



Facility Name & ID Number Apostolic Christian Resthaven

# 0029892 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,300	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	3,704	4,051		7,755	8
9	SNF/PED					9
10	ICF	3,372	6,457		9,829	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,076	10,508		17,584	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.09%

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

ACCURAL  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: 01/01/2008 Ending: 12/31/2008

**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	221,921	12,010	5,764	239,695	(3,152)	236,543	(11,060)	225,483		1
2	Food Purchase		99,972		99,972	(1,592)	98,380	(5,586)	92,794		2
3	Housekeeping	52,514	9,231		61,745		61,745		61,745		3
4	Laundry	33,640	5,248		38,888		38,888		38,888		4
5	Heat and Other Utilities			66,004	66,004		66,004		66,004		5
6	Maintenance	45,598	8,111	32,701	86,410		86,410		86,410		6
7	Other (specify):* <b>Waste Removal</b>			6,307	6,307		6,307		6,307		7
8	<b>TOTAL General Services</b>	<b>353,673</b>	<b>134,572</b>	<b>110,776</b>	<b>599,021</b>	<b>(4,744)</b>	<b>594,277</b>	<b>(16,646)</b>	<b>577,631</b>		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,316,700	50,060	918	1,367,678		1,367,678	(100)	1,367,578		10
10a	Therapy		70	696	766		766		766		10a
11	Activities	52,669	6,832	792	60,293		60,293	(87)	60,206		11
12	Social Services	24,534	102	2,752	27,388		27,388		27,388		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,393,903</b>	<b>57,064</b>	<b>8,158</b>	<b>1,459,125</b>		<b>1,459,125</b>	<b>(187)</b>	<b>1,458,938</b>		16
	<b>C. General Administration</b>										
17	Administrative	102,803			102,803		102,803		102,803		17
18	Directors Fees										18
19	Professional Services			29,244	29,244		29,244	(1,232)	28,012		19
20	Dues, Fees, Subscriptions & Promotions			8,788	8,788		8,788	(34)	8,754		20
21	Clerical & General Office Expenses	63,275	8,855	4,103	76,233		76,233	(183)	76,050		21
22	Employee Benefits & Payroll Taxes			467,441	467,441	4,744	472,185		472,185		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,852	13,852		13,852	(1,850)	12,002		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,633	33,633		33,633		33,633		26
27	Other (specify):* <b>Misc. Exp. / Vol. Exp.</b>			151	151	(2)	149	(148)	1		27
28	<b>TOTAL General Administration</b>	<b>166,078</b>	<b>8,855</b>	<b>557,212</b>	<b>732,145</b>	<b>4,742</b>	<b>736,887</b>	<b>(3,447)</b>	<b>733,440</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,913,654</b>	<b>200,491</b>	<b>676,146</b>	<b>2,790,291</b>	<b>(2)</b>	<b>2,790,289</b>	<b>(20,280)</b>	<b>2,770,009</b>		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## 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			122,444	122,444		122,444	(31,089)	91,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					2	2	(2)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			122,444	122,444	2	122,446	(31,091)	91,355			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,033	78,911	108,944		108,944		108,944			39
40	Barber and Beauty Shops			273	273		273		273			40
41	Coffee and Gift Shops		1,997		1,997		1,997	(1,997)				41
42	Provider Participation Fee			27,450	27,450		27,450		27,450			42
43	Other (specify):* <b>Apartment &amp; MPR</b>		175	80,103	80,278		80,278	(80,278)				43
44	<b>TOTAL Special Cost Centers</b>		32,205	186,737	218,942		218,942	(82,275)	136,667			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,913,654	232,696	985,327	3,131,677		3,131,677	(133,646)	2,998,031			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: 01/01/2008

Ending: 12/31/2008

**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	(5,586)	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	(87)	11		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(30,596)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(1,232)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(183)	21		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	(95,469)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (133,646)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (133,646)		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.

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Apostolic Christian Resthaven

ID# 0029892

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Out-Of-State Travel	\$ (1,637)	24	1
2	Apartment Expense	(80,103)	43	2
3	Vending Expense	(1,997)	41	3
4	Non-Care Vehicle Expense	(213)	24	4
5	Non-Patient Meals (Wage-Related Costs)	(11,060)	1	5
6	Multipurpose Room Expense	(175)	43	6
7	Volunteer Expense	(148)	27	7
8	Rent On Land Paid To Related Party	(2)	34	8
9	Dental Consultant	(100)	10	9
10	Bank Overdraft Fee	(34)	20	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>	(95,469)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

01/01/2008

Ending:

