

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0029892</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Apostolic Christian Resthaven</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>2750 W. Highland Avenue</u> <u>Elgin</u> <u>60124-4202</u>																																																			
Number City Zip Code																																																			
County: <u>Kane</u>																																																			
Telephone Number: <u>(847) 741-4543</u> Fax # <u>(847) 760-6224</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>11/07/1985</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other _____				
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In the event there are further questions about this report, please contact:																																																			
Name: <u>David Stieglitz, Administrator</u>																																																			
Telephone Number: <u>(847) 741-4543</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="6">Paid Preparer</td><td>(Type or Print Name) <u>David G. Stieglitz</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Signed) <u>An Independent Accountants' Compilation Report Is Attached.</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Matthew J. Schambach</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>Borhart Spellmeyer & Company, LLC</u> <u>1752 Capital Street, Suite 400, Elgin, IL 60124</u></td></tr><tr><td>(Telephone) <u>(847) 695-1775</u> Fax # <u>(847) 695-1984</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>David G. Stieglitz</u>	(Title) <u>Administrator</u>	(Signed) <u>An Independent Accountants' Compilation Report Is Attached.</u>	(Date) _____	(Print Name and Title) <u>Matthew J. Schambach</u> <u>CPA</u>	(Firm Name & Address) <u>Borhart Spellmeyer & Company, LLC</u> <u>1752 Capital Street, Suite 400, Elgin, IL 60124</u>	(Telephone) <u>(847) 695-1775</u> Fax # <u>(847) 695-1984</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		Phone # (217) 782-1630																																		
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven

0029892 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,301</u>	<u>3,248</u>		<u>4,549</u>	8
9	SNF/PED					9
10	ICF	<u>1,852</u>	<u>10,439</u>		<u>12,291</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,153</u>	<u>13,687</u>		<u>16,840</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.27%

D. How many bed-hold days during this year were paid by the Department?
8 (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 and housekeeping for apartment residents

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 11/07/1985

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS
ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: December 31 Fiscal Year: December 31

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

Facility Name & ID Number Apostolic Christian Resthaven # 0029892 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	223,553	12,842	4,711	241,106	(3,074)	238,032	(12,655)	225,377			1
2	Food Purchase		101,583		101,583	(1,399)	100,184	(5,758)	94,426			2
3	Housekeeping	56,352	11,647		67,999	395	68,394		68,394			3
4	Laundry	34,204	5,720		39,924		39,924		39,924			4
5	Heat and Other Utilities			69,076	69,076		69,076		69,076			5
6	Maintenance	92,625	6,838	54,016	153,479		153,479		153,479			6
7	Other (specify):* Waste Removal			6,549	6,549		6,549		6,549			7
8	TOTAL General Services	406,734	138,630	134,352	679,716	(4,078)	675,638	(18,413)	657,225			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	1,361,124	59,328	4,584	1,425,036		1,425,036		1,425,036			10
10a	Therapy		377	666	1,043		1,043		1,043			10a
11	Activities	58,726	8,006	832	67,564		67,564	(37)	67,527			11
12	Social Services	36,519	1,362	2,104	39,985		39,985		39,985			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,456,369	69,073	10,186	1,535,628		1,535,628	(37)	1,535,591			16
	C. General Administration											
17	Administrative	97,484			97,484		97,484		97,484			17
18	Directors Fees											18
19	Professional Services			25,571	25,571	(395)	25,176	(2,783)	22,393			19
20	Dues, Fees, Subscriptions & Promotions			11,970	11,970	50	12,020	(2,193)	9,827			20
21	Clerical & General Office Expenses	72,541	9,399	5,015	86,955		86,955		86,955			21
22	Employee Benefits & Payroll Taxes			442,230	442,230	4,473	446,703		446,703			22
23	Inservice Training & Education			250	250		250		250			23
24	Travel and Seminar			26,112	26,112	(50)	26,062	(3,129)	22,933			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			35,950	35,950		35,950		35,950			26
27	Other (specify):* Misc Exp & Vol Exp			300	300	(1)	299	(299)				27
28	TOTAL General Administration	170,025	9,399	547,398	726,822	4,077	730,899	(8,404)	722,495			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,033,128	217,102	691,936	2,942,166	(1)	2,942,165	(26,854)	2,915,311			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			164,076	164,076		164,076	(35,958)	128,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1	1	(1)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			164,076	164,076	1	164,077	(35,959)	128,118			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,098	66,398	103,496		103,496		103,496			39
40	Barber and Beauty Shops		98		98		98		98			40
41	Coffee and Gift Shops		959		959		959	(959)				41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):* Apt/MPR/Loss		75	97,512	97,587		97,587	(97,587)				43
44	TOTAL Special Cost Centers		38,230	191,285	229,515		229,515	(98,546)	130,969			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,033,128	255,332	1,047,297	3,335,757		3,335,757	(161,359)	3,174,398			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,758)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,910)	19		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(493)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	11		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(35,465)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(280)	20		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	(873)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,913)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(114,630)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,359)		\$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (161,359)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0029892

