FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 401-c-3			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 01/01/2016 to 12/31/2016 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) 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: 01/01/2016 Ending: 12/31/2016

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,456	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,392	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,581	27,618	3,095	33,294	8
9	SNF/PED					9
10	ICF	365	4,904		5,269	10
11	ICF/DD					11
12	SC		2,955		2,955	12
13	DD 16 OR LESS					13
14	TOTALS	2,946	35,477	3,095	41,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.62%

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)
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 4/01/2008

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 [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 3,095

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	652,887	26,843		679,730		679,730		679,730			1
2	Food Purchase		391,559		391,559	(15,917)	375,642	(31,598)	344,044			2
3	Housekeeping	157,256	51,865		209,121		209,121		209,121			3
4	Laundry	105,975	17,956		123,931		123,931	(3,130)	120,801			4
5	Heat and Other Utilities			195,973	195,973		195,973		195,973			5
6	Maintenance	202,975	68,105	293,163	564,243	(8,076)	556,167		556,167			6
7	Other (specify):* Waste			21,480	21,480		21,480		21,480			7
8	TOTAL General Services	1,119,093	556,328	510,616	2,186,037	(23,993)	2,162,044	(34,728)	2,127,316			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,162,906	281,932	2,713	4,447,551		4,447,551		4,447,551			10
10a	Therapy			429,893	429,893		429,893		429,893			10a
11	Activities	192,571			192,571		192,571	(130)	192,441			11
12	Social Services	204,736			204,736		204,736		204,736			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,560,213	281,932	444,606	5,286,751		5,286,751	(130)	5,286,621			16
	C. General Administration											
17	Administrative	256,908			256,908		256,908	(38,100)	218,808			17
18	Directors Fees											18
19	Professional Services			47,306	47,306		47,306	(13,145)	34,161			19
20	Dues, Fees, Subscriptions & Promotions			56,199	56,199		56,199	(20,772)	35,427			20
21	Clerical & General Office Expenses	294,892	25,942	154,330	475,164	(33,270)	441,894	(3,097)	438,797			21
22	Employee Benefits & Payroll Taxes			1,371,874	1,371,874	15,917	1,387,791	(14,477)	1,373,314			22
23	Inservice Training & Education											23
24	Travel and Seminar			47,306	47,306	(2,574)	44,732	(12,605)	32,127			24
25	Other Admin. Staff Transportation			2,596	2,596	2,574	5,170	(170)	5,000			25
26	Insurance-Prop.Liab.Malpractice			102,840	102,840		102,840		102,840			26
27	Other (specify):*											27
28	TOTAL General Administration	551,800	25,942	1,782,451	2,360,193	(17,353)	2,342,840	(102,366)	2,240,474			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,231,106	864,202	2,737,673	9,832,981	(41,346)	9,791,635	(137,224)	9,654,411			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.

