



Facility Name & ID Number Apostolic Christian Restmor

# 0047167 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

**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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,223	29,230	2,096	34,549	8
9	SNF/PED					9
10	ICF	146	5,165		5,311	10
11	ICF/DD					11
12	SC		3,490		3,490	12
13	DD 16 OR LESS					13
14	TOTALS	3,369	37,885	2,096	43,350	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 92.79%

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve 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?** Y

**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 04/01/2008

**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 48 and days of care provided 2,096

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 & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

**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	696,823	26,094		722,917		722,917		722,917		1
2	Food Purchase		431,077		431,077	(16,086)	414,991	(38,524)	376,467		2
3	Housekeeping	160,425	44,147		204,572		204,572		204,572		3
4	Laundry	100,943	15,178		116,121		116,121	(2,895)	113,226		4
5	Heat and Other Utilities			213,306	213,306		213,306		213,306		5
6	Maintenance	203,212	73,882	306,068	583,162	(8,076)	575,086		575,086		6
7	Other (specify):*			22,450	22,450		22,450		22,450		7
8	<b>TOTAL General Services</b>	<b>1,161,403</b>	<b>590,378</b>	<b>541,824</b>	<b>2,293,605</b>	<b>(24,162)</b>	<b>2,269,443</b>	<b>(41,419)</b>	<b>2,228,024</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	4,305,400	258,598	2,673	4,566,671		4,566,671		4,566,671		10
10a	Therapy			402,028	402,028		402,028		402,028		10a
11	Activities	224,637	13,205		237,842		237,842	(63)	237,779		11
12	Social Services	208,315			208,315		208,315		208,315		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>4,738,352</b>	<b>271,803</b>	<b>415,701</b>	<b>5,425,856</b>		<b>5,425,856</b>	<b>(63)</b>	<b>5,425,793</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	278,485			278,485		278,485	(38,100)	240,385		17
18	Directors Fees										18
19	Professional Services			40,792	40,792		40,792	(1,692)	39,100		19
20	Dues, Fees, Subscriptions & Promotions			65,727	65,727	3,980	69,707	(24,341)	45,366		20
21	Clerical & General Office Expenses	328,088	23,588	143,559	495,235	(36,385)	458,850	(3,421)	455,429		21
22	Employee Benefits & Payroll Taxes			1,447,260	1,447,260	16,086	1,463,346	(24,477)	1,438,869		22
23	Inservice Training & Education										23
24	Travel and Seminar			40,549	40,549	(3,118)	37,431	(5,121)	32,310		24
25	Other Admin. Staff Transportation			3,436	3,436	3,118	6,554	(1,554)	5,000		25
26	Insurance-Prop.Liab.Malpractice			100,602	100,602		100,602		100,602		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>606,573</b>	<b>23,588</b>	<b>1,841,925</b>	<b>2,472,086</b>	<b>(16,319)</b>	<b>2,455,767</b>	<b>(98,706)</b>	<b>2,357,061</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>6,506,328</b>	<b>885,769</b>	<b>2,799,450</b>	<b>10,191,547</b>	<b>(40,481)</b>	<b>10,151,066</b>	<b>(140,188)</b>	<b>10,010,878</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Apostolic Christian Restmor

#0047167

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

## 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			648,540	648,540		648,540	(100)	648,440			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					44,461	44,461		44,461			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			648,540	648,540	44,461	693,001	(100)	692,901			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			148,237	148,237		148,237		148,237			39
40	Barber and Beauty Shops	28,084	4,299		32,383		32,383		32,383			40
41	Coffee and Gift Shops			655	655		655	(655)				41
42	Provider Participation Fee			296,766	296,766	(3,980)	292,786		292,786			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	28,084	4,299	445,658	478,041	(3,980)	474,061	(655)	473,406			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	6,534,412	890,068	3,893,648	11,318,128		11,318,128	(140,943)	11,177,185			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	
	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

