FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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:** 0047167

Facility Name: Apostolic Christian Restmor

Address: 1500 Parkside Avenue (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: 309-284-1400 **Fax #** 309-266-7877

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1978

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code 501-c-3	[X] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name: Michael Kaiser   Telephone Number: 309-284-1402
Email Address:

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 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.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Michael Kaiser
	(Title)	Asst Administrator/CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone) ( )	Fax # ( )

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	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	4,454	24,536	3,818	32,808	8
9	SNF/PED					9
10	ICF	184	5,475		5,659	10
11	ICF/DD					11
12	SC		3,248		3,248	12
13	DD 16 OR LESS					13
14	TOTALS	4,638	33,259	3,818	41,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.29%

D. How many bed-hold days during this year were paid by the Department?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
meals on wheels

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date ____________ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 3,818

Medicare Intermediary Wisconsin Physicians Ins Co

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	387,214	36,936	164,147	588,297		588,297		588,297			1
2	Food Purchase		300,809		300,809	(6,749)	294,060	(17,058)	277,002			2
3	Housekeeping	135,880	41,277		177,157		177,157		177,157			3
4	Laundry	92,668	12,558		105,226		105,226		105,226			4
5	Heat and Other Utilities			227,936	227,936		227,936		227,936			5
6	Maintenance	168,766	19,984	254,829	443,579	(8,119)	435,460		435,460			6
7	Other (specify):*			21,863	21,863		21,863		21,863			7
8	**TOTAL General Services**	784,528	411,564	668,775	1,864,867	(14,868)	1,849,999	(17,058)	1,832,941			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,543,781	154,925	91,511	3,790,217		3,790,217		3,790,217			10
10a	Therapy			408,695	408,695		408,695		408,695			10a
11	Activities	137,255			137,255		137,255	(80)	137,175			11
12	Social Services	184,953		17,946	202,899		202,899		202,899			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,865,989	154,925	524,152	4,545,066		4,545,066	(80)	4,544,986			16
	C. General Administration											
17	Administrative	209,858			209,858		209,858	(33,600)	176,258			17
18	Directors Fees											18
19	Professional Services			78,361	78,361		78,361	(15,707)	62,654			19
20	Dues, Fees, Subscriptions & Promotions			35,459	35,459	2,290	37,749	(21,361)	16,388			20
21	Clerical & General Office Expenses	247,165	20,194	144,009	411,368	(33,102)	378,266	(9,189)	369,077			21
22	Employee Benefits & Payroll Taxes			1,174,354	1,174,354	4,459	1,178,813	(11,784)	1,167,029			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,941	29,941	(2,829)	27,112	(6,742)	20,370			24
25	Other Admin. Staff Transportation			6,229	6,229	2,829	9,058	(7,058)	2,000			25
26	Insurance-Prop.Liab.Malpractice			93,600	93,600		93,600		93,600			26
27	Other (specify):*											27
28	**TOTAL General Administration**	457,023	20,194	1,561,953	2,039,170	(26,353)	2,012,817	(105,441)	1,907,376			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,107,540	586,683	2,754,880	8,449,103	(41,221)	8,407,882	(122,579)	8,285,303			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			551,464	551,464		551,464	(2,985)	548,479			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			277,871	277,871		277,871	(7,194)	270,677			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					41,221	41,221		41,221			35
36	Other (specify):*											36
37	TOTAL Ownership			829,335	829,335	41,221	870,556	(10,179)	860,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,323	19,505	204,828		204,828		204,828			39
40	Barber and Beauty Shops	33,212		3,766	36,978		36,978		36,978			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,520	63,520		63,520		63,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	33,212	185,323	86,791	305,326		305,326		305,326			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,140,752	772,006	3,671,006	9,583,764		9,583,764	(132,758)	9,451,006			45

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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				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 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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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 Yes	2 No	3 Amount	4 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 Restmor

