



Facility Name & ID Number Apostolic Christian Resthaven

# 0029892 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,187	2,607		5,794	8	
9	SNF/PED					9	
10	ICF	3,197	8,677		11,874	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	6,384	11,284		17,668	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.81%

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

2 (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, 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: 01/01/2009 Ending: 12/31/2009

**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	219,438	15,692	4,586	239,716	(4,318)	235,398	(9,872)	225,526		1
2	Food Purchase		93,852		93,852	(1,892)	91,960	(4,235)	87,725		2
3	Housekeeping	58,997	9,681		68,678		68,678		68,678		3
4	Laundry	33,618	5,321		38,939		38,939		38,939		4
5	Heat and Other Utilities			62,449	62,449		62,449		62,449		5
6	Maintenance	60,434	13,610	29,770	103,814		103,814		103,814		6
7	Other (specify):* <b>Waste Removal</b>			5,851	5,851		5,851		5,851		7
8	<b>TOTAL General Services</b>	372,487	138,156	102,656	613,299	(6,210)	607,089	(14,107)	592,982		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,303,604	63,583	1,305	1,368,492		1,368,492		1,368,492		10
10a	Therapy		2	1,040	1,042		1,042		1,042		10a
11	Activities	57,841	8,031	808	66,680		66,680	(61)	66,619		11
12	Social Services	22,401	138	2,351	24,890		24,890		24,890		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,383,846	71,754	7,504	1,463,104		1,463,104	(61)	1,463,043		16
	<b>C. General Administration</b>										
17	Administrative	95,228			95,228		95,228		95,228		17
18	Directors Fees										18
19	Professional Services			28,125	28,125		28,125	(7,420)	20,705		19
20	Dues, Fees, Subscriptions & Promotions			7,314	7,314		7,314	(933)	6,381		20
21	Clerical & General Office Expenses	59,767	9,221	3,068	72,056		72,056	(283)	71,773		21
22	Employee Benefits & Payroll Taxes			404,334	404,334	6,304	410,638		410,638		22
23	Inservice Training & Education			325	325		325		325		23
24	Travel and Seminar			14,029	14,029		14,029	(123)	13,906		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,338	34,338		34,338		34,338		26
27	Other (specify):* <b>Misc. Exp/Vol. Exp.</b>			6,521	6,521	(95)	6,426	(1,971)	4,455		27
28	<b>TOTAL General Administration</b>	154,995	9,221	498,054	662,270	6,209	668,479	(10,730)	657,749		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,911,328	219,131	608,214	2,738,673	(1)	2,738,672	(24,898)	2,713,774		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 Resthaven

#0029892

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			124,820	124,820		124,820	(33,029)	91,791			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1	1	(1)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			124,820	124,820	1	124,821	(33,030)	91,791			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,185	93,617	119,802		119,802		119,802			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		2,014		2,014		2,014	(2,014)				41
42	Provider Participation Fee			27,034	27,034		27,034		27,034			42
43	Other (specify):* <b>Apartment &amp; MPR</b>		578	80,139	80,717		80,717	(80,717)				43
44	<b>TOTAL Special Cost Centers</b>		28,777	200,790	229,567		229,567	(82,731)	146,836			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,911,328	247,908	933,824	3,093,060		3,093,060	(140,659)	2,952,401			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,235)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,870)	19		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	(61)	11		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(32,536)	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	(3,550)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(933)	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	(94,981)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (140,659)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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>	\$ (140,659)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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