12/31/2008**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	(11,060)	0	0	0	0	0	0	0	0	0	0	(11,060)	1
2	Food Purchase	(5,586)	0	0	0	0	0	0	0	0	0	0	(5,586)	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>(16,646)</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>(16,646)</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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(87)	0	0	0	0	0	0	0	0	0	0	(87)	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>(187)</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>(187)</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	(1,232)	0	0	0	0	0	0	0	0	0	0	(1,232)	19
20	Fees, Subscriptions & Promotions	(34)	0	0	0	0	0	0	0	0	0	0	(34)	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	(1,850)	0	0	0	0	0	0	0	0	0	0	(1,850)	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):*	(148)	0	0	0	0	0	0	0	0	0	0	(148)	27
28	<b>TOTAL General Administration</b>	<b>(3,447)</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>(3,447)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(20,280)</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>(20,280)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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	(31,089)	0	0	0	0	0	0	0	0	0	0	(31,089)	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	(2)	0	0	0	0	0	0	0	0	0	0	(2)	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>(31,091)</b>	<b>0</b>	<b>(31,091)</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	(1,997)	0	0	0	0	0	0	0	0	0	0	(1,997)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(80,278)	0	0	0	0	0	0	0	0	0	0	(80,278)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(82,275)</b>	<b>0</b>	<b>(82,275)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(133,646)</b>	<b>0</b>	<b>(133,646)</b>	<b>45</b>									

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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	27 Land Lease	\$ 2	Apostolic Christian Church of Elgin	100.00%	\$ 2	\$	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		\$ 2			\$ 2	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven # 0029892 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

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.)

Facility Name & ID Number Apostolic Christian Resthaven# 0029892 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 (847) 741-4543 FAX #: (847) 760-6224

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending: 12/31/2008

**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:

01/01/2008 Ending: 12/31/2008

**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		\$ 1,181,464	4
5			1986	1986	10,064	252	40	252		5,665	5
6			1987	1987	67,246	1,681	40	1,681		36,142	6
7	1		1988	1988	91,817	2,295	40	2,295		47,051	7
8			1999	1999	74,929	1,873	40	1,380	(493)	14,187	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		15			3,525	13
14		Land Improvements - Court Yard		1992	26,596		15			26,595	14
15		Land Improvements - Front Court Yard		1997	15,126	1,008	15	1,008		11,511	15
16		Land Improvements - Black Topping		1997	16,291	1,086	15	1,086		12,308	16
17		Land Improvements - Parking Lot		2001	5,200	347	15	347		2,514	17
18		Land Improvements - Parking Lot Seal Coating		2001	2,095	139	15	139		1,013	18
19		Land Improvements - Sidewalk to Parking Lot		2005	5,315	354	15	354		1,211	19
20		Building Improvements - General Building Improvements		1987	8,669		20			8,654	20
21		Building Improvements - General Building Improvements		1988	28,461	712	20	712		28,460	21
22		Building Improvements - General Building Improvements		1989	500	25	20	25		492	22
23		Building Improvements - General Building Improvements		1990	6,091	305	20	305		5,622	23
24		Building Improvements - General Building Improvements		1991	6,846	342	20	342		5,890	24
25		Building Improvements - Air Conditioner		1992	13,749	687	20	687		11,339	25
26		Building Improvements - Light Fixture		1992	1,331	67	20	67		1,102	26
27		Building Improvements - RPZ Plumbing Valve		1994	885	44	20	44		636	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:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Building Improvements - Carpeting Lobby</u>	1996	\$ 5,853	\$	10	\$	\$	\$ 5,853	37
38	<u>Building Improvements - Sound System Lobby</u>	1996	809	40	20	40		510	38
39	<u>Building Improvements - Drapes in Lobby</u>	1996	182		10			181	39
40	<u>Building Improvements - Code Alert</u>	1997	1,164		10			1,162	40
41	<u>Building Improvements - Patio Door</u>	1998	2,100	105	20	105		1,129	41
42	<u>Building Improvements - Automatic Door</u>	1998	2,029	101	20	101		1,072	42
43	<u>Building Improvements - Carpeting Music Room</u>	1998	2,671	157	10	157		2,671	43
44	<u>Building Improvements - Kitchen Air Conditioner</u>	1999	9,367	468	20	468		4,581	44
45	<u>Building Improvements - Cabinets and Parts</u>	1999	699	35	20	35		341	45
46	<u>Building Improvements - Carpeting Two Offices</u>	1999	1,325	66	20	66		646	46
47	<u>Building Improvements - Dining Room Blinds</u>	1999	656	33	20	33		302	47
48	<u>Building Improvements - Garbage Disposal</u>	2000	1,975	99	20	99		848	48
49	<u>Building Improvements - Faucets</u>	2001	2,372	119	20	119		908	49
50	<u>Building Improvements - Grease Trap</u>	2001	3,769	189	20	189		1,444	50
51	<u>Building Improvements - Door Shades</u>	2001	562	28	20	28		206	51
52	<u>Building Improvements - Damper</u>	2001	710	36	20	36		254	52
53	<u>Building Improvements - Door for PT Room</u>	2001	600	30	20	30		213	53
54	<u>Building Improvements - Drapes Employee Dining Room</u>	2002	653	33	20	33		223	54
55	<u>Building Improvements - Drapes Resident Rooms</u>	2002	1,307	65	20	65		441	55
56	<u>Building Improvements - Electromagnetic Front Doors</u>	2003	1,717	86	20	86		508	56
57	<u>Building Improvements - Air Conditioning</u>	2003	3,100	155	20	155		840	57
58	<u>Building Improvements - Fire Dampers</u>	2003	2,160	108	20	108		558	58
59	<u>Building Improvements - Steam Table Restoration</u>	2004	3,700	185	20	185		909	59
60	<u>Building Improvements - Hot Water Coil Replacement</u>	2004	3,408	170	20	170		824	60
61	<u>Building Improvements - Activity Room Shelving</u>	2004	1,850	93	20	93		447	61
62	<u>Building Improvements - Exit Door Alarms At Service Entrance</u>	2004	994	49	20	49		224	62
63	<u>Building Improvements - Smoke Detectors With Office Window</u>	2004	953	48	20	48		202	63
64	<u>Building Improvements - Hot Water Heaters</u>	2005	8,650	433	20	433		1,694	64
65	<u>Building Improvements - Fire Doors and Wiring</u>	2005	3,230	161	20	161		538	65
66	<u>Building Improvements - 3 Wings Security Door Systems</u>	2005	6,600	330	20	330		1,045	66
67	<u>Building Improvements - Duct Detectors</u>	2005	1,167	58	20	58		180	67
68	<u>Building Improvements - Smoke Dampers</u>	2005	4,607	230	20	230		710	68
69	<u>Building Improvements - Smoke Detectors</u>	2005	5,159	258	20	258		774	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,548,345	\$ 65,834		\$ 65,341	\$ (493)	\$ 1,489,354	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:

01/01/2008 Ending: 12/31/2008

**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>		\$ 2,548,345	\$ 65,834		\$ 65,341	\$ (493)	\$ 1,489,354	1
2	Building Improvements - RN Station Cabinets and Counters	2006	12,126	809	15	809		2,088	2
3	Building Improvements - A/C Condenser for Kitchen	2006	2,800	187	15	187		467	3
4	Building Improvements - RN Station Carpeting	2006	3,700	740	5	740		1,665	4
5	Building Improvements - Replace Windows & Labor	2005	28,966	724	40	724		2,645	5
6	Building Improvements - Replace Windows	2006	24,955	624	40	624		1,456	6
7	Building Improvements - Elevator Motor	2008	3,846	80	20	80		80	7
8	Building Improvements - Generator	2008	2,510	42	5	42		42	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,627,248	\$ 69,040		\$ 68,547	\$ (493)	\$ 1,497,797	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	\$ 181,470	\$ 18,480	\$ 18,480	\$	5/10/12/15/20	\$ 114,083	71
72	Current Year Purchases	14,686	301	301		3/5/12	301	72
73	Fully Depreciated Assets	283,484	394	394		5/10	283,484	73
74								74
75	TOTALS	\$ 479,640	\$ 19,175	\$ 19,175	\$		\$ 397,868	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 E-350 Van	2006	\$ 36,327	\$ 3,633	\$ 3,633	\$	10	\$ 9,687	76
77										77
78										78
79										79
80	TOTALS			\$ 36,327	\$ 3,633	\$ 3,633	\$		\$ 9,687	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)		\$ 3,143,215	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 91,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 91,355	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)		\$ 1,905,352	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	\$ 460,959	86
87	Land Improvements - 86/90/91/97	94,036	2,646	77,327	87
88	Equipment - 1986-1999/2006	42,726	696	41,174	88
89	Building Improvements-99-03/06-08	46,366	2,460	9,105	89
90	Van-30% Non-Care Related - 2006	15,569	1,557	4,152	90
91	TOTALS	\$ 1,128,170	\$ 30,596	\$ 592,717	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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>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				6,876		6,876	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		6,653	78,911	1,910	6,653	80,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Personal Supplies</u>	39-2					21,247		21,247	13
14	TOTAL			\$	6,653	\$ 78,911	\$ 30,033	6,653	\$ 108,944	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 # 0029892 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (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	\$ 61,202	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 60,000 )	367,663		3
4	Supply Inventory (priced at cost )	13,655		4
5	Short-Term Investments	161,507		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	41,162		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 645,189	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	303,288		12
13	Land			13
14	Buildings, at Historical Cost	3,697,123		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	574,262		16
17	Accumulated Depreciation (book methods)	(2,501,520)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	142,247		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Capital In Risk Retention Group</u>	68,950		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,284,350	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,929,539	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 237,294	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,000		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,145		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	2,629		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Accrued expenses</u>	32,750		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 402,818	\$	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 Loans</u>	77,700		43
44	<u>Work Comp Assessment Payable</u>	40,264		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 117,964	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 520,782	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,408,757	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,929,539	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,405,632	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,405,632	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	3,125	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)	\$ 3,125	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,408,757	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven# 002982Report Period Beginning: 01/01/2008Ending: 12/31/2008**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	\$ 3,050,264	1
2	Discounts and Allowances for all Levels	(283,966)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,766,298</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,073	6
7	Oxygen	180	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,253</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	428	13
14	Non-Patient Meals	5,132	14
15	Telephone, Television and Radio	39	15
16	Rental of Facility Space		16
17	Sale of Drugs	83,951	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>\$ 89,550</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	67,595	24
25	Interest and Other Investment Income***	22,372	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 89,967</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 On Page 24</b>	<b>187,734</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 187,734</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,134,802</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	599,021	31
32	Health Care	1,459,125	32
33	General Administration	732,145	33
<b>B. Capital Expense</b>			
34	Ownership	122,444	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	191,492	35
36	Provider Participation Fee	27,450	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>\$ 3,131,677</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>3,125</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>\$ 3,125</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: 01/01/2008

