

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0016220</u></p> <p>Facility Name: <u>Apos Christian Timber Ridge</u></p> <p>Address: <u>2125 Veterans Road</u> <u>Morton</u> <u>61550</u> Number City Zip Code</p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>309-266-9781</u> Fax # <u>309-266-9468</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/1/1971</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Matthew D. Steffen</u> Telephone Number: <u>309-266-9781</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2016</u> to <u>6/30/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Matthew D. Steffen</u></td> </tr> <tr> <td></td> <td>(Title) <u>Finance and Operations Director</u></td> </tr> <tr> <td rowspan="5" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Matthew D. Steffen</u>		(Title) <u>Finance and Operations Director</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																				
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																				
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	(Date) _____																																					
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	(Telephone) () _____ Fax # () _____																																					

Facility Name & ID Number Apos Christian Timber Ridge

0016220 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	25,881			25,881	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,881			25,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.82%

D. How many bed reserve days during this year were paid by the Department?
298 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/71

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/16 Fiscal Year: 6/30/16

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

Facility Name & ID Number Apos Christian Timber Ridge # 0016220 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	284,276	23,306	5,466	313,048	(434)	312,614		312,614		1
2	Food Purchase		208,922		208,922		208,922		208,922		2
3	Housekeeping	127,296	17,211		144,507		144,507		144,507		3
4	Laundry	104,118	19,809		123,927	272	124,199		124,199		4
5	Heat and Other Utilities			93,215	93,215		93,215		93,215		5
6	Maintenance	105,295	25,376	44,677	175,348	3,146	178,494	(16,435)	162,059		6
7	Other (specify):*										7
8	TOTAL General Services	620,985	294,624	143,358	1,058,967	2,984	1,061,951	(16,435)	1,045,516		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,746,741	263,539	34,311	3,044,591	(47,306)	2,997,285	(11,135)	2,986,150		10
10a	Therapy	226,474	5,678	3,477	235,629	(1,385)	234,244		234,244		10a
11	Activities	284,894	7,473		292,367	(316)	292,051		292,051		11
12	Social Services	295,364	4,969	16,627	316,960	(76)	316,884		316,884		12
13	CNA Training		6,240		6,240	52,632	58,872		58,872		13
14	Program Transportation			54,032	54,032		54,032	15,174	69,206		14
15	Other (specify):*	122,750	2,125		124,875	(148)	124,727		124,727		15
16	TOTAL Health Care and Programs	3,676,223	290,024	108,447	4,074,694	3,401	4,078,095	4,039	4,082,134		16
	C. General Administration										
17	Administrative	91,933			91,933		91,933		91,933		17
18	Directors Fees										18
19	Professional Services			94,244	94,244		94,244		94,244		19
20	Dues, Fees, Subscriptions & Promotions			46,393	46,393		46,393	(23,611)	22,782		20
21	Clerical & General Office Expenses	77,651	21,756	47,523	146,930	470	147,400		147,400		21
22	Employee Benefits & Payroll Taxes			976,094	976,094		976,094	(26,824)	949,270		22
23	Inservice Training & Education			5,956	5,956		5,956		5,956		23
24	Travel and Seminar			2,158	2,158		2,158	(1,406)	752		24
25	Other Admin. Staff Transportation			3,347	3,347		3,347		3,347		25
26	Insurance-Prop.Liab.Malpractice			25,649	25,649		25,649	(10,533)	15,116		26
27	Other (specify):*			10,854	10,854	(10,951)	(97)		(97)		27
28	TOTAL General Administration	169,584	21,756	1,212,218	1,403,558	(10,481)	1,393,077	(62,374)	1,330,703		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,466,792	606,404	1,464,023	6,537,219	(4,096)	6,533,123	(74,770)	6,458,353		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

Apos Christian Timber Ridge

#0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,338	106,338		106,338	(49,599)	56,739			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					15,367	15,367	(15,367)	(1)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,450	2,450		2,450		2,450			35
36	Other (specify):*			107,787	107,787	(15,367)	92,421	(92,420)	1			36
37	TOTAL Ownership			216,575	216,575		216,575	(157,386)	59,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					4,096	4,096		4,096			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,476	228,476		228,476		228,476			42
43	Other (specify):*			3,734	3,734		3,734		3,734			43
44	TOTAL Special Cost Centers			232,210	232,210	4,096	236,306		236,306			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,466,792	606,404	1,912,808	6,986,004		6,986,004	(232,156)	6,753,848			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (16,435)	6	\$	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	(92,420)	36		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		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(10,533)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,611)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,999)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (142,999)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Apos Christian Timber Ridge

