

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0047167</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Apostolic Christian Restmor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</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>1500 Parkside Avenue</u> <u>Morton</u> <u>61550</u>																									
Number City Zip Code																									
County: <u>Tazewell</u>																									
Telephone Number: <u>309-284-1400</u> Fax # <u>309-266-7877</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Michael Kaiser</u></td></tr><tr><td>(Title) <u>Assistant Administrator CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Michael Kaiser</u>	(Title) <u>Assistant Administrator CFO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Michael Kaiser</u>																								
	(Title) <u>Assistant Administrator CFO</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>4/1/1978</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501-c-3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></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 _____	
☐ 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 _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Michael Kaiser</u> Telephone Number: <u>309-284-1402</u>																									
Email Address: _____																									

Facility Name & ID Number Apostolic Christian Restmor# 0047167 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	<u>116</u>	Skilled (SNF)	<u>116</u>	<u>42,456</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>12</u>	Sheltered Care (SC)	<u>12</u>	<u>4,392</u>	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,632</u>	<u>26,432</u>	<u>2,439</u>	<u>33,503</u>	8
9	SNF/PED					9
10	ICF	<u>666</u>	<u>6,137</u>		<u>6,803</u>	10
11	ICF/DD					11
12	SC		<u>3,578</u>		<u>3,578</u>	12
13	DD 16 OR LESS					13
14	TOTALS	5,298	36,147	2,439	43,884	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.67%

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

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? yesG. 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 42 and days of care provided 2,439Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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.

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	573,842	45,721	400	619,963		619,963		619,963		1
2	Food Purchase		390,808		390,808	(11,783)	379,025	(18,102)	360,923		2
3	Housekeeping	142,714	60,714		203,428		203,428		203,428		3
4	Laundry	102,017	14,176		116,193		116,193		116,193		4
5	Heat and Other Utilities			191,768	191,768	(1,751)	190,017		190,017		5
6	Maintenance	186,442	62,259	267,973	516,674	(8,119)	508,555		508,555		6
7	Other (specify):*			20,680	20,680		20,680		20,680		7
8	TOTAL General Services	1,005,015	573,678	480,821	2,059,514	(21,653)	2,037,861	(18,102)	2,019,759		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	3,865,338	264,913	4,465	4,134,716		4,134,716		4,134,716		10
10a	Therapy			329,787	329,787		329,787		329,787		10a
11	Activities	182,215			182,215		182,215	(87)	182,128		11
12	Social Services	186,646			186,646		186,646		186,646		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,234,199	264,913	344,252	4,843,364		4,843,364	(87)	4,843,277		16
	C. General Administration										
17	Administrative	230,329			230,329		230,329	(36,000)	194,329		17
18	Directors Fees										18
19	Professional Services			75,381	75,381		75,381	(18,286)	57,095		19
20	Dues, Fees, Subscriptions & Promotions			42,316	42,316		42,316	(21,496)	20,820		20
21	Clerical & General Office Expenses	269,710	15,618	162,108	447,436	(45,604)	401,832	(101,839)	299,993		21
22	Employee Benefits & Payroll Taxes			1,428,667	1,428,667	11,783	1,440,450	(17,064)	1,423,386		22
23	Inservice Training & Education										23
24	Travel and Seminar			42,186	42,186		42,186	(11,102)	31,084		24
25	Other Admin. Staff Transportation			1,788	1,788	1,751	3,539	(1,539)	2,000		25
26	Insurance-Prop.Liab.Malpractice			85,574	85,574		85,574		85,574		26
27	Other (specify):*										27
28	TOTAL General Administration	500,039	15,618	1,838,020	2,353,677	(32,070)	2,321,607	(207,326)	2,114,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,739,253	854,209	2,663,093	9,256,555	(53,723)	9,202,832	(225,515)	8,977,317		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			549,210	549,210		549,210		549,210			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,840	33,840		33,840	(7,860)	25,980			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					53,723	53,723		53,723			35
36	Other (specify):*											36
37	TOTAL Ownership			583,050	583,050	53,723	636,773	(7,860)	628,913			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			130,009	130,009		130,009		130,009			39
40	Barber and Beauty Shops	37,125		4,725	41,850		41,850		41,850			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			335,527	335,527		335,527	(42,021)	293,506			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	37,125		470,261	507,386		507,386	(42,021)	465,365			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,776,378	854,209	3,716,404	10,346,991		10,346,991	(275,396)	10,071,595			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	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (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	TOTAL (C): (sum of lines 38-46)			\$		47