ID# 0047167

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non allowable seminar	$ (895)	24	1
2	Non allowable dues/subs	(6,699)	20	2
3	Promotion	(14,310)	20	3
4	Employee Meal Income	(6,749)	22	4
5	Other Employee meal Income	(249)	2	5
6	Guest Meal Income	(1,264)	2	6
7	Misc Expense	(6,335)	21	7
8	Misc Income	(2,636)	21	8
9	Auto Expense	(7,058)	25	9
10	Depreciation	1,015	30	10
11	Legal and Professional	(15,707)	19	11
12	Meals on Wheels	(15,545)	2	12
13	Sunshine Cart Income	(80)	11	13
14	Parkside Management Fee	(33,600)	17	14
15	Out of State Travel	(5,847)	24	15
16	Penalties	(352)	20	16
17	Interest Income pension	(5,035)	22	17
18	Interest Income	(7,194)	32	18
19	Finance Charges	(218)	21	19
20	Gain on Sale of Equipment	(4,000)	30	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**	(132,758)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17,058)	0	0	0	0	0	0	0	0	0	0	(17,058)	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**	(17,058)	0	0	0	0	0	0	0	0	0	0	(17,058)	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	(80)	0	0	0	0	0	0	0	0	0	0	(80)	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**	(80)	0	0	0	0	0	0	0	0	0	0	(80)	16
	C. General Administration													
17	Administrative	(33,600)	0	0	0	0	0	0	0	0	0	0	(33,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,707)	0	0	0	0	0	0	0	0	0	0	(15,707)	19
20	Fees, Subscriptions & Promotions	(21,361)	0	0	0	0	0	0	0	0	0	0	(21,361)	20
21	Clerical & General Office Expenses	(9,189)	0	0	0	0	0	0	0	0	0	0	(9,189)	21
22	Employee Benefits & Payroll Taxes	(11,784)	0	0	0	0	0	0	0	0	0	0	(11,784)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,742)	0	0	0	0	0	0	0	0	0	0	(6,742)	24
25	Other Admin. Staff Transportation	(7,058)	0	0	0	0	0	0	0	0	0	0	(7,058)	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**	(105,441)	0	0	0	0	0	0	0	0	0	0	(105,441)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,579)	0	0	0	0	0	0	0	0	0	0	(122,579)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,985)	0	0	0	0	0	0	0	0	0	0	(2,985)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,194)	0	0	0	0	0	0	0	0	0	0	(7,194)	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**	(10,179)	0	0	0	0	0	0	0	0	0	0	(10,179)	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	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(132,758)	0	0	0	0	0	0	0	0	0	0	(132,758)	45

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jim Ritthaler	0			The Parkside of Morto	Morton	Congregate Living
Marty Rollins	0					
Joe Zimmerman	0					
Fred Kaiser	0					
Ed Kaiser	0					
Andy Aberle	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 [X] 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			$			$	$	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.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 1/1/2010 Ending: 2/31/2010

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	Building Mortgage	$35,106.00	6/28/2008	$ 5,500,000	$ 3,734,796	7/1/2028	6.5000	$ 277,871	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,106.00		$ 5,500,000	$ 3,734,796			$ 277,871	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,500,000	$ 3,734,796			$ 277,871	15

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

Item		Line
1. Real Estate Tax accrual used on 2009 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 2010 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:

Year	Amount	Line
2005		8
2006		9
2007		10
2008		11
2009		12

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 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 2009 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 2009.