ID# 0016220

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset day training transportation income	\$ (11,135)	10	1
2	Offset day training transportation income	15,174	14	2
3	Out-of-state Travel (Administrative Staff)	(273)	24	3
4	Depreciation of non-care vehicles	(49,599)	30	4
5	Offset medically necessary transportation income	0	38	5
6	Benefits allocated to day programming	(26,824)	22	6
7	Out-of-state Travel (Board of Directors)	(1,133)	24	7
8	Interest Expense	(15,367)	32	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
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	(89,157)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apos Christian Timber Ridge# 0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(16,435)	0	0	0	0	0	0	0	0	0	0	(16,435)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,435)	0	0	0	0	0	0	0	0	0	0	(16,435)	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	(11,135)	0	0	0	0	0	0	0	0	0	0	(11,135)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	15,174	0	0	0	0	0	0	0	0	0	0	15,174	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	4,039	0	0	0	0	0	0	0	0	0	0	4,039	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(23,611)	0	0	0	0	0	0	0	0	0	0	(23,611)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(26,824)	0	0	0	0	0	0	0	0	0	0	(26,824)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,406)	0	0	0	0	0	0	0	0	0	0	(1,406)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(10,533)	0	0	0	0	0	0	0	0	0	0	(10,533)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(62,374)	0	0	0	0	0	0	0	0	0	0	(62,374)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,770)	0	0	0	0	0	0	0	0	0	0	(74,770)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apos Christian Timber Ridge # 0016220 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(49,599)	0	0	0	0	0	0	0	0	0	0	(49,599) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(15,367)	0	0	0	0	0	0	0	0	0	0	(15,367) 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):*	(92,420)	0	0	0	0	0	0	0	0	0	0	(92,420) 36
37	TOTAL Ownership	(157,386)	0	0	0	0	0	0	0	0	0	0	(157,386) 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)	(232,156)	0	0	0	0	0	0	0	0	0	0	(232,156) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Apostolic Christian LifePoints, Inc.</u>	<u>100%</u>	<u>Oakwood Estate #0033712</u>	<u>Morton</u>	<u>Apostolic Christian</u>	<u>Morton</u>	<u>CILA Residential</u>
		<u>Linden Estate #0039305</u>	<u>Morton</u>	<u>CILA Services</u>		<u>Services for the</u>
						<u>Developmental</u>
						<u>& Intellectual</u>
						<u>Disabled</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

Apos Christian Timber Ridge

16220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Virgil Metzger	Vice-Chairman	Director	0.00	213	0.5		Travel	\$ 564	line 24; col. 3	1
2	Ben Knochel	Director	Director	0.00	0	0.5			0		2
3	Paul Kelson	Director	Director	0.00	36	0.5		Travel	96	line 24; col. 3	3
4	Dennis Mott	Director	Director	0.00	85	0.5		Travel	226	line 24; col. 3	4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		5
6	Bryan Stoller	Chairman	Director	0.00	35	0.5		Travel	92	line 24; col. 3	6
7	Kathy Woodruff	Director	Director	0.00	343	0.5		Travel	907	line 24; col. 3	7
8	Ed Leman	Director	Director	0.00	0	0.5			0		8
9	Tim Steffen	Director	Director	0.00	0	0.5			0		9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0		10
11	Wendy Witzig	Director	Director	0.00	0	0.5			0		11
12											12
13								TOTAL	\$ 1,885		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

Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	Virgil Metzger	BOD						1
2	Ben Knochel	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Roger Beutel	BOD						5
6	Bryan Stoller	BOD						6
7	Kathy Woodruff	BOD						7
8	Ed Leman	BOD						8
9	Tim Steffen	BOD						9
10	Royce Scheiler	BOD						10
11	Wendy Witzig	BOD						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 Apos Christian Timber Ridge # 0016220 Report Period Beginning: 7/1/2016 Ending: 5/30/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Morgan Stanley (PLA/LAL)		x	State Payment Delays	Interest	10/2008	4,667,000		None	3.0000	15,367	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,667,000	\$			\$ 15,367	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,667,000	\$			\$ 15,367	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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:	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

FOR BHF USE ONLY

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

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apos Christian Timber Ridge COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0016220

