



Facility Name & ID Number Apostolic Christian Restmor

# 0047167 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,651	29,496	3,315	36,462	8
9	SNF/PED					9
10	ICF		3,792		3,792	10
11	ICF/DD					11
12	SC		3,052		3,052	12
13	DD 16 OR LESS					13
14	TOTALS	3,651	36,340	3,315	43,306	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.69%

D. How many bed-hold days during this year were paid by the Department? \_\_\_\_\_ (Do not include bed-hold days in Section B.)

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

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

meals on wheels

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 4/1/2008

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 42 and days of care provided 3,315

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name &amp; ID Number

Apostolic Christian Restmor

# 0047167

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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	627,810	46,344		674,154		674,154		674,154		1
2	Food Purchase		408,719		408,719	(16,933)	391,786	(22,563)	369,223		2
3	Housekeeping	147,536	59,037		206,573		206,573		206,573		3
4	Laundry	98,690	14,224		112,914		112,914	(2,530)	110,384		4
5	Heat and Other Utilities			200,763	200,763		200,763		200,763		5
6	Maintenance	195,797	39,374	286,218	521,389	(8,110)	513,279		513,279		6
7	Other (specify):*			20,371	20,371		20,371		20,371		7
8	<b>TOTAL General Services</b>	<b>1,069,833</b>	<b>567,698</b>	<b>507,352</b>	<b>2,144,883</b>	<b>(25,043)</b>	<b>2,119,840</b>	<b>(25,093)</b>	<b>2,094,747</b>		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	4,044,443	257,502	3,331	4,305,276		4,305,276		4,305,276		10
10a	Therapy			417,679	417,679		417,679		417,679		10a
11	Activities	197,983			197,983		197,983	(139)	197,844		11
12	Social Services	206,002			206,002		206,002		206,002		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>4,448,428</b>	<b>257,502</b>	<b>433,010</b>	<b>5,138,940</b>		<b>5,138,940</b>	<b>(139)</b>	<b>5,138,801</b>		16
	<b>C. General Administration</b>										
17	Administrative	245,485			245,485		245,485	(36,900)	208,585		17
18	Directors Fees										18
19	Professional Services			55,813	55,813		55,813	(16,511)	39,302		19
20	Dues, Fees, Subscriptions & Promotions			36,482	36,482		36,482	(22,368)	14,114		20
21	Clerical & General Office Expenses	265,709	25,829	143,465	435,003	(42,449)	392,554	(12,786)	379,768		21
22	Employee Benefits & Payroll Taxes			1,366,591	1,366,591	16,933	1,383,524	(22,538)	1,360,986		22
23	Inservice Training & Education										23
24	Travel and Seminar			43,859	43,859	(3,123)	40,736	(15,279)	25,457		24
25	Other Admin. Staff Transportation			3,557	3,557	3,123	6,680	(4,180)	2,500		25
26	Insurance-Prop.Liab.Malpractice			106,078	106,078		106,078		106,078		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>511,194</b>	<b>25,829</b>	<b>1,755,845</b>	<b>2,292,868</b>	<b>(25,516)</b>	<b>2,267,352</b>	<b>(130,562)</b>	<b>2,136,790</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>6,029,455</b>	<b>851,029</b>	<b>2,696,207</b>	<b>9,576,691</b>	<b>(50,559)</b>	<b>9,526,132</b>	<b>(155,794)</b>	<b>9,370,338</b>		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.

## 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			577,576	577,576		577,576	(100)	577,476			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					50,559	50,559		50,559			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			577,576	577,576	50,559	628,135	(100)	628,035			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			150,993	150,993		150,993		150,993			39
40	Barber and Beauty Shops	35,806		4,963	40,769		40,769		40,769			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,978	288,978		288,978		288,978			42
43	Other (specify):*			1,747	1,747		1,747	(1,747)				43
44	<b>TOTAL Special Cost Centers</b>	35,806		446,681	482,487		482,487	(1,747)	480,740			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,065,261	851,029	3,720,464	10,636,754		10,636,754	(157,641)	10,479,113			45