Apostolic Christian RestmorID# 0047167Report Period Beginning: 1/1/2012Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non Allowable Seminar	\$ (3,801)	24	1
2	Non Allowable Dues and Subscriptions	(4,745)	20	2
3	Promotion and Yellow Pages	(16,605)	20	3
4	Employee Meal Income	(9,929)	22	4
5	Guest Meal Income	(2,224)	2	5
6	Misc Expense	0	21	6
7	Misc Income	(87,731)	21	7
8	Auto Expense	(1,539)	25	8
9	Depreciation	0	30	9
10	Professional Fees	(18,286)	19	10
11	Meals and Wheels Expense	(15,878)	2	11
12	Activities Income	(87)	11	12
13	ILU Management fee	(36,000)	17	13
14	Out of State Travel	(7,301)	24	14
15	Penalties	(146)	20	15
16	Pension Interest Income	(7,135)	22	16
17	Other Interest Income	(7,860)	32	17
18	Finance Charges	(1,982)	21	18
19	Non allowable furnishings expense	(12,126)	21	19
20	Prior Period Bed Tax	(42,021)	42	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(275,396)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(18,102)	0	0	0	0	0	0	0	0	0	0	(18,102)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,102)	0	0	0	0	0	0	0	0	0	0	(18,102)	8
	B. Health Care and Programs													
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	(87)	0	0	0	0	0	0	0	0	0	0	(87)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(87)	0	0	0	0	0	0	0	0	0	0	(87)	16
	C. General Administration													
17	Administrative	(36,000)	0	0	0	0	0	0	0	0	0	0	(36,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,286)	0	0	0	0	0	0	0	0	0	0	(18,286)	19
20	Fees, Subscriptions & Promotions	(21,496)	0	0	0	0	0	0	0	0	0	0	(21,496)	20
21	Clerical & General Office Expenses	(101,839)	0	0	0	0	0	0	0	0	0	0	(101,839)	21
22	Employee Benefits & Payroll Taxes	(17,064)	0	0	0	0	0	0	0	0	0	0	(17,064)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,102)	0	0	0	0	0	0	0	0	0	0	(11,102)	24
25	Other Admin. Staff Transportation	(1,539)	0	0	0	0	0	0	0	0	0	0	(1,539)	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	TOTAL General Administration	(207,326)	0	0	0	0	0	0	0	0	0	0	(207,326)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(225,515)	0	0	0	0	0	0	0	0	0	0	(225,515)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,860)	0	0	0	0	0	0	0	0	0	0	(7,860)	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	TOTAL Ownership	(7,860)	0	0	0	0	0	0	0	0	0	0	(7,860)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(42,021)	0	0	0	0	0	0	0	0	0	0	(42,021)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(42,021)	0	0	0	0	0	0	0	0	0	0	(42,021)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(275,396)	0	0	0	0	0	0	0	0	0	0	(275,396)	45

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
Marty Rollins	0			The Parkside of Morton	Morton	congregate living
Joe Zimmerman	0					
Fred Kaiser	0					
Greg Kaiser	0					
Bruce Sauder	0					
Nate Koch	0					

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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	Morton Community Bank		X	Mortgage	\$16,567.00	06/01/2011	\$ 1,770,000	\$	05/16/2016	5.0000	\$ 33,840	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$16,567.00		\$ 1,770,000	\$			\$ 33,840	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,770,000	\$			\$ 33,840	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.)

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

B. Real Estate Taxes

[illegible]

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.

2011 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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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? 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet: 86,000

B. General Construction Type: Exterior Brick Frame Stick Number of Stories 1

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

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

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

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

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

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Site	849,420		\$ 327,810	1
2	vacant land	435,600		75,000	2
3	TOTALS	1,285,020		\$ 402,810	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Apostolic Christian Restmor