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,135 B. General Construction Type: Exterior Brick Frame Fireproof Constructor 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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: LTC Facility, 821,980, 1969, \$ 33,227, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 821,980, (blank), \$ 33,227, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	37		1972	\$ 647,557	\$	40	\$	\$	\$ 647,557	4
5	37		1977	1,006,746	24,893	40	24,893		1,002,678	5
6										6
7										7
8										8
	Improvement Type**									
9	3--Original Storage Building		1974	8,047		40			8,047	9
10	4--Second Floor Storage		1975	281		40			281	10
11	5--Balcony Storage		1976	289		40			289	11
12	6--Tub & Water Heater		1976	448		40			448	12
13	19--New Addition Phase 2		1979	47,854	1,196	40	1,196		46,416	13
14	7--Additional Storage Building Phase 1		1981	4,660	117	40	117		4,253	14
15	21--Activity Room/ TVs		1981	1,265		40			1,133	15
16	8--Additional Storage Building Phase 2		1982	21,495	537	40	537		19,078	16
17	22--Front Entrance		1982	8,046	201	40	201		7,210	17
18	9--Electrical Upgrade		1983	126	3	40	3		109	18
19	23--Security System & Energy Saver		1983	9,724		40			8,231	19
20	24--Courtyard Foyer		1984	6,477	162	40	162		5,485	20
21	10--Garage Extension		1985	842	21	40	21		694	21
22	25--Nursing Foyer		1985	24,285	607	40	607		19,970	22
23	26--Upkeep (Windows,Furnace,Fixtures)		1986	9,877	247	40	247		7,878	23
24	27--North End & East Wing		1987	26,990	675	40	675		20,864	24
25	1--3 stall garage		1988	22,885	572	40	572		16,877	25
26	28--1988 Additions		1988	27,441	686	40	686		20,537	26
27	29--1989 Additions		1989	48,259	1,206	40	1,206		34,931	27
28	30--1990 Additions		1990	60,923	1,523	40	1,523		42,596	28
29	31--1991 Additions		1991	11,832	296	40	296		7,981	29
30	32--1992 Additions		1992	14,999	375	40	375		9,748	30
31	33--1994 Additions		1994	31,810	795	40	795		19,109	31
32	34--1995 Additions		1995	32,834	821	40	821		18,916	32
33	35--1996 Additions		1996	6,371	159	40	159		3,514	33
34	36--1997 Additions		1997	23,216	580	40	580		12,232	34
35	2--Garage Door for Van		1998	667		15			667	35
36	37--1998 Additions		1998	6,263	157	40	157		3,145	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 Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	38--1999 Additions	1999	\$ 17,738	\$ 443	40	\$ 443	\$	\$ 8,472	37
38	39--Air Conditioner	2000	1,882	47	40	47		824	38
39	40--Heat Pump	2000	3,100	78	40	78		1,357	39
40	41--Automatic Rear Door	2000	1,773	44	40	44		776	40
41	42--Power Panels/Generator	2000	14,000	350	40	350		6,125	41
42	43--Office Window to Lobby	2000	1,057	26	40	26		462	42
43	44--Exhaust Fan in Womens N Bathroom	2000	580	14	40	14		253	43
44	45--Dining Room Remodeling	2000	10,565	264	40	264		4,622	44
45	46--Fire Alarm Relay	2000	2,400	60	40	60		1,050	45
46	47--Remodel Bathrooms	2000	22,147	554	40	554		9,689	46
47	48--Water Coolers at both ends	2000	2,701	68	40	68		1,182	47
48	49--Roof Repairs	2000	1,133		40			467	48
49	471--Garage Lights	2001	1,400		15			1,400	49
50	472--OT/PT Decorating	2001	1,111		15			1,111	50
51	473--Slab Jacking	2001	1,312		15			1,312	51
52	474--Roof Replacement	2001	21,380		15			21,380	52
53	475--Roof Replacement	2001	16,779		15			16,779	53
54	476--Lobby Carpet and Redecorating	2001	11,774		15			11,774	54
55	477--Dining Room Remodeling	2001	3,308		15			3,308	55
56	478--Additional OMRP office (by activities)	2001	2,393		15			2,393	56
57	479--Pipe Insulation	2001	2,613		15			2,613	57
58	480--North Resident Renovation	2001	4,632		15			4,632	58
59	481--Activity Room Remodeling	2001	1,903		15			1,903	59
60	482--Sourth Whirlpool Room	2001	2,676		15			2,676	60
61	483--Hand Rails	2001	2,844		15			2,844	61
62	484--South Living Remodeling	2001	5,107		15			5,107	62
63	537--Garage Door	2002	594	20	15	20		594	63
64	538--Key pad entry for south end	2002	2,500	83	15	83		2,500	64
65	540--Water heater plumbing	2002	706	24	15	24		706	65
66	541--Water heaters	2002	8,482	283	15	283		8,482	66
67	542--Lighting - small office in lobby	2002	545	18	15	18		545	67
68	545--Air conditioner - south living room	2002	3,196	107	15	107		3,196	68
69	575--Roof on large garage	2003	8,941	596	15	596		8,643	69
70	TOTAL (lines 4 thru 69)		\$ 2,295,781	\$ 38,908		\$ 38,908	\$	\$ 2,130,051	70