Facility Name & ID Number Apostolic Christian Restmor #0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			578,070	578,070		578,070		578,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					41,346	41,346		41,346			35
36	Other (specify):*											36
37	**TOTAL Ownership**			578,070	578,070	41,346	619,416		619,416			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			160,074	160,074		160,074		160,074			39
40	Barber and Beauty Shops	32,105		5,374	37,479		37,479		37,479			40
41	Coffee and Gift Shops			426	426		426	(426)				41
42	Provider Participation Fee			277,979	277,979		277,979		277,979			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	32,105		443,853	475,958		475,958	(426)	475,532			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,263,211	864,202	3,759,596	10,887,009		10,887,009	(137,650)	10,749,359			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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non allowable seminar	$ (5,393)	24	1
2	Non allowable dues and subscriptions	(8,141)	20	2
3	Promotions and yellow pages	(12,565)	20	3
4	Employee meal income	(13,256)	22	4
5	Guest meal income	(7,630)	2	5
6	Misc expense	(1,823)	21	6
7	Misc income	(1,015)	21	7
8	Auto Expense	(170)	25	8
9	Professional fees	(3,145)	19	9
10	Meals on wheels expense	(23,968)	2	10
11	Sunshine cart income	(130)	11	11
12	POM management fee	(38,100)	17	12
13	Travel	(7,212)	24	13
14	Penalties	(66)	20	14
15	Interest income pension	(1,221)	22	15
16	Misc program expense	(426)	41	16
17	Private pay laundry	(3,130)	4	17
18	Telephone Income	(21)	21	18
19	Legal	(10,000)	19	19
20	Finance charges	(238)	21	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**	(137,650)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor **#** 0047167 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(31,598)	0	0	0	0	0	0	0	0	0	0	(31,598)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,130)	0	0	0	0	0	0	0	0	0	0	(3,130)	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**	(34,728)	0	0	0	0	0	0	0	0	0	0	(34,728)	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	(130)	0	0	0	0	0	0	0	0	0	0	(130)	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**	(130)	0	0	0	0	0	0	0	0	0	0	(130)	16
	C. General Administration													
17	Administrative	(38,100)	0	0	0	0	0	0	0	0	0	0	(38,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,145)	0	0	0	0	0	0	0	0	0	0	(13,145)	19
20	Fees, Subscriptions & Promotions	(20,772)	0	0	0	0	0	0	0	0	0	0	(20,772)	20
21	Clerical & General Office Expenses	(3,097)	0	0	0	0	0	0	0	0	0	0	(3,097)	21
22	Employee Benefits & Payroll Taxes	(14,477)	0	0	0	0	0	0	0	0	0	0	(14,477)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(12,605)	0	0	0	0	0	0	0	0	0	0	(12,605)	24
25	Other Admin. Staff Transportation	(170)	0	0	0	0	0	0	0	0	0	0	(170)	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**	(102,366)	0	0	0	0	0	0	0	0	0	0	(102,366)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(137,224)	0	0	0	0	0	0	0	0	0	0	(137,224)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor # 0047167 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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	(426)	0	0	0	0	0	0	0	0	0	0	(426)	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**	(426)	0	0	0	0	0	0	0	0	0	0	(426)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(137,650)	0	0	0	0	0	0	0	0	0	0	(137,650)	45

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Bruce Sauder	0					
Nate Koch	0					
Brian Bahr	0					
Gary Psinas	0					
Joe Zimmerman	0					
John Dill	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.**

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 15,081,596	$ 377,040	40	$ 377,040	$	$ 3,299,100	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Site preparation and grading			2008	395,786		40				9
10	Remote unattached storage building			2008	207,121	5,178	20	5,178		45,308	10
11	Road and parking area			2008	194,661	9,733	20	9,733		85,164	11
12	Brick Edging and Landscaping			2008	10,923	546	15	546		4,690	12
13	New Sidewalk			2009	8,245	550	20	550		4,033	13
14	Concrete drainage ways for stormwater			2009	10,656	533	15	533		3,819	14
15	Additional Heat Pump for Spa area			2009	7,020	468	15	468		3,588	15
16	Additional Lighting			2009	9,232	615	15	615		4,715	16
17	New Ventilators in Spa area			2009	6,791	453	15	453		3,443	17
18	Additional Smoke Devices			2009	2,667	178	15	178		1,394	18
19	Additional Door Holders			2009	2,758	184	20	184		1,349	19
20	Courtyard concrete finish			2010	11,808	590	37	590		3,983	20
21	Re keying all doors			2010	9,980	270	37	270		1,800	21
22	Smokedoors			2010	10,570	286	37	286		1,883	22
23	New Trees			2010	5,000	135	36	135		844	23
24	New Trees			2011	3,900	108	12	108		576	24
25	Linoleum in laundry room			2011	7,667	639	12	639		3,727	25
26	Paneling in patient rooms			2011	9,550	796	35	796		4,444	26
27	Geo Thermal Retrocommissioning			2012	357,300	10,209	35	10,209		49,343	27
28	Enclose Porches in resident living rooms			2012	25,892	740	35	740		3,083	28
29	Lighting Upgrade on exterior doors			2012	3,402	97	35	97		396	29
30	Air Filters			2013	3,000	86	35	86		337	30
31	Air Conditioning Reconfiguration			2013	48,300	1,380	35	1,380		4,830	31
32	Automatic Doors for four outside entrances			2013	23,651	676	35	676		2,425	32
33	Kick Resistant Panel			2013	5,630	161	34	161		563	33
34	Heat Pump			2014	5,418	159	34	159		451	34
35	LED Oustide Lighting			2014	10,113	297	34	297		817	35
36	Paneling in patient rooms			2014	10,000	294	34	294		784	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C Reconfiguration	2014	$ 8,120	$ 239	34	$ 239	$	$ 538	37
38	Revise electrical outlets	2014	18,900	556	34	556		1,158	38
39	Hearing Loop	2015	6,985	218	32	218		418	39
40	ID Card System	2015	6,665	208	32	208		382	40
41	Paneling Rm 532, 605, 607, 614, 712, 204, 211, 312,406, 410, 412	2015	7,118	222	32	222		352	41
42	Water Softener	2015	20,000	625	32	625		885	42
43	Bathroom Flooring	2015	8,801	275	32	275		367	43
44	Paneling Rm 514, 528, 718, 720, 711, 528, Haircare area	2016	6,955	112	31	112		112	44
45	Nurse Call Addition	2016	5,770	47	31	47		47	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)		$ 16,577,951	$ 414,903		$ 414,903	$	$ 3,541,148	70