0047167

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	128		2008	2008	\$ 15,081,596	\$ 377,040	40	\$ 377,040	\$	\$ 1,790,940
5										
6										
7										
8										
	Improvement Type**									
9	Land Site preparation and grading			2008	395,786					
10	Remote unattached storage building			2008	207,121	5,178	40	5,178		24,596
11	Road and parking area			2008	194,661	9,733	20	9,733		46,232
12	Brick Edging and Landscaping			2008	10,923	546	20	546		2,506
13	New Sidewalk			2009	8,245	550	15	550		1,833
14	Concrete drainage ways for stormwater			2009	10,656	533	20	533		1,687
15	Additional Heat Pump for Spa area			2009	7,020	468	15	468		1,716
16	Additional Lighting			2009	9,232	615	15	615		2,255
17	New Ventilators in Spa area			2009	6,791	453	15	453		1,631
18	Additional Smoke Devices			2009	2,667	178	15	178		682
19	Additional Door Holders			2009	2,758	184	15	184		613
20	Courtyard concrete finish			2010	11,808	590	20	590		1,623
21	Re keying all doors			2010	9,980	270	37	270		720
22	Smokedoors			2010	10,570	286	37	286		739
23	New Trees			2010	5,000	135	37	135		304
24	New Trees			2011	3,900	108	36	108		144
25	Linoleum in laundry room			2011	7,667	639	12	639		1,171
26	Paneling in patient rooms			2011	9,550	796	12	796		1,260
27	Geo Thermal Retrocommissioning			2012	357,300	8,507	35	8,507		8,507
28	Enclose Porches in resident living rooms			2012	25,892	123	35	123		123
29	Lighting Upgrade on exterior doors			2012	3,402	8	35	8		8
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 16,382,525	\$ 406,940		\$ 406,940	\$	\$ 1,889,290	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,809,883	\$124,361	\$124,361	\$	4--15	\$798,367	71
72	Current Year Purchases	102,899	9,817	9,817		4--10	9,817	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,912,782	\$134,178	\$134,178	\$		\$808,184	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 Transp	1996 Dodge Van	1996	\$21,621	\$	\$	\$		\$21,621	76
77	Staff Transp	Chevy Ventur Van	1998	24,913					24,913	77
78	Machinery	mowing		8,720					8,720	78
79	Patient Transp	Chvy Ex Pass; Chvy Braun	2010-2011	56,649	8,093	8,093		7	14,726	79
80	TOTALS			\$111,903	\$8,093	\$8,093	\$		\$69,980	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)	\$18,810,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$549,211	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$549,211	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)	\$2,767,454	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	ILU Land	\$25,652	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$25,652	\$	\$	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: \$53,723
- Description: Several large copiers (\$45604) and a bus for resident transportation (\$8119)
- (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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

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)	
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.

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	10a	hrs	\$		\$ 24,767	\$		\$ 24,767	1
2	Licensed Speech and Language Development Therapist	10a	hrs			55,210			55,210	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			38,392			38,392	4
5	Physician Care	39	visits			3,040			3,040	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				109,870		109,870	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39				17,099			17,099	12
13	Other (specify):									13
14	TOTAL			\$		\$ 138,508	\$ 109,870		\$ 248,378	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.

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	\$ 741,166	\$	1
2	Cash-Patient Deposits	6,641		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 77,830)	634,121		3
4	Supply Inventory (priced at cost)	64,528		4
5	Short-Term Investments	1,867,227		5
6	Prepaid Insurance	132,476		6
7	Other Prepaid Expenses	34,015		7
8	Accounts Receivable (owners or related parties)	19,099		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,499,273	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	402,810		13
14	Buildings, at Historical Cost	15,081,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,024,684		16
17	Accumulated Depreciation (book methods)	(2,767,454)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Equipment</u>)	856,711		22
23	Other(specify): <u>Building Improvements</u>	469,870		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,068,217	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,567,490	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,628	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,641		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	556,095		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,953		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
	Other Current Liabilities(specify):			
36	<u>Accrued Pension</u>	367,571		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,212,888	\$	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)	\$ 1,212,888	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,354,602	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,567,490	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,848,329	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,848,329	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	506,273	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)	\$ 506,273	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)	\$ 18,354,602	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Restmor# 0047167Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,224,119	1
2	Discounts and Allowances for all Levels	(836,777)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,387,342	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	646,029	6
7	Oxygen	35,866	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 681,895	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	53,253	13
14	Non-Patient Meals	32,414	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	87,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,917	19
20	Radiology and X-Ray		20
21	Other Medical Services	252,178	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 446,402	23
	D. Non-Operating Revenue		
24	Contributions	192,175	24
25	Interest and Other Investment Income***	14,995	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 207,170	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Electric rebate	87,681	28
28a	page 24	42,774	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 130,455	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,853,264	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,059,514	31
32	Health Care	4,843,364	32
33	General Administration	2,353,677	33
	B. Capital Expense		
34	Ownership	583,050	34
	C. Ancillary Expense		
35	Special Cost Centers	507,386	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,346,991	40
41	Income before Income Taxes (line 30 minus line 40)**	506,273	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 506,273	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 744,266	44
45	Private Pay - Net Inpatient Revenue	8,173,787	45
46	Medicare - Net Inpatient Revenue	469,289	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,387,342	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.