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Apartment Expense	\$ (86,716)	43	1
2	Non-Care Travel Expense	(299)	24	2
3	Vending Expense	(959)	41	3
4	Non-Patient Meals (Wage-Related Costs)	(12,655)	1	4
5	Multipurpose Room Expense	(75)	43	5
6	Volunteer Expense	(299)	27	6
7	Rent on Land Paid to Related Party	(1)	34	7
8	Out-of-State Travel	(2,830)	24	8
9	Unrealized Loss / Marketable Securities Adjustment	(10,796)	43	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
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26				26
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(114,630)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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
Apostolic Christian Church of Elgin	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	27/34	Land Lease	\$ 1	Apostolic Christian Church of Elgin	100.00%	\$ 1	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1			\$ 1	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Resthaven # 0029892 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 2010 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 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Apostolic Christian Resthaven</u>	COUNTY	<u>Kane</u>
---------------	--------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0029892

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 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 24,100

B. General Construction Type: Exterior 80% Brick/20% Cedar Frame Steel Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Eighteen (18) congregate housing units (apartments) are attached to the nursing home. Utilities are separately metered and costs are handled separately.

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

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		1985	1985	\$ 2,012,999	\$ 50,325	40	\$ 50,325	\$	\$ 1,324,872	4
5			1986	1986	10,064	252	40	252		6,420	5
6			1987	1987	67,246	1,681	40	1,681		41,186	6
7	1		1988	1988	91,817	2,295	40	2,295		53,937	7
8			1999	1999	74,929	1,873	40	1,380	(493)	18,328	8
	Improvement Type**										
9	Land Improvements - General Land Improvement:			1985	24,667		15			24,667	9
10	Land Improvements - General Land Improvement:			1986	4,800		15			4,800	10
11	Land Improvements - General Land Improvement:			1989	2,069		15			2,069	11
12	Land Improvements - General Land Improvement:			1990	590		15			590	12
13	Land Improvements - Court Yard			1992	13,298		15			13,298	13
14	Land Improvements - Front Court Yard			1997	15,126	1,008	15	1,008		14,536	14
15	Land Improvements - Black Topping			1997	16,291	1,086	15	1,086		15,567	15
16	Land Improvements - Parking Lot			2001	5,200	347	15	347		3,554	16
17	Land Improvements - Sidewalk to Parking Lot			2005	5,315	354	15	354		2,274	17
18	Land Improvements - Timber Landscap			2009	4,100	410	10	410		957	18
19	Land Improvements - Retaining Walls			2009	7,300	365	20	365		821	19
20	Land Improvements - Landscaping & Court Yarc			2010	1,800	180	10	180		255	20
21	Land Improvements - Storm Water Structure & Piping for Downspout:			2010	12,477	499	25	499		707	21
22	Land Improvements - Concrete Patio Outside New Activity Room:			2011	2,025	90	15	90		90	22
23	Land Improvements - Fencing Around New Activity Room Patio			2011	3,018	189	8	189		189	23
24	Land Improvements - Landscaping Around New Activity Room Patio			2011	4,560	228	10	228		228	24
25	Building Improvements - General Building Improvement:			1987	8,669		20			8,669	25
26	Building Improvements - General Building Improvement:			1988	28,461		20			28,461	26
27	Building Improvements - General Building Improvement:			1989	500		20			500	27
28	Building Improvements - General Building Improvement:			1990	6,091	12	20	12		6,091	28
29	Building Improvements - General Building Improvement:			1991	6,846	271	20	271		6,846	29
30	Building Improvements - Air Conditioner			1992	13,749	688	20	688		13,401	30
31	Building Improvements - Light Fixtures			1992	1,331	67	20	67		1,301	31
32	Building Improvements - RPZ Plumbing Valve			1994	885	44	20	44		768	32
33	Building Improvements - Curtains			1995	1,944		10			1,944	33
34	Building Improvements - Carpeting Music Room			1995	1,332		10			1,332	34
35	Building Improvements - Drapes			1995	2,989		10			2,989	35
36	Building Improvements - Carpet on Walls			1995	6,262		10			6,262	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	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 Building Improvements - Wallpaper	1995	\$ 3,703	\$	10	\$	\$	\$ 3,703	37
38 Building Improvements - Drapes	1995	884		10			884	38
39 Building Improvements - Carpeting Office	1995	1,344		10			1,344	39
40 Building Improvements - Wallpaper and Drapes	1996	540		10			540	40
41 Building Improvements - Drapes in Lobby	1996	594		10			594	41
42 Building Improvements - Carpeting Lobby	1996	5,853		10			5,853	42
43 Building Improvements - Sound System Lobby	1996	809	40	20	40		631	43
44 Building Improvements - Code Alert	1997	1,164		10			1,164	44
45 Building Improvements - Patio Door	1998	2,100	105	20	105		1,444	45