<b>BHF USE ONLY</b>							
48		49		50		51	52

**Apostolic Christian Resthaven**

ID# 0029892

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Apartment Expense	\$ (80,139)	43	1
2	Non-Care Travel Expense	(123)	24	2
3	Vending Expense	(2,014)	41	3
4	Non-Patient Meals (Wage-Related Costs)	(9,872)	1	4
5	Multipurpose Room Expense	(578)	43	5
6	Volunteer Expense	(1,971)	27	6
7	Rent on Land Paid to Related Party	(1)	34	7
8	Newsletter Expense	(283)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(94,981)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(9,872)	0	0	0	0	0	0	0	0	0	0	(9,872)	1
2	Food Purchase	(4,235)	0	0	0	0	0	0	0	0	0	0	(4,235)	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>(14,107)</b>	<b>0</b>	<b>(14,107)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(61)	0	0	0	0	0	0	0	0	0	0	(61)	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>(61)</b>	<b>0</b>	<b>(61)</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	(7,420)	0	0	0	0	0	0	0	0	0	0	(7,420)	19
20	Fees, Subscriptions & Promotions	(933)	0	0	0	0	0	0	0	0	0	0	(933)	20
21	Clerical & General Office Expenses	(283)	0	0	0	0	0	0	0	0	0	0	(283)	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	(123)	0	0	0	0	0	0	0	0	0	0	(123)	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):* <b>Volunteer exp</b>	(1,971)	0	0	0	0	0	0	0	0	0	0	(1,971)	27
28	<b>TOTAL General Administration</b>	<b>(10,730)</b>	<b>0</b>	<b>(10,730)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(24,898)</b>	<b>0</b>	<b>(24,898)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(33,029)	0	0	0	0	0	0	0	0	0	0	(33,029)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1)	0	0	0	0	0	0	0	0	0	0	(1)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(33,030)</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>(33,030)</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	(2,014)	0	0	0	0	0	0	0	0	0	0	(2,014)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):* <b>MPR &amp; Apt Exp</b>	<b>(80,717)</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>(80,717)</b>	<b>43</b>
44	<b>TOTAL Special Cost Centers</b>	<b>(82,731)</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>(82,731)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(140,659)</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>(140,659)</b>	<b>45</b>

**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	\$ 1	Apostolic Christian Church of Elgin	100.00%	\$ 1	\$	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		\$ 1			\$ 1	\$ *	14

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

Facility Name & ID Number Apostolic Christian Resthaven # 0029892 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

**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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

Apostolic Christian Resthaven

# 0029892

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<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.)

\*\* 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:

01/01/2009 Ending:

12/31/2009

**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

Facility Name & ID Number Apostolic Christian Resthaven# 0029892

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		1985	1985	\$ 2,020,183	\$ 50,541	40	\$ 50,541	\$	\$ 1,228,591	4
5			1986	1986	10,064	252	40	252		5,917	5
6			1987	1987	67,246	1,681	40	1,681		37,823	6
7	1		1988	1988	91,817	2,295	40	2,295		49,346	7
8			1999	1999	74,929	1,873	40	1,380	(493)	15,568	8
	<b>Improvement Type**</b>										
9		Land Improvements - General Land Improvement:	1985		24,667		15			24,667	9
10		Land Improvements - General Land Improvement:	1986		4,800		15			4,800	10
11		Land Improvements - General Land Improvement:	1989		2,069		15			2,069	11
12		Land Improvements - General Land Improvement:	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	1	15	1		26,596	14
15		Land Improvements - Front Court Yard	1997		15,126	1,008	15	1,008		12,519	15
16		Land Improvements - Black Topping	1997		16,291	1,086	15	1,086		13,395	16
17		Land Improvements - Parking Lot	2001		5,200	347	15	347		2,860	17
18		Land Improvements - Parking Lot Seal Coating	2001		2,095	140	15	140		1,153	18
19		Land Improvements - Sidewalk to Parking Lot	2005		5,315	354	15	354		1,565	19
20		Land Improvements - Timber Landscape	2009		4,100	137	10	137		228	20
21		Building Improvements - General Building Improvement:	1987		8,669	15	20	15		8,669	21
22		Building Improvements - General Building Improvement:	1988		28,461	1	20	1		28,461	22
23		Building Improvements - General Building Improvement:	1989		500	8	20	8		500	23
24		Building Improvements - General Building Improvement:	1990		6,091	305	20	305		5,926	24
25		Building Improvements - General Building Improvement:	1991		6,846	342	20	342		6,232	25
26		Building Improvements - Air Conditioner	1992		13,749	688	20	688		12,027	26
27		Building Improvements - Light Fixture	1992		1,331	67	20	67		1,168	27
28		Building Improvements - RPZ Plumbing Valve	1994		885	44	20	44		680	28
29		Building Improvements - Curtains	1995		1,944		10			1,944	29
30		Building Improvements - Carpeting Music Room	1995		1,332		10			1,332	30
31		Building Improvements - Drapes	1995		2,989		10			2,989	31
32		Building Improvements - Carpet on Walls	1995		6,262		10			6,262	32
33		Building Improvements - Wallpaper	1995		3,703		10			3,703	33
34		Building Improvements - Drapes	1995		884		10			884	34
35		Building Improvements - Carpeting Office	1995		1,344		10			1,344	35
36		Building Improvements - Wallpaper and Drapes	1996		540		10			540	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 Resthaven# 0029892