BHF USE ONLY							
48		49		50		51	
							52

**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

Apostolic Christian Restmor

ID# 0047167

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Seminars	\$ (1,398)	24	1
2	Non Allowable Dues Subs	(5,451)	20	2
3	Promotions and Yellow Pages	(16,180)	20	3
4	Employee Meal Income	(12,927)	22	4
5	Guest Meal Income	(11,694)	2	5
6	Misc Expense	(2,791)	21	6
7	Misc Income	(517)	21	7
8	Auto Expense	(1,554)	25	8
9	Gain on Sale of Van	(100)	30	9
10	Legal Fees Non Allowable	(1,692)	19	10
11	Meals on Wheels Expense	(26,830)	2	11
12	Sunshine Cart Expense	(63)	11	12
13	POM Managemnet Fee	(38,100)	17	13
14	Travel Out of State	(3,723)	24	14
15	Penalties	(110)	20	15
16	Pension Interest Income	(6,572)	22	16
17	Misc	(655)	41	17
18	Private Pay Laundry	(2,895)	4	18
19	Contribution to Midwest Foof Bank	(2,600)	20	19
20	Excess Life Insurance	(4,978)	22	20
21	Finance Charges	(113)	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>	(140,943)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

## 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	(38,524)	0	0	0	0	0	0	0	0	0	0	(38,524)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,895)	0	0	0	0	0	0	0	0	0	0	(2,895)	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>(41,419)</b>	<b>0</b>	<b>(41,419)</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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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>(63)</b>	<b>0</b>	<b>(63)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	(38,100)	0	0	0	0	0	0	0	0	0	0	(38,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,692)	0	0	0	0	0	0	0	0	0	0	(1,692)	19
20	Fees, Subscriptions & Promotions	(24,341)	0	0	0	0	0	0	0	0	0	0	(24,341)	20
21	Clerical & General Office Expenses	(3,421)	0	0	0	0	0	0	0	0	0	0	(3,421)	21
22	Employee Benefits & Payroll Taxes	(24,477)	0	0	0	0	0	0	0	0	0	0	(24,477)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,121)	0	0	0	0	0	0	0	0	0	0	(5,121)	24
25	Other Admin. Staff Transportation	(1,554)	0	0	0	0	0	0	0	0	0	0	(1,554)	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>(98,706)</b>	<b>0</b>	<b>(98,706)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(140,188)</b>	<b>0</b>	<b>(140,188)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

## 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	(655)	0	0	0	0	0	0	0	0	0	0	(655)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(655)</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>(655)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(140,943)</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>(140,943)</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

**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	Joe Zimmerman, Pres	BOD						1
2	Gary Psinas, V Pres	BOD						2
3	Brian Bahr, Secretary/ Treas	BOD						3
4	John Dill, Asst Sec/Treas	BOD						4
5	Curt Tanner	BOD						5
6	John Knobloch	BOD						6
7	Nate Koch	BOD						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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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:

01/01/2017

Ending: 2/31/2017

**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 Restmor

# 0047167

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

**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		7	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**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 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 2017 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:	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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.**

**2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Apostolic Christian Restmor

# 0047167

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Stick Number of Stories \_\_\_\_\_

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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>	<u>849,420</u>		\$ <u>327,810</u>	<u>1</u>
2	<u>vacant land</u>	<u>435,600</u>		<u>75,000</u>	<u>2</u>
3	TOTALS	<u>1,285,020</u>		\$ <u>402,810</u>	<u>3</u>