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	1,946	2,084	\$ 96,239	\$ 46.18	1
2	Assistant Director of Nursing	2,134	2,238	75,342	33.66	2
3	Registered Nurses	32,544	35,761	999,845	27.96	3
4	Licensed Practical Nurses	21,655	23,608	531,660	22.52	4
5	CNAs & Orderlies	117,152	125,902	1,821,345	14.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,019	4,469	76,062	17.02	8
9	Activity Director	1,686	1,808	27,688	15.31	9
10	Activity Assistants	12,509	13,694	154,527	11.28	10
11	Social Service Workers	4,688	5,098	102,099	20.03	11
12	Dietician	822	869	18,696	21.51	12
13	Food Service Supervisor	1,968	2,080	67,189	32.30	13
14	Head Cook	6,202	6,850	98,091	14.32	14
15	Cook Helpers/Assistants	35,159	37,467	389,866	10.41	15
16	Dishwashers					16
17	Maintenance Workers	8,493	9,255	186,442	20.15	17
18	Housekeepers	12,846	14,041	142,714	10.16	18
19	Laundry	8,084	8,769	102,017	11.63	19
20	Administrator	1,821	2,080	124,276	59.75	20
21	Assistant Administrator	1,925	2,360	106,053	44.94	21
22	Other Administrative	3,434	3,951	84,547	21.40	22
23	Office Manager					23
24	Clerical	10,817	12,427	248,843	20.02	24
25	Vocational Instruction					25
26	Academic Instruction	1,770	1,995	70,534	35.36	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	8,792	9,536	148,036	15.52	31
32	Other Health Care: Dementia Director	1,882	2,114	46,275	21.89	32
33	Other(specify) <u>Vol Dir, Hair Care</u>	2,946	3,243	57,992	17.88	33
34	TOTAL (lines 1 - 33)	305,294	331,699	\$ 5,776,378 *	\$ 17.41	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		\$		35
36	Medical Director		10,000	9--3	36
37	Medical Records Consultant	35	2,460	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)	35	\$ 12,460		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

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

** See instructions.

STATE OF ILLINOIS

0047167

Report Period Beginning:

1/1/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Apostolic Christian Restmor

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	
John Kelley	Adm/CEO		\$ 124,276	Workers' Compensation Insurance	\$ 120,557	IDPH License Fee	\$ 3,980	
Michael Kaiser	Asst Adm/CFO		106,053	Unemployment Compensation Insurance	9,854	Advertising: Employee Recruitment	3,364	
				FICA Taxes	421,911	Health Care Worker Background Check	990	
				Employee Health Insurance	455,195	(Indicate # of checks performed 33)		
				Employee Meals	1,854	Patient Background Checks	67	
				Illinois Municipal Retirement Fund (IMRF)*		State Association dues	9,208	
				Employee Relations	12,820	State Fire Marshall boiler dues	500	
				Pension Expense	354,109	Tazewell County Dietary License	350	
				Uniform Rental	17,595	Other Dues	1,758	
				Employee Hiring and Training	3,464			
				Dental Insurance	4,064	Less: Public Relations Expense	()	
				Employee Health Services	8,963	Non-allowable advertising	()	
				Tuition Reimbursement	13,000	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		TOTAL (agree to Sch. V,		
(List each licensed administrator separately.) \$ 230,329				line 22, col.8) \$ 1,423,386		line 20, col. 8) \$ 20,820		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			Out-of-State Travel	
(Attach a copy of any management service agreement) \$								
C. Professional Services								
Vendor/Payee	Type	Amount						
Heinold Banwart	Accounting	\$ 2,800						
Clifton Larson	Auditing	22,400						
Morton Community Bank	Loan Processing	3,097						
Bush, Michael	Legal	1,775					In-State Travel	
Duane Morris	Legal	13,867						
Heyl Royster Voelker & Allen	Legal	350						
Polsinelli Schugart PC	Legal	2,272						
BLDD Architects	Consulting	2,316						
FGMK LLC	Compliance/ Cost Report	20,350					Seminar Expense	
Principal Financial Group	Pension Adminstration	3,143					Silverchair Learning network	
Personnel Planners Inc	U/C adm	1,653						
Various small legal services	Legal	1,358						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.) \$ 75,381				\$			(agree to Sch. V,	
							line 24, col. 8) \$ 31,084	

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. LSN \$9208

(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? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,865 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. \$ 335,527
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. \$ 11,783 Has any meal income been offset against related costs? _____ Indicate the amount. \$ 9,929

(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? none, but not tr
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? review
Firm Name: Clifton Larson

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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? yes
Attach invoices and a summary of services for all architect and appraisal fees.

APOSTOLIC CHRISTIAN RESTMOR #23952 12/31/2011

SCHEDULE XVII PAGE 19
LINE 28a

Social Activities Income	2521
Private Pay Laundry	2075
Persona Supplies Income	59
Finance Charges	1982
Parkside Management fee	36000
Sunshine Cart Income	87
Misc Income	50
TOTAL	42774