	(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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Stick Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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 [X] 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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		2008	2008	$ 15,081,596	$ 377,040	40	$ 377,040	$	$ 1,036,860	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Site preparation and grading			2008	395,786						9
10	Remote unattached storage building			2008	207,121	5,178	40	5,178		14,240	10
11	Road and parking area			2008	194,661	9,733	20	9,733		26,766	11
12	Brick Edging and Landscaping			2008	10,923	546	20	546		1,414	12
13	New Sidewalk			2009	8,245	550	15	550		733	13
14	Concrete drainage ways for stormwater			2009	10,656	533	20	533		621	14
15	Additional Heat Pump for Spa area			2009	7,020	468	15	468		780	15
16	Additional Lighting			2009	9,232	615	15	615		1,025	16
17	New Ventilators in Spa area			2009	6,791	453	15	453		725	17
18	Additional Smoke Devices			2009	2,667	178	15	178		326	18
19	Additional Door Holders			2009	2,758	184	15	184		245	19
20	Courtyard concrete finish			2010	11,808	443	20	443		443	20
21	Re keying all doors			2010	9,980	180	37	180		180	21
22	Smokedoors			2010	10,570	167	37	167		167	22
23	New Trees			2010	5,000	34	37	34		34	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 15,974,814	$ 396,302		$ 396,302	$	$ 1,084,559	70

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,686,578	$ 150,092	$ 150,092	$	4--15	$ 525,790	71
72	Current Year Purchases	66,389	4,209	4,209		8--10	4,209	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,752,967	$ 154,301	$ 154,301	$		$ 529,999	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transp	Bus 1996 Dodge	1996	$ 60,654	$	$	$		$ 60,654	76
77	Staff Transp	Chevy Venture Van	1998	24,913					24,913	77
78	Machinery	mowing		14,719		1,014	1,014		14,719	78
79	Patient Transp	Chevy Express Pass Van	2010	24,149	862	862		7	862	79
80	TOTALS			$ 124,435	$ 862	$ 1,876	$ 1,014		$ 101,148	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)	$ 18,255,026	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 551,465	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 552,479	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,014	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,715,706	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.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 41,221 Description: Two large copiers and a bus used for patient outings
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff: Units of Service	3 Staff: Cost	4 Outside Practitioner (other than consultant): Units	5 Outside Practitioner (other than consultant): Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 38,413	$		$ 38,413	1
2	Licensed Speech and Language Development Therapist		hrs			86,039			86,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			37,190			37,190	4
5	Physician Care		visits			5,648			5,648	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			185,323			185,323	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab					13,857			13,857	12
13	Other (specify):									13
14	TOTAL			$		$ 366,470	$		$ 366,470	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.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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	$ 555,614	$	1
2	Cash-Patient Deposits	8,460		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	976,885		3
4	Supply Inventory (priced at)	74,924		4
5	Short-Term Investments	2,235,014		5
6	Prepaid Insurance	56,868		6
7	Other Prepaid Expenses	31,673		7
8	Accounts Receivable (owners or related parties)	44,316		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,983,754	$	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	1,877,402		16
17	Accumulated Depreciation (book methods)	(1,715,706)		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 (spe **Land Improvements**	852,811		22
23	Other(specify): **Building Improvements**	66,059		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,564,972	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,548,726	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,438	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,460		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	514,252		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,437		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,660		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued PTO	234,144		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 978,391	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,734,796		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)**	$ 3,734,796	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,713,187	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,835,539	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 20,548,726	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Restmor # 0047167 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,575,309	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,575,309	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,260,230	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)**	$ 1,260,230	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)**	$ 15,835,539	24 *

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,533,727	1
2	Discounts and Allowances for all Levels	(802,293)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,731,434	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	792,521	6
7	Oxygen	103,684	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 896,205	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	42,366	13
14	Non-Patient Meals	29,721	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	152,849	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,013	19
20	Radiology and X-Ray		20
21	Other Medical Services	203,095	21
22	Laundry	2,390	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 449,434	23
	D. Non-Operating Revenue		
24	Contributions	710,573	24
25	Interest and Other Investment Income***	12,229	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 722,802	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	gain on sale of vehicle	4,000	28
28a	Page 24	40,119	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,119	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,843,994	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,864,867	31
32	Health Care	4,545,066	32
33	General Administration	2,039,170	33
	B. Capital Expense		
34	Ownership	829,335	34
	C. Ancillary Expense		
35	Special Cost Centers	241,806	35
36	Provider Participation Fee	63,520	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,583,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,260,230	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,260,230	43