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,148,732	$ 149,448	$ 149,448	$	4--15	$ 1,415,838	71
72	Current Year Purchases	157,209	5,627	5,627		4--15	5,627	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,305,941	$ 155,075	$ 155,075	$		$ 1,421,465	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1996 Dodge Van	1996	$ 21,621	$	$	$		$ 21,621	76
77	Machinery			8,720					8,720	77
78	Patient Transportation	Chevy Ex Pas Van	2010	24,149	3,450	3,450		7	21,562	78
79	Patient Transportation	2009 Dodge Braun	2011	32,500	4,643	4,643			25,536	79
80	TOTALS			$ 86,990	$ 8,093	$ 8,093	$		$ 77,439	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 19,373,692	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 578,071	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 578,071	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,040,052	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 33,270 Description: copiers
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	resident transportation	For Elkhart	$ 673.00	$ 8,076	17
18					18
19					19
20					20
21	TOTAL		$ 673.00	$ 8,076	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: 01/01/2016 Ending: 12/31/2016

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.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 37,639	$		$ 37,639	1
2	Licensed Speech and Language Development Therapist		hrs			57,008			57,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			58,154			58,154	4
5	Physician Care		visits			1,769			1,769	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				131,910		131,910	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB					26,395			26,395	12
13	Other (specify):									13
14	TOTAL			$		$ 180,965	$ 131,910		$ 312,875	14

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

Facility Name & ID Number Apostolic Christian Restmor **#** 0047167 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ 1,231,618	$	1
2	Cash-Patient Deposits	4,811		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,830)	630,914		3
4	Supply Inventory (priced at)	87,546		4
5	Short-Term Investments	2,631,967		5
6	Prepaid Insurance	50,408		6
7	Other Prepaid Expenses	40,481		7
8	Accounts Receivable (owners or related parties)	51,058		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,728,803	$	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	2,392,930		16
17	Accumulated Depreciation (book methods)	(5,040,047)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,579,085		21
22	Other Long-Term Assets (spe**Land Improvements**	856,711		22
23	Other(specify): Bldg Imp and WIP	1,711,895		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,984,980	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 22,713,783	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 129,880	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,811		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	715,849		30
31	Accrued Taxes Payable (excluding real estate taxes)	93,633		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		556,474		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,500,647	$	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)**	$ 1,500,647	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,213,136	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 22,713,783	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 20,372,608	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 20,372,608	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	840,527	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) **rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 840,528	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)**	$ 21,213,136	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,854,013	1
2	Discounts and Allowances for all Levels	(730,793)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,123,220	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	752,188	6
7	Oxygen	55,031	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 807,219	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	51,135	13
14	Non-Patient Meals	47,775	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,296	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,430	19
20	Radiology and X-Ray		20
21	Other Medical Services	243,931	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 491,567	23
	D. Non-Operating Revenue		
24	Contributions	225,509	24
25	Interest and Other Investment Income***	32,334	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 257,843	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Page 23	47,687	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 47,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,727,536	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,162,044	31
32	Health Care	5,286,751	32
33	General Administration	2,342,840	33
	B. Capital Expense		
34	Ownership	619,416	34
	C. Ancillary Expense		
35	Special Cost Centers	197,979	35
36	Provider Participation Fee	277,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,887,009	40
41	**Income before Income Taxes (line 30 minus line 40)****	840,527	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 840,527	43