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<a href="#">Building Improvements - Drapes in Lobby</a>	1996	\$ 412	\$ 1	10	\$ 1	\$	\$ 412	37
38	<a href="#">Building Improvements - Carpeting Lobby</a>	1996	5,853		10			5,853	38
39	<a href="#">Building Improvements - Sound System Lobby</a>	1996	809	40	20	40		550	39
40	<a href="#">Building Improvements - Drapes in Lobby</a>	1996	182	1	10	1		182	40
41	<a href="#">Building Improvements - Code Alert</a>	1997	1,164	2	10	2		1,164	41
42	<a href="#">Building Improvements - Patio Door</a>	1998	2,100	105	20	105		1,234	42
43	<a href="#">Building Improvements - Automatic Door</a>	1998	2,029	102	20	102		1,174	43
44	<a href="#">Building Improvements - Carpeting Music Room</a>	1998	2,671		10			2,671	44
45	<a href="#">Building Improvements - Kitchen Air Conditioner</a>	1999	9,367	468	20	468		5,050	45
46	<a href="#">Building Improvements - Cabinets and Parts</a>	1999	699	35	20	35		376	46
47	<a href="#">Building Improvements - Carpeting Two Offices</a>	1999	1,325	66	20	66		712	47
48	<a href="#">Building Improvements - Dining Room Blinds</a>	1999	656	33	20	33		334	48
49	<a href="#">Building Improvements - Garbage Disposal</a>	2000	1,975	99	20	99		947	49
50	<a href="#">Building Improvements - Faucets</a>	2001	2,372	119	20	119		1,027	50
51	<a href="#">Building Improvements - Grease Trap</a>	2001	3,769	188	20	188		1,633	51
52	<a href="#">Building Improvements - Door Shades</a>	2001	562	28	20	28		234	52
53	<a href="#">Building Improvements - Damper</a>	2001	710	36	20	36		290	53
54	<a href="#">Building Improvements - Door for PT Room</a>	2001	600	30	20	30		243	54
55	<a href="#">Building Improvements - Drapes Employee Dining Room</a>	2002	653	33	20	33		256	55
56	<a href="#">Building Improvements - Drapes Residents Rooms</a>	2002	1,307	65	20	65		506	56
57	<a href="#">Building Improvements - Electromagnetic Front Doors</a>	2003	1,717	86	20	86		594	57
58	<a href="#">Building Improvements - Air Conditioning</a>	2003	3,100	155	20	155		995	58
59	<a href="#">Building Improvements - Fire Dampers</a>	2003	2,160	108	20	108		666	59
60	<a href="#">Building Improvements - Steam Table Restoration</a>	2004	3,700	185	20	185		1,095	60
61	<a href="#">Building Improvements - Hot Water Coil Replacement</a>	2004	3,408	170	20	170		994	61
62	<a href="#">Building Improvements - Activity Room Shelving</a>	2004	1,850	93	20	93		540	62
63	<a href="#">Building Improvements - Exit Door Alarms at Service Entrance</a>	2004	994	50	20	50		273	63
64	<a href="#">Building Improvements - Smoke Detectors with Office Window</a>	2004	953	48	20	48		250	64
65	<a href="#">Building Improvements - Hot Water Heaters</a>	2005	8,650	433	20	433		2,126	65
66	<a href="#">Building Improvements - Fire Doors and Wiring</a>	2005	3,230	161	20	161		700	66
67	<a href="#">Building Improvements - 3 Wings Security Door Systems</a>	2005	6,600	330	20	330		1,375	67
68	<a href="#">Building Improvements - Duct Detectors</a>	2005	1,167	58	20	58		238	68
69	<a href="#">Building Improvements - Smoke Dampers</a>	2005	4,607	230	20	230		941	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,541,494	\$ 64,743		\$ 64,250	\$ (493)	\$ 1,549,508	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,541,494	\$ 64,743		\$ 64,250	\$ (493)	\$ 1,549,508	1
2	Building Improvements - Smoke Detectors	2005	5,159	258	20	258		1,032	2
3	Building Improvements - RN Station Cabinets and Counters	2006	12,126	808	15	808		2,897	3
4	Building Improvements - A/C Condenser for Kitchen	2006	2,800	187	15	187		653	4
5	Building Improvements - RN Station Carpeting	2006	3,700	740	5	740		2,405	5
6	Building Improvements - Replace Windows & Labor	2005	28,966	724	40	724		3,369	6
7	Building Improvements - Replace Windows	2006	24,955	624	40	624		2,080	7
8	Building Improvements - Elevator Motor	2008	3,846	192	20	192		272	8
9	Building Improvements - Generator	2008	2,510	502	5	502		544	9
10	Building Improvements - RN Cabinets	2009	7,350	408	15	408		408	10
11	Building Improvements - Wood Room Doors	2009	8,669	433	15	433		433	11
12	Building Improvements - New Tub	2009	14,388		20				12
13	Land Improvements - Retaining Walls	2009	7,300	91	20	91			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>		\$ 2,663,263	\$ 69,710		\$ 69,217	\$ (493)	\$ 1,563,601	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	\$ 154,022	\$ 16,346	\$ 16,346	\$	/5/10/12/15/2	\$ 91,337	71
72	Current Year Purchases	2,952	24	24		10	24	72
73	Fully Depreciated Assets	299,786	2,571	2,571		5/10	299,786	73
74								74
75	TOTALS	\$ 456,760	\$ 18,941	\$ 18,941	\$		\$ 391,147	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	\$ 13,320	76
77										77
78										78
79										79
80	TOTALS			\$ 36,327	\$ 3,633	\$ 3,633	\$		\$ 13,320	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)	\$ 3,156,350	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,284	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,791	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)	\$ 1,968,068	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 - 1986/1991/1999/06/09	\$ 976,558	\$ 23,825	\$ 482,454	86
87	Land Improvements - 86/90/91/97	94,036	2,646	79,973	87
88	Equipment - 1986-1999/2006/2009	53,036	774	41,948	88
89	Building Improvements-99-03/06-09	58,989	3,734	12,839	89
90	Van-30% Non-Care Related - 2006	15,569	1,557	5,709	90
91	TOTALS	\$ 1,198,188	\$ 32,536	\$ 622,923	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