**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	\$ 15,081,596	\$ 368,186	40	\$ 368,186	\$	\$ 3,667,286	4
5				2017	(850,000)		see SS1 attached			(198,333)	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Land Site preparation and grading		2008	395,786		40				9
10		Remote unattached storage building		2008	207,121	5,178	20	5,178		50,486	10
11		Road and parking area		2008	194,661	9,733	20	9,733		94,897	11
12		Brick Edging and Landscaping		2008	10,923	546	15	546		5,236	12
13		New Sidewalk		2009	8,245	550	20	550		4,583	13
14		Concrete drainage ways for stormwater		2009	10,656	533	15	533		4,352	14
15		Additional Heat Pump for Spa area		2009	7,020	468	15	468		4,056	15
16		Additional Lighting		2009	9,232	615	15	615		5,330	16
17		New Ventilators in Spa area		2009	6,791	453	15	453		3,896	17
18		Additional Smoke Devices		2009	2,667	178	15	178		1,572	18
19		Additional Door Holders		2009	2,758	184	20	184		1,533	19
20		Courtyard concrete finish		2010	11,808	590	37	590		4,573	20
21		Re keying all doors		2010	9,980	270	37	270		2,070	21
22		Smokedoors		2010	10,570	286	37	286		2,169	22
23		New Trees		2010	5,000	135	36	135		979	23
24		New Trees		2011	3,900	108	12	108		684	24
25		Linoleum in laundry room		2011	7,667	639	12	639		4,366	25
26		Paneling in patient rooms		2011	9,550	796	35	796		5,240	26
27		Geo Thermal Retrocommissioning		2012	357,300	10,209	35	10,209		59,552	27
28		Enclose Porches in resident living rooms		2012	25,892	740	35	740		3,823	28
29		Lighting Upgrade on exterior doors		2012	3,402	97	35	97		493	29
30		Air Filters		2013	3,000	86	35	86		423	30
31		Air Conditioning Reconfiguration		2013	48,300	1,380	35	1,380		6,210	31
32		Automatic Doors for four outside entrances		2013	23,651	676	35	676		3,101	32
33		Kick Resistant Panel		2013	5,630	161	34	161		724	33
34		Heat Pump		2014	5,418	159	34	159		610	34
35		LED Outside Lighting		2014	10,113	297	34	297		1,114	35
36		Paneling in patient rooms		2014	10,000	294	34	294		1,078	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	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/C Reconfiguration	2014	\$ 8,120	\$ 239	34	\$ 239	\$	\$ 777	37
38	Revise electrical outlets	2014	18,900	556	34	556		1,714	38
39	Hearing Loop	2015	6,985	218	32	218		636	39
40	ID Card System	2015	6,665	208	32	208		590	40
41	Paneling Rm 532, 605, 607, 614, 712, 204, 211, 312,406, 410, 412	2015	7,118	222	32	222		574	41
42	Water Softener	2015	20,000	625	32	625		1,510	42
43	Bathroom Flooring	2015	8,801	275	32	275		642	43
44	Paneling Rm 514, 528, 718, 720, 711, 528, Haircare area	2016	6,955	224	31	224		336	44
45	Nurse Call Addition	2016	5,770	186	31	186		233	45
46	Building addition which connects Pine and Spruce wings together	2017	1,206,374	38,915	31	38,915		38,915	46
47	Panelam Rm 304 ,311 ,323 ,418 ,520 ,713 ,714 ,604	2017	6,975	194	30	194		194	47
48	Vinyl Flooring Rm 222, 303, 409, 607, 608, 612, 713, 719, 925, 928	2017	10,073	224	30	224		224	48
49	New Roof Entire Building	2017	936,561	13,008	30	13,008		13,008	49
50	Replace Concrete in Employee and Visitor Parking Lots	2017	612,479	5,104	30	5,104		5,104	50
51	Electronic Door for Employee Corridor	2017	4,308	24	30	24		24	51
52	River Rock placed around building edge	2017	10,300	29	30	29		29	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>		\$ 18,515,021	\$ 463,798		\$ 463,798	\$	\$ 3,806,613	70

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

Facility Name & ID Number Apostolic Christian Restmor

# 0047167

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 2,305,941	\$ 162,863	\$ 162,863	\$	4-15	\$ 1,584,328	71
72	Current Year Purchases	169,917	11,026	11,026			11,026	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,475,858	\$ 173,889	\$ 173,889	\$		\$ 1,595,354	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	2017 Dodge Grand Caravan	2017	\$ 38,037	\$ 3,623	\$ 3,623	\$	7	\$ 3,623	76
77	Machinery			8,720					8,720	77
78	Patient Transportation	Chevy Express Passenger Van	2010	24,149	2,587	2,587			24,149	78
79	Patient Transportation	2009 Dodge Braun	2011	32,500	4,643	4,643			30,179	79
80	TOTALS			\$ 103,406	\$ 10,853	\$ 10,853	\$		\$ 66,671	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)	\$ 21,497,095	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 648,540	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 648,540	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)	\$ 5,468,638	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: 01/01/2017

Ending: 12/31/2017

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 36,385

Description: Copiers

(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	<u>Resident Transportation</u>	<u>Ford Elkhart</u>	\$ <u>673.00</u>	\$ <u>8,076</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>673.00</b>	\$ <b>8,076</b>	21