46 Building Improvements - Automatic Door	1998	2,029	101	20	101		1,376	46
47 Building Improvements - Carpeting Music Room	1998	2,671		10			2,671	47
48 Building Improvements - Kitchen Air Conditioner	1999	9,367	468	20	468		5,986	48
49 Building Improvements - Cabinets	1999	699	35	20	35		445	49
50 Building Improvements - Carpeting 2 Offices	1999	1,325	66	20	66		844	50
51 Building Improvements - Dining Room Blinds	1999	656	33	20	33		400	51
52 Building Improvements - Garbage Disposal	2000	1,975	99	20	99		1,145	52
53 Building Improvements - Faucets	2001	2,372	119	20	119		1,264	53
54 Building Improvements - Grease Trap	2001	3,769	188	20	188		2,010	54
55 Building Improvements - Door Shades	2001	562	28	20	28		290	55
56 Building Improvements - Damper	2001	710	36	20	36		361	56
57 Building Improvements - Door for PT Room	2001	600	30	20	30		303	57
58 Building Improvements - Drapes for Employee Dining Room	2002	653	33	20	33		321	58
59 Building Improvements - Drapes for Residents Rooms	2002	1,307	65	20	65		637	59
60 Building Improvements - Electromagnetic Front Doors	2003	1,717	86	20	86		766	60
61 Building Improvements - Air Conditioning	2003	3,100	155	20	155		1,305	61
62 Building Improvements - Fire Dampers	2003	2,160	108	20	108		882	62
63 Building Improvements - Steam Table Restoration	2004	3,700	185	20	185		1,465	63
64 Building Improvements - Hot Water Coil Replacement	2004	3,408	170	20	170		1,335	64
65 Building Improvements - Activity Room Shelving	2004	1,850	93	20	93		725	65
66 Building Improvements - Exit Door Alarms at Service Entrance	2004	994	50	20	50		373	66
67 Building Improvements - Smoke Detectors with Office Window	2004	953	48	20	48		345	67
68 Building Improvements - Hot Water Heaters	2005	8,650	433	20	433		2,991	68
69 Building Improvements - Fire Doors and Wiring	2005	3,230	162	20	162		1,023	69
70 TOTAL (lines 4 thru 69)		\$ 2,534,198	\$ 65,200		\$ 64,707	\$ (493)	\$ 1,653,329	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,534,198	\$ 65,200		\$ 64,707	\$ (493)	\$ 1,653,329	1
2	Building Improvements - 3 Wings Security Door Systems	2005	6,600	330	20	330		2,035	2
3	Building Improvements - Duct Detectors	2005	1,167	58	20	58		355	3
4	Building Improvements - Smoke Dampers	2005	4,607	230	20	230		1,401	4
5	Building Improvements - Smoke Detectors	2005	5,159	258	20	258		1,548	5
6	Building Improvements - Replace Windows & Labor	2005	28,966	724	40	724		4,817	6
7	Building Improvements - Replace Windows & Labor	2006	24,955	624	40	624		3,327	7
8	Building Improvements - RN Station Cabinets and Counters	2006	12,127	808	15	808		4,514	8
9	Building Improvements - A/C Condenser for Kitchen	2006	2,800	187	15	187		1,027	9
10	Building Improvements - RN Station Carpeting	2006	3,700	555	5	555		3,700	10
11	Building Improvements - Elevator Motor	2008	3,846	192	20	192		657	11
12	Building Improvements - Generator	2008	2,511	502	5	502		1,548	12
13	Building Improvements - RN Station Cabinets	2009	7,350	490	15	490		1,388	13
14	Building Improvements - Wood Room Doors	2009	8,669	578	15	578		1,589	14
15	Building Improvements - Elevator Pump Motor & Soft Start	2010	5,399	270	20	270		495	15
16	Building Improvements - New Tub for Residents	2010	14,963	748	20	748		1,372	16
17	Building Improvements - Upgrade Ansul System & Rewire Hood	2010	5,669	567	10	567		709	17
18	Building Improvements - Relocate 5 & Furnish 5 A/C Condensing	2010	36,336	2,422	15	2,422		3,028	18
19	Building Improvements - Drapes / Coverings for Resident Rooms	2010	2,532	506	5	506		548	19
20	Building Improvements - Drapes / Coverings for Resident Rooms	2011	3,129	574	5	574		574	20
21	Building Improvements - New Activity Room Sound System	2011	15,382	1,025	10	1,025		1,025	21
22	Building Improvements - New Activity Room Vinyl Flooring	2011	18,937	1,263	10	1,263		1,263	22
23	Building Improvements - New Activity Room Blinds & Window C	2011	4,581	611	5	611		611	23
24	Building Improvements - Internal Sewer Line Replacement	2011	9,611	240	20	240		240	24
25	Building Improvements - Kitchen A/C Replace Condenser Coil	2011	10,665	237	15	237		237	25
26	Building Improvements - Fire Protection System	2011	113,422	3,025	25	3,025		3,025	26
27	Building Improvements - New Activity Room Shell Construction	2011	161,499	2,692	40	2,692		2,692	27
28	Building Improvements - New Activity Room Carpentry & Millwo	2011	120,857	5,371	15	5,371		5,371	28
29	Building Improvements - New Activity Room Aluminum Doors	2011	7,070	236	20	236		236	29
30	Building Improvements - New Activity Room Plumbing & Radian	2011	14,299	636	15	636		636	30
31	Building Improvements - New Activity Room Roofing	2011	8,398	560	10	560		560	31
32	Building Improvements - New Activity Room Electrical System	2011	62,500	2,315	18	2,315		2,315	32
33	Building Improvements - New Activity Room Painting	2011	12,723	1,696	5	1,696		1,696	33
34	TOTAL (lines 1 thru 33)		\$ 3,274,627	\$ 95,730		\$ 95,237	\$ (493)	\$ 1,707,868	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Apostolic Christian Resthaven