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,080	$ 103,328	$ 49.68	1
2	Assistant Director of Nursing	1,979	2,190	76,639	34.99	2
3	Registered Nurses	41,861	45,511	1,257,845	27.64	3
4	Licensed Practical Nurses	20,069	22,058	534,476	24.23	4
5	CNAs & Orderlies	118,280	128,285	1,897,308	14.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,817	3,397	59,393	17.48	8
9	Activity Director	1,580	1,826	26,728	14.64	9
10	Activity Assistants	12,122	13,009	165,843	12.75	10
11	Social Service Workers	5,079	5,574	123,358	22.13	11
12	Dietician	866	906	22,945	25.33	12
13	Food Service Supervisor	1,984	2,165	77,258	35.68	13
14	Head Cook	6,183	6,790	108,493	15.98	14
15	Cook Helpers/Assistants	39,195	41,729	444,191	10.64	15
16	Dishwashers					16
17	Maintenance Workers	8,658	9,414	202,975	21.56	17
18	Housekeepers	12,626	13,466	157,256	11.68	18
19	Laundry	7,870	8,564	105,975	12.37	19
20	Administrator	1,748	2,080	138,859	66.76	20
21	Assistant Administrator	1,905	2,200	118,049	53.66	21
22	Other Administrative	3,409	3,954	81,378	20.58	22
23	Office Manager					23
24	Clerical	10,988	12,322	276,037	22.40	24
25	Vocational Instruction					25
26	Academic Instruction	1,474	1,664	55,663	33.45	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,380	8,010	121,571	15.18	31
32	Other Health C: Dir Mem Support	1,861	2,104	56,683	26.94	32
33	Other(specify) Hair Care Vol Dir	2,950	3,192	50,960	15.96	33
34	TOTAL (lines 1 - 33)	314,868	342,490	$ 6,263,211 *	$ 18.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		12,000	9--3	36
37	Medical Records Consultant	34	2,491	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)	34	$ 14,491		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Kelley	Administrator		$ 138,859
Michael Kaiser	Asst Admin		118,049
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 256,908

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 Larson Allen	Auditing	$ 23,650
FGMK LLC	Cost Report	3,518
FGMK LLC	consulting	3,145
Benckenforf	Legal	2,126
Polsinelli Shughart	Legal	7,874
Marcum	consulting HIPAA	367
Principlal Financial	Pension	3,000
Heinold Banwart	Wage Consulting	1,898
Personnel Planners	UC Management	1,728
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 47,306

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,667
Unemployment Compensation Insurance	7,163
FICA Taxes	451,695
Employee Health Insurance	373,317
Employee Meals	2,661
Illinois Municipal Retirement Fund (IMRF)*	
Disability Ins	6,007
Employee Relations	8,057
403-b Cost	394,029
Uniform Rental	16,800
Employee Hiring and Training	1,918
Tuition Reimbursement	11,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,373,314

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	17,891
Health Care Worker Background Check	
(Indicate # of checks performed 25)	700
Patient Background Checks 113	1,130
Leading Age Dues	11,652
Affordable Care Act Fees	3,068
other	986
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,427

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Leading Age IL convention travel	4,657
Other	3,793
Seminar Expense	
	6,890
Relias Training	16,787
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,127

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **Leading Age 11652**

(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? **4--15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,993** 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. $ **277,979**
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. $ **15,917** Has any meal income been offset against related costs? Indicate the amount. $ **13,256**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **no**
Attach invoices and a summary of services for all architect and appraisal fees

SCHEDULE XVII PAGE 19
LINE 28a

Social Activities Income	3848
Private Pay Laundry	3130
Finance Charges	239
Telephone	21
Personal Supplies Income	1204
Sunshine Cart Income	130
Misc Income	727
POM Management Fee	38100
Misc Income	288
	47687