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

Facility Name & ID Number Apostolic Christian Restmor

# 0047167

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

**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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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>	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						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

## Apostolic Christian Restmor

ID# 0047167

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Seminar	\$ (6,129)	24	1
2	Dues and Fees	(11,061)	20	2
3	Promotion	(9,481)	20	3
4	Employee Meal Income	(13,706)	22	4
5	Guest Meal Income	(4,945)	2	5
6	Misc Expense	(423)	21	6
7	Misc Income	(11,828)	21	7
8	Auto Expense	(4,180)	25	8
9	Professional Fees	(14,551)	19	9
10	Meals on Wheels	(17,618)	2	10
11	Sunshine Cart Income	(139)	11	11
12	Management Fee	(36,900)	17	12
13	Out of State Travel	(9,150)	24	13
14	Penalties	(1,826)	20	14
15	Interest Income Pension	(8,832)	22	15
16	Gain on Sale of Equipment	(100)	30	16
17	Misc	(1,747)	43	17
18	Private Pay Laundry	(2,530)	4	18
19	Telephone Income	(13)	21	19
20	Legal	(1,960)	19	20
21	Contributions	(522)	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>		(157,641)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(22,563)	0	0	0	0	0	0	0	0	0	0	(22,563)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,530)	0	0	0	0	0	0	0	0	0	0	(2,530)	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>(25,093)</b>	<b>0</b>	<b>(25,093)</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	(139)	0	0	0	0	0	0	0	0	0	0	(139)	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>(139)</b>	<b>0</b>	<b>(139)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	(36,900)	0	0	0	0	0	0	0	0	0	0	(36,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,511)	0	0	0	0	0	0	0	0	0	0	(16,511)	19
20	Fees, Subscriptions & Promotions	(22,368)	0	0	0	0	0	0	0	0	0	0	(22,368)	20
21	Clerical & General Office Expenses	(12,786)	0	0	0	0	0	0	0	0	0	0	(12,786)	21
22	Employee Benefits & Payroll Taxes	(22,538)	0	0	0	0	0	0	0	0	0	0	(22,538)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(15,279)	0	0	0	0	0	0	0	0	0	0	(15,279)	24
25	Other Admin. Staff Transportation	(4,180)	0	0	0	0	0	0	0	0	0	0	(4,180)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(130,562)</b>	<b>0</b>	<b>(130,562)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(155,794)</b>	<b>0</b>	<b>(155,794)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

1/1/2014 Ending:

12/31/2014

## 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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(100)</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>(100)</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	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,747)	0	0	0	0	0	0	0	0	0	0	(1,747)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,747)</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>(1,747)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(157,641)</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>(157,641)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Greg Kaiser						
Marty Rollins						
Bruce Sauder						
Nate Koch						
Brian Bahr						
Gary Psinas						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

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 Restmor

# 0047167

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Apostolic Christian Restmor

# 0047167

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6																	
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$	\$			\$						
	<b>B. Non-Facility Related*</b>																
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047167

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

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Stick 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).

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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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	facility site	849,420		\$ 327,810	1
2	vacant land	435,600		75,000	2
3	TOTALS	1,285,020		\$ 402,810	3