0029892

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	
1	Totals from Page 12B, Carried Forward		\$ 3,274,627	\$ 95,730		\$ 95,237	\$ (493)	\$ 1,707,868	1
2	Building Improvements - New Activity Room Accordion Door	2011	5,892	393	10	393		393	2
3	Building Improvements - New Activity Room HVAC System	2011	42,670	1,896	15	1,896		1,896	3
4	Building Improvements - New Activity Room Cabinets	2011	30,808	1,369	15	1,369		1,369	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
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18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,353,997	\$ 99,388		\$ 98,895	\$ (493)	\$ 1,711,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 165,785	\$ 17,071	\$ 17,071	\$	5/10/12/15/20	\$ 99,698	71
72	Current Year Purchases	62,295	6,737	6,737		/10/12/15/18/20	6,737	72
73	Fully Depreciated Assets	293,481	1,782	1,782		3/5/10	293,481	73
74								74
75	TOTALS	\$ 521,561	\$ 25,590	\$ 25,590	\$		\$ 399,916	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	Van - Care Related Use	2006 Ford E-350 Van	2006	\$ 36,327	\$ 3,633	\$ 3,633	\$	10	\$ 20,585
77									
78									
79									
80	TOTALS			\$ 36,327	\$ 3,633	\$ 3,633	\$		\$ 20,585

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 3,911,885
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 128,611
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 128,118
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (493)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 2,132,027

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments-1986/1991/1999/06/09	\$ 976,558	\$ 24,414	\$ 531,283	86
87	Land Improvements-86/90/91/97	94,036	2,646	85,266	87
88	Equipment-1986-1999/2006/2009	53,036	1,381	44,960	88
89	Building Improvements-99-03/06-11	87,131	5,467	23,279	89
90	Van-30% Non-Care Related-2006	15,569	1,557	8,822	90
91	TOTALS	\$ 1,226,330	\$ 35,465	\$ 693,610	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2012	\$ _____
13.	_____/2013	\$ _____
14.	_____/2014	\$ _____

