	90,317	9.35	19
20	Administrator	1,710	2,080	105,760	50.85	20
21	Assistant Administrator	1,928	2,080	86,272	41.48	21
22	Other Administrative	1,620	1,966	37,821	19.24	22
23	Office Manager					23
24	Clerical	8,458	9,215	160,390	17.41	24
25	Vocational Instruction	1,697	1,872	59,349	31.70	25
26	Academic Instruction	1,794	2,080	64,963	31.23	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,588	3,960	71,957	18.17	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,358	10,361	131,029	12.65	31
32	Other Health C: Vol Coord	1,142	1,195	17,459	14.61	32
33	Other(specify) Barber	1,475	1,642	26,460	16.11	33
34	TOTAL (lines 1 - 33)	259,470	281,931	\$ 4,352,558 *	\$ 15.44	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		6,755	9-3	36
37	Medical Records Consultant	34	2,313	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	34	\$ 9,068		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

Facility Name & ID Number Apostolic Christian Restmor

Report Period Beginning: 1-1-2007 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	Repair rooftop a/c unit	7/04	\$ 1,049	3	\$ 175	\$ 350	\$ 350	\$ 174	\$	\$	\$	\$	\$
2	Repair dishwasher	2/05	1,989	3		663	663	663					
3	Repair kitchen furnace	3/05	2,538	3		846	846	846					
4	Repair nurse station	4/06	2,253	3			751	751	751				
5	Repair A/C unit	1/06	1,710	3			570	570	570				
6	Plumbing Repairs	1/06	1,173	3			391	391	391				
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 10,712		\$ 175	\$ 1,859	\$ 3,571	\$ 3,395	\$ 1,712	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Restmor**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. LSN, 6593
- (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? N/A
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. \$ 65,379 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. \$ 65,700
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. \$ 9,030 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,575
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
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? _____
- d. Have vehicle usage logs been maintained? No
- 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? _____
- 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? Review
Firm Name: Clifton gunderson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet prepared
- (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.

Apostolic Christian Restmor #23952

Listing of items for Schedule XVII, line 28

Meals on wheels income	22161
social activities income	3853
private pay laundry	840
personal supplies income	1652
Telephone income	631
sunshine cart income	478
misc income	<u>7191</u>
Total	<u><u>36806</u></u>