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

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

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

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

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

YES  NO

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

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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-2	visits				3,479		3,479	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescripts		6,349	93,617	2,486	6,349	96,103	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					20,220		20,220	13
14	TOTAL			\$	6,349	\$ 93,617	\$ 26,185	6,349	\$ 119,802	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 Resthaven# 0029892Report Period Beginning: 01/01/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 657,776	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>44,412</u> )	173,674		3
4	Supply Inventory (priced at <u>Cost</u> )	17,422		4
5	Short-Term Investments	315,649		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	29,388		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,193,909	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,792,846		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	561,692		16
17	Accumulated Depreciation (book methods)	(2,594,935)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	70,192		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Capital in Insurance Groups</u>	81,763		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,911,558	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,105,467	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 224,009	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,637		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,342		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	752		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Current Portion - Work Comp Assessmt</u>	30,240		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 368,980	\$	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 - Apartment Loans</u>	46,500		43
44	<u>Work Comp Assessment Payable</u>	30,236		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 76,736	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 445,716	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,659,751	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,105,467	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,408,757</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,408,757</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>250,994</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>250,994</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,659,751</b>	<b>24</b> *

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

Facility Name & ID Number Apostolic Christian Resthaven# 0029892Report Period Beginning: 01/01/2009Ending: 12/31/2009

**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	\$ 3,210,670	1
2	Discounts and Allowances for all Levels	(299,607)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,911,063</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</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		13
14	Non-Patient Meals	3,708	14
15	Telephone, Television and Radio	61	15
16	Rental of Facility Space		16
17	Sale of Drugs	100,531	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>\$ 104,300</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	117,269	24
25	Interest and Other Investment Income***	31,281	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 148,550</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Other Revenues</u>	180,141	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 180,141</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,344,054</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	613,299	31
32	Health Care	1,463,104	32
33	General Administration	662,270	33
<b>B. Capital Expense</b>			
34	Ownership	124,820	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	202,533	35
36	Provider Participation Fee	27,034	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>\$ 3,093,060</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>250,994</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 250,994</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.

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

Facility Name & ID Number Apostolic Christian Resthaven

# 0029892

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	1,666	1,884	\$ 60,051	\$ 31.87	1
2	Assistant Director of Nursing	1,912	2,088	62,252	29.81	2
3	Registered Nurses	14,087	15,318	396,417	25.88	3
4	Licensed Practical Nurses	6,486	7,001	149,880	21.41	4
5	CNAs & Orderlies	47,164	50,678	599,608	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,662	1,853	21,477	11.59	8
9	Activity Director	1,933	2,096	28,929	13.80	9
10	Activity Assistants	2,627	2,767	28,912	10.45	10
11	Social Service Workers	1,636	1,732	22,401	12.93	11
12	Dietician					12
13	Food Service Supervisor	2,187	2,290	34,393	15.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,506	17,131	175,173	10.23	15
16	Dishwashers					16
17	Maintenance Workers	3,165	3,403	60,434	17.76	17
18	Housekeepers	6,128	6,765	58,997	8.72	18
19	Laundry	2,494	2,774	33,618	12.12	19
20	Administrator	1,831	2,088	95,228	45.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,035	3,311	55,376	16.72	23
24	Clerical	392	463	4,391	9.48	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>	1,091	1,223	13,919	11.38	33
34	TOTAL (lines 1 - 33)	115,002	124,865	\$ 1,901,456 *	\$ 15.23	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	103	\$ 4,680	1-3 / 1-5	35
36	Medical Director	12	2,000	9-3	36
37	Medical Records Consultant	12	825	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	17	1,040	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	808	11-3	44
45	Social Service Consultant	27	2,351	12-3	45
46	Other(specify) <u>Dental Consultant</u>	10	480	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	197	\$ 12,184		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 Resthaven# 0029892Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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 2,210; AAHSA 944
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,956 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. \$ 27,034  
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. \$ 6,304 Has any meal income been offset against related costs? no Indicate the amount. \$ \_\_\_\_\_
- (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? 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: \_\_\_\_\_
- (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.