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	128		2008	2008	\$ 15,081,596	\$ 377,040	40	\$ 377,040	\$	\$ 2,545,020	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Land Site preparation and grading	2008	2008	395,786						9
10		Remote unattached storage building	2008	2008	207,121	5,178	40	5,178		34,952	10
11		Road and parking area	2008	2008	194,661	9,733	20	9,733		65,698	11
12		Brick Edging and Landscaping	2008	2008	10,923	546	20	546		3,598	12
13		New Sidewalk	2009	2009	8,245	550	15	550		2,933	13
14		Concrete drainage ways for stormwater	2009	2009	10,656	533	20	533		2,753	14
15		Additional Heat Pump for Spa area	2009	2009	7,020	468	15	468		2,652	15
16		Additional Lighting	2009	2009	9,232	615	15	615		3,485	16
17		New Ventilators in Spa area	2009	2009	6,791	453	15	453		2,537	17
18		Additional Smoke Devices	2009	2009	2,667	178	15	178		1,038	18
19		Additional Door Holders	2009	2009	2,758	184	15	184		981	19
20		Courtyard concrete finish	2010	2010	11,808	590	20	590		2,803	20
21		Re keying all doors	2010	2010	9,980	270	37	270		1,260	21
22		Smokedoors	2010	2010	10,570	286	37	286		1,311	22
23		New Trees	2010	2010	5,000	135	37	135		574	23
24		New Trees	2011	2011	3,900	108	36	108		360	24
25		Linoleum in laundry room	2011	2011	7,667	639	12	639		2,449	25
26		Paneling in patient rooms	2011	2011	9,550	796	12	796		2,852	26
27		Geo Thermal Retrocommissioning	2012	2012	357,300	10,209	35	10,209		28,925	27
28		Enclose Porches in resident living rooms	2012	2012	25,892	740	35	740		1,603	28
29		Lighting Upgrade on exterior doors	2012	2012	3,402	97	35	97		202	29
30		Air Filters	2013	2013	3,000	86	35	86		165	30
31		Air Conditioning Reconfiguration	2013	2013	48,300	1,380	35	1,380		2,070	31
32		Automatic Doors for four outside entrances	2013	2013	23,651	676	35	676		1,073	32
33		Kick Resistant Panel	2013	2013	5,630	161	35	161		241	33
34		Heat Pump	2014	2014	5,418	133	34	133		133	34
35		LED Outside Lighting	2014	2014	10,113	223	34	223		223	35
36		Paneling in patient rooms	2014	2014	10,000	196	34	196		196	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

**XI. OWNERSHIP COSTS (continued)**

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C Reconfiguration	2014	\$ 8,120	\$ 60	34	\$ 60	\$	\$ 60	37
38	Revise electrical outlets	2014	18,900	46	34	46		46	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 16,515,657	\$ 412,309		\$ 412,309	\$	\$ 2,712,193	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 2,046,729	\$ 146,976	\$ 146,976	\$	4--15	\$ 1,099,518	71
72	Current Year Purchases	115,481	10,200	10,200		8--12	10,200	72
73	Fully Depreciated Assets							73
74	Rental van	(28,000)					(1,200)	74
75	TOTALS	\$ 2,134,210	\$ 157,176	\$ 157,176	\$		\$ 1,108,518	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1996 Dodge Van	1996	\$ 21,621	\$	\$	\$		\$ 21,621	76
77	Machinery			8,720					8,720	77
78	Patient Transportation	Chevy Ex Pas Van	2010	24,149	3,450	3,450		7	14,662	78
79	Patient Transportation	2009 Dodge Braun	2011	32,500	4,643	4,643			16,250	79
80	TOTALS			\$ 86,990	\$ 8,093	\$ 8,093	\$		\$ 61,253	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)	\$ 19,139,667	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 577,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 577,578	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,881,964	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Apostolic Christian Restmor

# 0047167

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 50,559 Description: Several copiers and patient care bus

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2014 Ending: 12/31/2014  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 40,175	\$		\$ 40,175	1
2	Licensed Speech and Language Development Therapist		hrs				69,379			69,379	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				65,579			65,579	4
5	Physician Care		visits				1,906			1,906	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts				0	125,891		125,891	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): <u>Lab</u>						23,196			23,196	12
13	Other (specify):										13
14	<b>TOTAL</b>			\$			\$ 200,235	\$ 125,891		\$ 326,126	14