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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			
		1	2	3	4
		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	\$		\$ 35,904	\$		\$ 35,904	1
2	Licensed Speech and Language Development Therapist		hrs			36,245			36,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			58,651			58,651	4
5	Physician Care		visits			3,114			3,114	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				129,831		129,831	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab/Xray</u>						15,292		15,292	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$ 133,914	\$ 145,123		\$ 279,037	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: 01/01/2017Ending: 12/31/2017

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,183,156	\$	1
2	Cash-Patient Deposits	4,235		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>52,830</u> )	562,035		3
4	Supply Inventory (priced at )	92,681		4
5	Short-Term Investments	2,717,151		5
6	Prepaid Insurance	54,648		6
7	Other Prepaid Expenses	36,699		7
8	Accounts Receivable (owners or related parties)	33,628		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,684,233	\$	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	14,231,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,579,263		16
17	Accumulated Depreciation (book methods)	(5,468,633)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,083,541		21
22	Other Long-Term Assets (spe <u>Land Improvements</u> )	856,711		22
23	Other(specify): <u>Building Improvements</u>	3,452,365		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 19,137,653	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 23,821,886	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 95,925	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,235		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	687,528		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,958		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>Insurance Payable</u>	153,232		36
37	<u>Accrued Pension</u>	411,252		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,391,130	\$	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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,391,130	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 22,430,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 23,821,886	\$	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>21,213,136</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>21,213,136</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,217,620</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>1,217,620</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>22,430,756</b>	<b>24</b> *

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

Facility Name & ID Number **Apostolic Christian Restmor**# **0047167**Report Period Beginning: **01/01/2017**Ending: **12/31/2017****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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,658,800	1
2	Discounts and Allowances for all Levels	(757,734)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,901,066	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	638,641	6
7	Oxygen	64,337	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 702,978	8
<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	48,233	13
14	Non-Patient Meals	53,420	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	100,007	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,862	19
20	Radiology and X-Ray		20
21	Other Medical Services	223,997	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 442,519	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	122,162	24
25	Interest and Other Investment Income***	16,296	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 138,458	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Page SS2</u>	350,727	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 350,727	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,535,748	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,293,605	31
32	Health Care	5,425,856	32
33	General Administration	2,472,086	33
<b>B. Capital Expense</b>			
34	Ownership	648,540	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	181,275	35
36	Provider Participation Fee	296,766	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,318,128	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,217,620	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,217,620	43