**Page 19, Schedule XVII, Line 28, Other Revenues**

<u>Account</u>	
8050 Apartment Income	\$ 177,228
8023 Vending Income	1,168
6902 Activity Income	990
8020 Cookbook Sales	520
8026 Miscellaneous Non-Operating	5
6911 Miscellaneous Operating	230
	<hr/>
	\$ 180,141
	<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, Salary & Wage Reconciliation**

Total Wages Reported on Page 20, Line 34	\$ 1,901,456
Dietary Wages Allocated to Non-Patient Meals, as per Adjustment on Page 5A	<hr/> 9,872
Total Salary / Wages Reported on Page 4, Column 1	<hr/> \$ 1,911,328

**Page 3, Schedule V, Line 7, Other**

Expenses related to removal of general waste	\$	5,851
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**Page 3, Schedule V, Line 27, Other Expenses**

Loss on Retirement of Assets	\$	4,219
Volunteer Expense		1,971
General Service Fees		236
Dietary Department Assistance		94
Land Rent Paid to Related Party		1

Column 4 Total		6,521
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Volunteer Expense on Page 5A, Non-Allowable Expenses		(1,971)
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**RECLASSIFICATIONS:**

Land Rent Paid to Related Party From Line 27 Col 5 to Line 34 Col 5		(1)
Dietary Department Assistance From Line 27 Col 5 to Line 1 Col 5		(94)

Column 8, Adjusted Total	\$	4,455
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**Page 4, Schedule V, Line 43, Other Expenses**

Apartment Expense	\$	80,139
Multipurpose Room Expense		578

Column 4 Total		80,717
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Apartment Expense - Page 5A - Non-Allowable Expense		(80,139)
Multipurpose Room Expense - Page 5A - Non-Allowable Expense		(578)

Column 8, Adjusted Total	\$	-
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**Page 3, Schedule V, Column 5 Reclassifications**

Reclassify Staff Meals From Line 1, Dietary Wages	\$	(4,412)
Reclassify Staff Meals From Line 2, Meal Costs		(1,892)
Reclassify Staff Meals To Line 22, Employee Benefits		6,304

Reclassify Payment Related to Land Rent From Line 27, Other		(1)
Reclassify Payment Related to Land Rent To Line 34, Rent Facility & Grou		1

Reclassify Dietary Department Assistance From Line 27, Other		(94)
Reclassify Dietary Department Assistance To Line 1, Dietary		94

Net Effect Of All Reclassifications	\$	-
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**Page 21, Schedule XIX, Section D, Pension Expense**

Pension Costs For Owners and Related Parties	\$ -
Pension Costs For All Other Employees	<u>56,378</u>
	<u>\$ 56,378</u>

Note - 59 employees were covered under the pension plan for the year 2009.

**Attachment to Schedule XIII**

Nurse assistants were not trained in Basic Nurse Assistant courses during the 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 12 nurse assistants leave employment during 2009 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 no costs included for out-of-state travel in the cost report for 2009.

**2009 Board of Directors and Officers:**

Glen Pfeifer, President	37W951 McKee Road, Batavia, IL 60510
Jeff Kellenberger, Vice-President	11N528 Muirhead Road, Elgin, IL 60124
David Martin, Treasurer	24107 W. Grant Highway, Marengo, IL 60152
Richard Kilgus, Secretary	775 Regency Park Drive, Crystal Lake, IL 60014
Robert Schambach	251 Brookside Drive, Elgin, IL 60123
Roger Weiss	804 Elm Street, Hampshire, IL 60140
Morris Young	8261 S. Mayfield Road, DeKalb, IL 60115

No board members directly provided services to the nursing home during 2009.

Robert Schambach of Schambach Construction, Inc. was the only board member's business that conducted business with the nursing home during 2009. Schambach Construction, Inc. installed windows in the independent congregate living units that are Non-Care Related.