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

Facility Name & ID Number Apostolic Christian Restmor# 0047167Report Period Beginning: 1/1/2014Ending: 12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(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	\$ 1,259,932	\$	1
2	Cash-Patient Deposits	5,499		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>52,830</u> )	691,663		3
4	Supply Inventory (priced at )	89,534		4
5	Short-Term Investments	2,183,872		5
6	Prepaid Insurance	70,248		6
7	Other Prepaid Expenses	22,952		7
8	Accounts Receivable (owners or related parties)	50,319		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,374,019	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	402,810		13
14	Buildings, at Historical Cost	15,081,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,221,199		16
17	Accumulated Depreciation (book methods)	(3,881,961)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,687,941		21
22	Other Long-Term Assets (specify):	856,711		22
23	Other(specify):	603,001		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 16,971,297	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 21,345,316	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 315,854	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,499		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	633,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	91,435		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Pension</u>	386,205		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,432,093	\$	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				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,432,093	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 19,913,223	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 21,345,316	\$	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>18,743,433</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>18,743,433</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,169,790	<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>1,169,790</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>19,913,223</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,871,323	1
2	Discounts and Allowances for all Levels	(785,844)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,085,479</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	843,750	6
7	Oxygen	60,945	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 904,695</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	48,527	13
14	Non-Patient Meals	39,652	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,753	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,170	19
20	Radiology and X-Ray		20
21	Other Medical Services	327,049	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 529,151</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	215,072	24
25	Interest and Other Investment Income***	16,506	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 231,578</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Page 24</u>	55,641	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 55,641</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 11,806,544</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,144,883	31
32	Health Care	5,264,831	32
33	General Administration	2,292,868	33
<b>B. Capital Expense</b>			
34	Ownership	577,576	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	67,618	35
36	Provider Participation Fee	288,978	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>\$ 10,636,754</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,169,790</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>\$ 1,169,790</b>	<b>43</b>

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	<b>49</b>

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

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

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

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

Facility Name & ID Number Apostolic Christian Restmor

# 0047167

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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	1,772	2,080	\$ 94,920	\$ 45.63	1
2	Assistant Director of Nursing	2,333	2,534	87,216	34.42	2
3	Registered Nurses	36,001	39,564	1,141,355	28.85	3
4	Licensed Practical Nurses	21,153	23,011	553,405	24.05	4
5	CNAs & Orderlies	121,481	131,575	1,854,025	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,103	4,515	79,862	17.69	8
9	Activity Director	1,243	1,333	19,721	14.79	9
10	Activity Assistants	13,812	14,436	178,262	12.35	10
11	Social Service Workers	5,507	6,079	117,531	19.33	11
12	Dietician	836	884	19,743	22.33	12
13	Food Service Supervisor	1,984	2,160	71,331	33.02	13
14	Head Cook	6,524	6,065	107,795	17.77	14
15	Cook Helpers/Assistants	39,728	43,333	428,941	9.90	15
16	Dishwashers					16
17	Maintenance Workers	8,480	9,436	195,797	20.75	17
18	Housekeepers	11,695	12,996	147,536	11.35	18
19	Laundry	7,584	8,564	98,690	11.52	19
20	Administrator	1,787	2,080	130,871	62.92	20
21	Assistant Administrator	1,920	2,220	114,614	51.63	21
22	Other Administrative	3,592	3,969	88,471	22.29	22
23	Office Manager					23
24	Clerical	10,442	11,458	245,415	21.42	24
25	Vocational Instruction					25
26	Academic Instruction	1,684	1,973	54,996	27.87	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	7,672	8,608	128,252	14.90	31
32	Other Health C: Dir Memory Supp	1,795	2,095	50,412	24.06	32
33	Other(specify) Vol Dir Hair Care	2,782	3,207	56,100	17.49	33
34	TOTAL (lines 1 - 33)	315,910	344,175	\$ 6,065,261 *	\$ 17.62	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	12,000	9--3	36	
37	Medical Records Consultant	40	2,938	10--3	37
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	40	\$ 14,938	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



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

1/1/2014

Ending:

12/31/2014**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. Leading Age
- (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--12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,354 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 288,978  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 16,933 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,706
- (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? Majority  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Review  
Firm Name: clifton larson
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE XVII PAGE 19  
LINE 28a

Social Activities Income	2297
Private Pay Laundry	2530
Finance Charges	1834
Gain of sale of equipment	100
Telephone Income	13
Sunshine Cart Income	139
Misc Income	17
POM Management Fee	36900
Misc Income	11811
	55641