Ending:

12/31/2008

**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	1,698	1,888	\$ 58,365	\$ 30.91	1
2	Assistant Director of Nursing	1,870	2,096	55,123	26.30	2
3	Registered Nurses	13,698	14,823	391,363	26.40	3
4	Licensed Practical Nurses	5,842	6,346	155,084	24.44	4
5	CNAs & Orderlies	47,040	50,618	611,124	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,828	2,087	30,714	14.72	8
9	Activity Director	1,960	2,096	27,870	13.30	9
10	Activity Assistants	2,156	2,360	24,799	10.51	10
11	Social Service Workers	1,694	1,852	24,534	13.25	11
12	Dietician					12
13	Food Service Supervisor	1,949	2,104	36,845	17.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,715	17,147	174,016	10.15	15
16	Dishwashers					16
17	Maintenance Workers	1,970	2,178	45,598	20.94	17
18	Housekeepers	5,750	6,337	52,514	8.29	18
19	Laundry	2,643	2,881	33,640	11.68	19
20	Administrator	1,909	2,096	102,803	49.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,111	3,423	56,831	16.60	23
24	Clerical	647	677	6,444	9.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Nursing Secretary</u>	1,190	1,364	14,927	10.94	33
34	TOTAL (lines 1 - 33)	112,670	122,373	\$ 1,902,594 *	\$ 15.55	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	130	\$ 5,764	1-3	35
36	Medical Director	6	3,000	9-3	36
37	Medical Records Consultant	12	818	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	11	696	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	792	11-3	44
45	Social Service Consultant	32	2,752	12-3	45
46	Other(specify) <u>Beautician</u>	18	273	40-3	46
47	<u>Dental Consultant</u>	2	100	10-3	47
48					48
49	TOTAL (lines 35 - 48)	227	\$ 14,195		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