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

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	1,656	1,912	$ 69,878	$ 36.55	1
2	Assistant Director of Nursing	2,331	2,425	82,298	33.94	2
3	Registered Nurses	33,458	36,726	952,157	25.93	3
4	Licensed Practical Nurses	21,367	23,643	506,660	21.43	4
5	CNAs & Orderlies	113,637	123,294	1,619,037	13.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,125	4,679	69,636	14.88	8
9	Activity Director	1,851	1,917	28,368	14.80	9
10	Activity Assistants	12,048	12,937	108,887	8.42	10
11	Social Service Workers	5,508	6,274	106,795	17.02	11
12	Dietician	1,456	1,633	30,969	18.96	12
13	Food Service Supervisor					13
14	Head Cook	6,203	6,736	91,990	13.66	14
15	Cook Helpers/Assistants	25,506	27,072	264,255	9.76	15
16	Dishwashers					16
17	Maintenance Workers	8,681	9,513	168,766	17.74	17
18	Housekeepers	13,129	14,122	135,880	9.62	18
19	Laundry	8,167	8,732	92,668	10.61	19
20	Administrator	1,805	2,080	111,893	53.79	20
21	Assistant Administrator	1,977	2,160	97,965	45.35	21
22	Other Administrative	3,759	4,107	78,158	19.03	22
23	Office Manager					23
24	Clerical	10,869	12,443	229,074	18.41	24
25	Vocational Instruction					25
26	Academic Instruction	1,824	2,080	70,391	33.84	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	10,074	10,706	130,370	12.18	31
32	Other Health Ca Directo dementia	1,890	2,080	43,354	20.84	32
33	Other(specify) vol dir, barber	2,837	3,145	51,303	16.31	33
34	TOTAL (lines 1 - 33)	294,158	320,416	$ 5,140,752 *	$ 16.04	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		6,000	9--3	36
37	Medical Records Consultant	27	2,036	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)	27	$ 8,036		49

C. CONTRACT NURSES

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Kelley	Adm		$ 111,336
Michael Kaiser	A. Adm		98,522
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 209,858

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson	Audit/Tax	$ 22,875
Heinold Banwart	Wage Survey	2,000
Benckendorf & Benckendorf	Legal	4,919
Michael Bush	Legal	1,348
Heyl Royster	Legal	621
KPMG	Medicare	475
Polsinelli Shugart	Legal	7,058
Go to My PC	Computer Networking	848
Windworx Software	Fixed Asset Software Lease	4,672
Frost Ruttenberg Rothblatt	Medicare	1,907
Principle Financial	Pension Adm	30,418
Stanley Security solutions	Security service	1,220
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 78,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,444
Unemployment Compensation Insurance	8,871
FICA Taxes	369,875
Employee Health Insurance	293,790
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	330,561
Uniform Rental	8,703
Employee hiring/training	0
Employee Relations	10,075
Tuition Reimbursement	11,710
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,167,029

* Attach copy of IMRF notifications

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,724
Health Care Worker Background Check	0
(Indicate # of checks performed 99)	1,210
Patient Background Checks 108	1,080
Dues, Fees, Subs	9,374
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,388

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,703
Seminar Expense	9,667
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,370

**See instructions.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 $4232**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8--10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,483** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **63,520**
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. $ **6,749** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,998**

(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? **50%**
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? Indicate the amount of income earned from providing such transportation during this reporting period. $ **NO**

(17) Has an audit been performed by an independent certified public accounting firm? **Review**
Firm Name: **Clifton Gunderson**

(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.

APOSTOLIC CHRISTIAN RESTMOR #23952 12/31/2010

Schedule XVII Page 19
Line 28a

Social Activities Income	2066
Personal Supplies Income	967
Finance Charges	218
Personal Supplies Income	80
POM management fee	33600
Staff Development Income	35
Misc Income	3153
Total line 28a	40119