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-2	visits				3,992		3,992	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescrpts		5,154	66,398	2,027	5,154	68,425	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Personal Supplies</u>	39-2					31,079		31,079	13
14	TOTAL			\$	5,154	\$ 66,398	\$ 37,098	5,154	\$ 103,496	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 573,099	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,412)	195,937		3
4	Supply Inventory (priced at cost)	16,526		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 785,562	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	109,572		12
13	Land			13
14	Buildings, at Historical Cost	4,511,722		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	626,493		16
17	Accumulated Depreciation (book methods)	(2,830,567)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	150,000		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Capital in Insurance Groups	110,280		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,677,500	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,463,062	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 276,451	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,107		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,670		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,179		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 409,407	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 409,407	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,053,655	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,463,062	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,882,939	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,882,939	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	170,716	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 170,716	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,053,655	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,093,921	1
2	Discounts and Allowances for all Levels	(134,516)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,959,405	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,811	14
15	Telephone, Television and Radio	33	15
16	Rental of Facility Space		16
17	Sale of Drugs	77,721	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 80,565	23
	D. Non-Operating Revenue		
24	Contributions	260,205	24
25	Interest and Other Investment Income***	9,115	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 269,320	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenues	197,183	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 197,183	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,506,473	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	679,716	31
32	Health Care	1,535,628	32
33	General Administration	726,822	33
	B. Capital Expense		
34	Ownership	164,076	34
	C. Ancillary Expense		
35	Special Cost Centers	202,140	35
36	Provider Participation Fee	27,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,335,757	40
41	Income before Income Taxes (line 30 minus line 40)**	170,716	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 170,716	43

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

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

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

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

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	1,622	1,872	\$ 63,312	\$ 33.82	1
2	Assistant Director of Nursing	1,880	2,080	63,391	30.48	2
3	Registered Nurses	15,156	16,512	455,702	27.60	3
4	Licensed Practical Nurses	5,448	6,021	140,588	23.35	4
5	CNAs & Orderlies	47,647	50,749	596,535	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,952	2,088	26,435	12.66	8
9	Activity Director	1,977	2,080	29,443	14.16	9
10	Activity Assistants	2,482	2,661	29,283	11.00	10
11	Social Service Workers	1,947	2,090	36,519	17.47	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,080	36,448	17.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,290	16,694	174,450	10.45	15
16	Dishwashers					16
17	Maintenance Workers	3,695	4,160	92,625	22.27	17
18	Housekeepers	6,178	6,706	56,352	8.40	18
19	Laundry	2,733	2,947	34,204	11.61	19
20	Administrator	1,886	2,080	97,484	46.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,710	3,040	57,538	18.93	23
24	Clerical	1,245	1,364	15,003	11.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Nursing Secretary	1,110	1,274	15,161	11.90	33
34	TOTAL (lines 1 - 33)	116,951	126,498	\$ 2,020,473 *	\$ 15.97	34

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	97	\$ 4,711	1-3	35
36	Medical Director	2	2,000	9-3	36
37	Medical Records Consultant	12	842	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	77	3,042	10-3	39
40	Physical Therapy Consultant	10	666	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	832	11-3	44
45	Social Service Consultant	24	2,104	12-3	45
46	Other(specify) Dental Consultant	18	700	10-3	46
47	Housekeeping Consultant	36	395	3-5	47
48					48
49	TOTAL (lines 35 - 48)	292	\$ 15,292		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
David G. Stieglitz	Administrator	0	\$ 97,484	Workers' Compensation Insurance		\$ 44,927	IDPH License Fee	\$
				Unemployment Compensation Insurance		(297)	Advertising: Employee Recruitment	236
				FICA Taxes		154,031	Health Care Worker Background Check	50
				Employee Health Insurance		162,790	(Indicate # of checks performed 8)	
				Employee Meals		4,473	Patient Background Checks	21 200
				Illinois Municipal Retirement Fund (IMRF)*			Newsletter/Advertising	1,913
				Employee Life Insurance		1,108	Assn. Dues/City Busn. Lic./Bank Fees	7,977
				Employee Pension Expense		62,673	Anti-Virus Subscription/Publications	842
				Employee Health Services		3,561	Elev. Lic./Payroll Subscr./Sec. of State Fee	602
				Employee Relations		13,437	Bulk Mail Permit/Business License	200
							Less: Public Relations Expense	()
							Non-allowable advertising	(2,193)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)			\$ 97,484			\$ 446,703	\$ 9,827	
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	\$
							David Stieglitz, Adm. - Leading Age	(2,830)
							In-State Travel	
							Vehicle Expense	996
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense	25,066
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Borhart Spellmeyer & Company	CPA - Cost Report & 990		\$ 7,750					
Thomas D. Chase	Collections Attorney		873					
Polsinelli Shughart PC	Attorney		653					
American United Life	Document Prep Service		250					
Betty Harvel	Housekeeping Assistance		395					
MCC Technology	Network Support		4,650					
CDS Office Technology	Copier Support		996					
QuickBooks	Direct Deposit Service		2,728					
DirecTV	Satellite Television Service		1,910					
MDI Achieve/HGIS	Medical Records Software		3,946					
Information Controls	Time & Attendance Software		1,145					
Mihai Vlad	Open House Musician		275					
TOTAL (agree to Schedule V, line 19, column 3)							Less: Non-Care Vehicle Expense	(299)
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,571				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 22,933