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>	\$	49

\* 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: 01/01/2017

Ending: 12/31/2017

**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	1,808	1,995	\$ 91,072	\$ 45.65	1
2	Assistant Director of Nursing	2,325	2,480	91,246	36.79	2
3	Registered Nurses	39,392	42,548	1,355,625	31.86	3
4	Licensed Practical Nurses	18,926	20,913	514,456	24.60	4
5	CNAs & Orderlies	128,269	137,623	1,965,476	14.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,042	1,136	24,257	21.35	8
9	Activity Director	2,214	2,342	40,371	17.24	9
10	Activity Assistants	15,669	16,837	184,266	10.94	10
11	Social Service Workers	5,292	5,918	127,645	21.57	11
12	Dietician	1,109	1,241	28,556	23.01	12
13	Food Service Supervisor	1,912	2,140	77,971	36.44	13
14	Head Cook	5,912	7,798	122,788	15.75	14
15	Cook Helpers/Assistants	38,407	40,013	467,508	11.68	15
16	Dishwashers					16
17	Maintenance Workers	8,339	9,132	203,212	22.25	17
18	Housekeepers	12,668	13,981	160,425	11.47	18
19	Laundry	7,967	9,205	100,943	10.97	19
20	Administrator	1,870	2,080	132,600	63.75	20
21	Assistant Administrator	2,796	3,196	145,885	45.65	21
22	Other Administrative	3,356	3,599	80,670	22.41	22
23	Office Manager					23
24	Clerical	10,566	11,625	303,906	26.14	24
25	Vocational Instruction					25
26	Academic Instruction	1,866	2,119	61,608	29.07	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	7,203	8,178	137,084	16.76	31
32	Other Health C: Dir Memory Care	1,996	2,287	64,576	28.24	32
33	Other(specify) Hair Car/ Vol Dir	2,696	3,104	52,266	16.84	33
34	TOTAL (lines 1 - 33)	323,600	351,490	\$ 6,534,412 *	\$ 18.59	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	44	11,000	9--3	36
37	Medical Records Consultant	34	2,494	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)	78	\$ 13,494		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. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
John Kelley	Administrator		\$ 85,472	Workers' Compensation Insurance	\$ 105,056	IDPH License Fee	\$ 3,980	
Michael Kaiser	Administrator & CFO		124,763	Unemployment Compensation Insurance	21	Advertising: Employee Recruitment	17,857	
Jeremiah Psinas	COO		68,250	FICA Taxes	479,204	Health Care Worker Background Check	924	
				Employee Health Insurance	404,580	(Indicate # of checks performed )		
				Employee Meals	3,159	Patient Background Checks	69	
				Illinois Municipal Retirement Fund (IMRF)*		Leading Age Assn Dues	12,078	
				403-B Contributions	398,237	IL Aging Svc Network	9,174	
				Disability	3,705	Tazewell Cty Health Permit	350	
				Employee Relations	10,081	ACA PCORI Fee	242	
				Uniform Rental	8,739	Other Dues	16,251	
				Employee Hiring/Training Costs	11,898	Less: Public Relations Expense	(16,180)	
				Tuition Reimbursement	14,189	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 278,485	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)					\$ 1,438,869		\$ 45,366	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	7,426
							Seminar Expense	5,551
							Relias Learning	15,745
							Annual convention	3,588
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 32,310
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
Clifton Larsen Allen	Accounting/Auditing		24,300					
Benckendorf & Benckendorf	Legal		1,377					
Polsinelli shughart PC	Legal		315					
Duane Morris LLP	Legal		3,729					
FGMK	Accounting/Auditing		4,007					
Marcum LLP	Healthcare Consultation		643					
Principal Financial Group	Pension Administration		3,350					
Heinold Banwart Ltd	Accounting/Auditing		2,000					
Personnel Planners	U/C managemnet		1,071					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 40,792					
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Apostolic Christian Restmor# 0047167Report Period Beginning: 01/01/2017Ending: 12/31/2017**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?  
If YES, give association name and amount. Leading Age \$21,252
- (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? 7--15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,050 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. \$ 292,786  
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. \$ 16,086 Has any meal income been offset against related costs? Y Indicate the amount. \$ 12,927
- (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? Travel is only for e  
d. Have vehicle usage logs been maintained? Used exclusively for patients  
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? N/A  
g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm?  
Firm Name: Review by CLA
- (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. Yes  
Attach invoices and a summary of services for all architect and appraisal fees

## SS1

A hail storm completely ruined the roof of the facility. The insurance company totaled the roof, and paid for a new one. According to our Independent Accountants, Clifton, Larsen Allen, we had to have the estimated value of the roof on the building, which was estimated at \$850,000 be removed from the cost of the original building as an involuntary conversion in order to comply with their understanding of GAAP. The associated accumulated depreciation on the condemned portion of the building that was removed was \$198,333. The new roof is shown as a building improvement on page 12A.

**SS2**

APOSTOLIC CHRISTIAN RESTMOR

#23952

12/31/2017

SCHEDULE XVII PAGE 19

LINE 28a

Social Activities Income	2586
Private Pay Laundry	2895
Personal Supplies Income	9
Finance Charge	113
Sunshine Cart Income	63
Misc Income	17
Parkside Management Fee Income	38100
Gain On Sale of Van	100
Insurance Reimbursements For Roof	306344
Misc Income	500
	350727

**SS3**

## Legal Fees

Date	Name	Description	Payment	Allowable	Non Allowable
May-17	Benckendorf	By-Laws work	1281		1281
17-Sep	Polsinelli	Medicare consultation	315		315
17-Nov	Benckendorf	Annual Report	96		96

## Travel and Seminar

Jul-17	Relias Learning	Online Continuing Ed required	15745	15745	
17-Apr	Leading Age	Annual Convention	3588	3588	
	Various	Sundry other seminars	5551	5551	
		Out of State	1398	0	1398
				24884	