# 0029892

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
David G. Stieglitz	Administrator	0	\$ 102,803	Workers' Compensation Insurance	\$ 106,291	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	(2,569)	Advertising: Employee Recruitment	1,572		
				FICA Taxes	145,201	Health Care Worker Background Check	330		
				Employee Health Insurance	152,345	(Indicate # of checks performed <u>27</u> )			
				Employee Meals	4,744	Patient Background Checks <u>22</u>	270		
				Illinois Municipal Retirement Fund (IMRF)*		Publications/Secretary Of State Fee	308		
				Life Insurance	909	Buying Group/Lab Fee	450		
				Pension Expense - See Schedule Page 26	49,260	Association Dues/Domain Name Registr	3,314		
				Employee Health Services	2,344	Bulk Mail Fee	180		
				Employee Relations - See Schedule Page 26	13,660	Restaurant License/Elev Inspection Fee	340		
						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,803	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 472,185		\$ 8,754			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$ 1,637	
							See Attachments For Details		
							In-State Travel		
							Vehicle Expense	709	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	11,506	
							See Attachments For Details		
C. Professional Services							Less: Out-Of-State Travel	(1,637)	
Vendor/Payee	Type	Amount					Less: Non-Care Vehicle Expense	(213)	
Paychex Inc	Payroll Services	\$ 5,489					Entertainment Expense	( )	
Borhart Spellmeyer & Company	CPA (Cost Report & 990)	8,732					(agree to Sch. V, line 24, col. 8)		
CDS	Office Equipment Service	767					TOTAL	\$ 12,002	
MDI Achieve	Medical Software Support	2,681							
Thomas D Chase	Attorney - Collections	1,232							
Polsinelli etal	General Attorney Services	3,300							
American United Life	Form 5500	310							
Information Controls	Time & Attendance Maint	525							
MCC Technologies	Computer Network Support	1,945							
Quickbooks	Payroll Processing	69							
Amanda Weiss	General Clerical Work	3,585							
Healthcare Information Sol'ns	Medical Software Support	609							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 29,244	TOTAL		\$			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Apostolic Christian Resthaven

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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 2,211; AAHSA 878
- (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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,761 Line 10-2
- (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. \$ 27,450  
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? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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>		
8050	Apartment Income	\$ 184,495
8023	Vending Income	1,406
6902	Activity Income	846
8020	Cookbook Sales	612
8026	Miscellaneous Non-Operating	35
6911	Miscellaneous Operating	340
		<hr/>
		\$ 187,734
		<hr/> <hr/>

Notes:

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

Page 20, Schedule XVIII, Line 34 Reconciliation

Total Wages Reported on Page 20, Line 34	\$ 1,902,594
Dietary Wages Allocated to Non-Patient Meals, as per Adjustment on Page 5A	<hr/> 11,060
Total Salary / Wages Reported on Page 4, Column 1	<hr/> <hr/> \$ 1,913,654

Page 3, Schedule V, Line 7, Other

Expenses related to removal of general waste	<u>\$ 6,307</u>
--	-----------------

Page 3, Schedule V, Line 27, Other Expense

	Other Expenses
Volunteer Expense	\$ 148
Land Rent Paid To Related Party	2
Rounding Variance On Asset Account Reconciliation	<u>1</u>
Column 4 Total	151
Volunteer Expense on Page 5A, Non-Allowable Expenses	(148)
<b><u>RECLASSIFICATIONS:</u></b>	
Land Rent Paid To Related Party From Line 27 Col 5 to Line 34 Col 5	<u>(2)</u>
Column 8 Adjusted Total	<u>\$ 1</u>

Page 4, Schedule V, Line 43, Other Expense

	Other Expenses
Apartment Expense	\$ 80,103
Multipurpose Room Expense	<u>175</u>
Column 4 Total	80,278
Page 5A - Non-Allowable Expenses	
Apartment Expense	(80,103)
Multipurpose Room Expense	<u>(175)</u>
Column 8 Adjusted Total	<u>\$ -</u>

Page 3, Schedule V, Column 5 Reclassifications

Reclassify Staff Meals From Line 1 Dietary Wages	\$ (3,152)
Reclassify Staff Meals From Line 2 Meal Costs	(1,592)
Reclassify Staff Meals To Line 22 Employee Benefits	4,744
Reclassify Payment Related To Land Rent From Line 27 Other	(2)
Reclassify Payment Related To Land Rent To Line 34 Rent Facility Ground	<u>2</u>
Net Effect Of All Reclassifications	<u>\$ -</u>

Page 21, Schedule XIX, Section D, Employee Relations

1	Gifts For Sympathy / Get Well	\$	109
2	Christmas Gifts		5,695
3	Staff Appreciation Dinner		1,735
4	Anniversary Gifts For Years Of Service		505
5	Employee Assistance Program		2,025
6	Other		<u>3,591</u>
	Total Employee Relations	\$	<u><u>13,660</u></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>49,260</u>
	\$	<u><u>49,260</u></u>

Note - 58 employees were covered under the pension plan for year 2008.

**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 23 nurse assistants leave employment during 2008 and all replacements met the above requirement.

**Attachment to Schedule XX, General Information #14**

A portion of the building consists of 18 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 12-15, 2008, David Stieglitz, Administrator, attended the American Association of Homes and Services for the Aging Annual Meeting held in Philadelphia, Pennsylvania. This convention included topics related to employee recruitment and retention, regulatory compliance, the future of long term care, and board management.

**2008 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
Richard Kilgus	775 Regency Park Drive, Crystal Lake, IL 60014