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

****See instructions.**

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	Amount of Expense Amortized Per Year								
					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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Life Services Network - \$6,366

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,779 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 27,375
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,473 Has any meal income been offset against related costs? no Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 3, Schedule V, Line 7, Other

Expenses related to removal of general waste	\$ 6,549
--	----------

Page 3, Schedule V, Line 27, Other Expenses

Volunteer Expense	\$ 299
Land Rent Paid to Related Party	1

Column 4 Total	300
----------------	-----

Volunteer Expense on Page 5A, Non-Allowable Expenses	(299)
--	-------

RECLASSIFICATIONS:

Land Rent Paid to Related Party From Line 27 Col 5 to Line 34 Col 5	(1)
---	-----

Column 8, Adjusted Total	\$ -
--------------------------	------

Page 4, Schedule V, Line 43, Other Expenses

Apartment Expense	\$ 86,716
Unrealized Loss / Marketable Securities Adjustment	10,796
Multipurpose Room Expense	75

Column 4 Total	97,587
----------------	--------

Apartment Expense - Page 5A - Non-Allowable Expense	(86,716)
---	----------

Unrealized Loss - Page 5A - Non-Allowable Expense	(10,796)
---	----------

Multipurpose Room Expense - Page 5A - Non-Allowable Expense	(75)
---	------

Column 8, Adjusted Total	\$ -
--------------------------	------

Page 3, Schedule V, Column 5 Reclassifications

Reclassify Staff Meals From Line 1, Dietary Wages	\$ (3,074)
Reclassify Staff Meals From Line 2, Meal Costs	(1,399)
Reclassify Staff Meals To Line 22, Employee Benefits	4,473

Reclassify Payment Related To Land Rent From Line 27, Other	(1)
---	-----

Reclassify Payment Related To Land Rent to Line 34, Rent Facility & Grounds	1
---	---

Reclassify Employee Background Checks/Fingerprinting From Line 24, Travel & Seminar	(50)
---	------

Reclassify Employee Background Checks/Fingerprinting To Line 20, Dues, Fees, Subscriptic	50
--	----

Reclassify Housekeeping Assistance From Line 19, Professional Services	(395)
--	-------

Reclassify Housekeeping Assistance To Line 3, Housekeeping	395
--	-----

Net Effect Of All Reclassifications	\$ -
-------------------------------------	------

Page 19, Schedule XVII, Line 28, Other Revenues

Account		
8050	Apartment Income	\$ 193,679
8026	Miscellaneous Non-Operating	1,539
8023	Vending Income	956
6902	Activity Income	651
6911	Miscellaneous Operating	220
8020	Cookbook Sales	138
		\$ 197,183

Notes:

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

Page 20, Schedule XVIII, Line 34, Salary & Wage Reconciliation

Total Wages Reported on Page 20, Line 34	\$ 2,020,473
Dietary Wages Allocated to Non-Patient Meals, as per Adjustment on Page 5A	12,655
Total Salary / Wages Reported on Page 4, Column 1	\$ 2,033,128

Page 21, Schedule XIX, Section D, Pension Expense

Pension Costs For Owners and Related Parties	\$ -
Pension Costs For All Other Employees	62,673
	\$ 62,673

Note - 56 employees were covered under the pension plan for the year 2011.

Page 19, Schedule XVII, Line 25, Interest Income

Interest income was not offset against interest expense, as there was no interest expense incurred during 2011.

Attachment to Schedule XIII

Nurse assistants were not trained in Basic Nurse Assistant courses during the report period due to our policy to hire nursing assistants who are currently enrolled in a Basic Nurse Assistant Training program or are already listed on the Illinois Nurse Assistant Registry. Our facility had nine (9) nurse assistants leave employment during 2011 and all replacements met the above requirement.

Attachment to Schedule XX, General Information # 14

A portion of the building consists of 18 independent congregate living units. Costs are allocated to this portion of the building on the basis of square footage, exact costs (if able to be determined), and provider estimates of service costs.

Attachment to Schedule XX, General Information # 16a

From October 16, to October 21, 2011, David Stieglitz, Administrator, attended the annual meeting of Leading Age, formerly the American Association of Homes and Services for the Aging. The meeting was held in Washington, DC, and included topics on staff retention, new initiatives in long-term care, best practices, and culture change. The costs related to this out-of-state travel have been adjusted out of the cost report.

2011 Board of Directors and Officers:

Jeff Kellenberger, President	11N528 Muirhead Road, Elgin, IL 60124
Robert Schambach, Vice-President	251 Brookside Drive, Elgin, IL 60123
Eric Schieler, Treasurer	1403 Blume Drive, Elgin, IL 60124
Richard Kilgus, Secretary	775 Regency Park Drive, Crystal Lake, IL 60014
Don Heiniger	38W644 Arrowmaker Pass, Elgin, IL 60124
Boyd Metzger	1440 N. State Parkway, 17C, Chicago, IL 60610
Morris Young	8261 S. Mayfield Road, DeKalb, IL 60115

Board Vice-President Robert Schambach is the owner of Schambach Construction, Inc. In that capacity, he has served as the general contractor for Apostolic Christian Resthaven's recent construction project, the addition of activity and dining space completed during 2011.

Name	Title	Date	City	State	Seminar Title	Sponsor	Cost
Eileen Feuser Jean Jablonski Eileen Cowell	RN RN RN	2/2/2011	Crystal Lake	IL	The Aging Brain	Institute for Natural Resources	\$243
Virginia Scappino Sue Sneed	DON ADON	3/15 & 4/12/2011	Elgin	IL	Infection Control and Prevention	LSN	\$149
Barb Ternoir Merlita Mayhew Darlene Schuman	RN LPN LPN	4/5/2011	Elgin	IL	Anger, Forgiveness & the Healing Process	Institute for Brain Potential	\$222
Sue Sneed Karen Erickson Jan Mogler Gretchen Hagerman Tiffany Weiby	ADON RN RN RN LPN	3/23-3/25/2011	Chicago	IL	LSN Annual Convention Seminar - Hotel - Food	LSN	\$3,256
Eileen Feuser Jean Jablonski Eileen Cowell	RN RN RN	8/3/2011	Rockford	IL	Arthritis, Backache & Bone Disease	Institute for Natural Resources	\$237
Virginia Scappino	DON	7/20/2011	Elgin	IL	Balancing Quality of Life with Nutrition	LSN	\$49
Tonya Dietz	RN	7/4/11-10/23/11	Naperville	IL	Transition to Professional Nursing	Chamberlain College of Nursing	\$1,770
Tiffany Weiby	LPN	12/8/2011	Crystal Lake	IL	Conquering Pain	Institute of Natural Resources	\$84
Tonya Dietz	RN	7/4/11-10/23/11	Naperville	IL	Transition to Professional Nursing	Chamberlain College of Nursing	\$1,770
Tonya Dietz	RN	10/24-2/26/12	Naperville	IL	Community Health Nursing	Chamberlain College of Nursing	\$2,360
# 7044 - Nurse Education - SUBTOTAL							\$10,140

Name	Title	Date	City	State	Seminar Title	Sponsor	Cost
Donna Warren	Activity Director	5/11/2011	Naperville	IL	FRAPA	FRAPA	\$23
Donna Warren	Activity Director	6/8/2011	Naperville	IL	FRAPA	FRAPA	\$23
Donna Warren	Activity Director	6/11/2011	Naperville	IL	FRAPA	FRAPA	\$45
Loni Axford Gail Wonneberg	Act. Asstnt Act. Asstnt	9/21/2011	Arlington Hts	IL	Teepa Snow	Alzheimer's Assn of Greater IL	\$147
Donna Warren	Activity Director	8/10/2011	Naperville	IL	FRAPA	FRAPA	\$26
Donna Warren	Activity Director	9/14/2011	Naperville	IL	FRAPA	FRAPA	\$25
Donna Warren	Activity Director	11/9/2011	Naperville	IL	FRAPA	FRAPA	\$25
# 7230 - Activity Education - SUBTOTAL							\$314
David Stieglitz	Administrator	3/23-3/25/2011	Chicago	IL	LSN Annual Convention Seminar - Hotel - Food	LSN	\$1,132
David Stieglitz	Administrator	6/1/2011	Elgin	IL	Brave Questions	Dr. Alan Zimmerman	\$32
David Stieglitz	Administrator	8/11/2011	Elgin	IL	Retirement Plan Management Series	LSN	\$99
David Stieglitz	Administrator	10/15-10/20/11	Washington	DC	Annual Convention	Leading Age	\$2,830
# 7853 - Administrative Education - SUBTOTAL							\$4,093

Name	Title	Date	City	State	Seminar Title	Sponsor	Cost
Bethany Schmidgall	Dietary Mgr	3/26/2011	Peoria	IL	Certified Dietary Mgr Credentialing Exam	Dietary Managers Association	\$390
Sonia Madrigal	Relief Cook	3/11 & 3/18/2011	Rockford	IL	Sanitation Class	Nutrition Care Systems	\$65
Bethany Schmidgall	Dietary Mgr	3/23-3/25/2011	Chicago	IL	LSN Annual Convention Seminar - Hotel - Food	LSN	\$796
Bethany Schmidgall	Dietary Mgr	5/10/11	St. Charles	IL	Certification	Dietary Managers Association	\$145
Bethany Schmidgall	Dietary Mgr	7/20/2011	Elgin	IL	Balancing Quality of Life with Nutrition	LSN	\$50
Bethany Schmidgall	Dietary Mgr	9/8/11	Elgin	IL	Creating Nutrition Care Plans under MDS 3.0	Dietary Managers Assn	\$50
Daniel Toebe	Relief Cook	9/15 & 9/22/2011	Rockford	IL	Sanitation Class	Nutrition Care Systems	\$90
# 7529 - Diet Education - SUBTOTAL							\$1,586

Name	Title	Date	City	State	Seminar Title	Sponsor	Cost
All Staff		1/1/2011			Online Silverchair Learning	Silverchair	\$3,330
Maria Garcia Sharmeen Ahmed Wendy Raya	Laundry Asst/Hskpr CNA CNA	1/3/2011	Elgin	IL	Physicals	Provena St. Joseph Hopt	\$300
Sakeena Walker Margaret Reid	Relief Cook CNA	4/1/2011	Elgin	IL	Physicals	Provena St. Joseph Hopt	\$175
Jan Mogler	RN	4/4/2011	Elgin	IL	Door Sign	Balsis Awards & Engraving	\$6
Mary Braun	RN	4/29/2011	Elgin	IL	Nameplate	Balsis Awards & Engraving	\$12
Graciela Lopez	Dietary Aide	6/1/2011	Elgin	IL	Chest X-ray	Midwest X-ray	\$30
All Staff		7/30/2011	Elgin	IL	Fire Safety training	Fox Valley Fire & Safety	\$375
Hector Lopez	Dietary Aide	8/1/2011	Elgin	IL	Physical & Fingerprinting	Provena St. Joseph Hopt	\$80
All Staff		8/12/2011	Elgin	IL	Fire Safety training	Fox Valley Fire & Safety	\$375
Shari Anatra Perla Maldonado Karina Arreguin Joelene Schmitz	CNA CNA CNA CNA	9/1/2011	Elgin	IL	Physical & Fingerprinting	Provena St. Joseph Hopt	\$675
Tonya Dietz	RN	9/20/2011	Elgin	IL	Nameplate	Balsis Awards & Engraving	\$6
Dan Toebe	Relief Cook	4/1/2011	Elgin	IL	Physicals	Provena St. Joseph Hopt	\$40
Taylor McDonald	CNA	11/1/2011	Elgin	IL	Physical	Provena St. Joseph Hopt	\$100
All Staff		11/9/2011	Elgin	IL	Employment Law Posters	Illinois Chamber of Commerce	\$99
All Staff		12/1/2011			Online Silverchair Learning	Silverchair	\$3,330
# 7926 - Employee Hiring and Training - SUBTOTAL							\$8,933
GRAND TOTAL:							\$25,066