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

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,295,781	\$ 38,908		\$ 38,908	\$	\$ 2,130,051	1
2	576--Garage door on small garage	2003	647	43	15	43		625	2
3	613--Plumb and insulate water lines	2004	7,274	485	15	485		6,547	3
4	614--Flooring for Corridors	2004	23,007	1,534	15	1,534		20,706	4
5	616--Air Conditioner	2004	1,259	84	15	84		1,133	5
6	617--Courtyard Carpet	2004	981	65	15	65		883	6
7	618--Heat Pump & Blower	2004	4,885	326	15	326		4,397	7
8	619--Electrical for Fuel tanks	2004	1,686	112	15	112		1,517	8
9	620--Heat pump	2004	3,980	265	15	265		3,582	9
10	621--Foot valve for Hopper	2004	637	42	15	42		573	10
11	622--Bathroom partitions	2004	3,176	212	15	212		2,859	11
12	623--Air conditioner south wing	2004	1,181	79	15	79		1,063	12
13	276--Fully Depreciated Assets	1971	104,543		20			104,543	13
14	277--Gravel Driveway	1974	1,220		20			1,220	14
15	278--Gravel Driveway	1974	500		20			500	15
16	279--Chain Link Fence	1976	3,440		20			3,440	16
17	280--Road Prep for New addition	1976	5,769		20			5,769	17
18	281--Bar-B-Que Pit	1981	277		20			277	18
19	282--Electric & Water to Picnic Area	1981	783		20			783	19
20	283--Chain Link Fence	1982	38		20			38	20
21	284--Chain Link Fence	1983	5,843		20			5,843	21
22	285--Ornamental Fence	1985	565		20			565	22
23	286--South Patio	1985	1,008		20			1,008	23
24	287--Resurfacing Driveway	1986	22,000		20			22,000	24
25	1208--Flooring 400, 500, 600 halls	2017	39,271	2,618	15	2,618		2,618	25
26	289--South Patio Sod & Lighting	1990	1,408		20			1,408	26
27	290--Pole Light	1993	975		20			975	27
28	291--Asphalt Parking Lot & Driveway	1993	5,530		20			5,530	28
29	1214/1224--Lobby Offices Remodeling	2017	19,822	1,321	15	1,321		1,321	29
30	293--Sewer Repair	1994	6,700		20			6,700	30
31	294--Tile Drain	1995	721		20			721	31
32	295--Asphalt Patching	1995	1,290		20			1,290	32
33	296--Excavate & Asphalt Drive	1997	15,136		20			15,136	33
34	TOTAL (lines 1 thru 33)		\$ 2,581,333	\$ 46,094		\$ 46,094	\$	\$ 2,355,621	34

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

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,581,333	\$ 46,094		\$ 46,094	\$	\$ 2,355,621	1
2	297--Asphalt South Drive	1998	39,261	1,963	20	1,963		39,261	2
3	298--Install Parking Lot Light Poles	1999	4,000	200	20	200		3,700	3
4	299--Repair Asphalt	1999	3,500	175	20	175		3,238	4
5	511--Blacktop Ramp at Rear Entrance	2001	770		10			770	5
6	512--Landscape Drive Entrance	2001	1,447		15			1,447	6
7	513--Landscape around Timber Ridge	2001	1,230		15			1,230	7
8	564--Sidewalk/entry apron	2002	11,816	394	15	394		11,816	8
9	647--Catch Basin & Tile @ South Drive	2004	3,344	223	15	223		3,009	9
10	648--Garage Door Opener	2005	720	48	15	48		600	10
11	649--Canopy Lighting	2005	788	53	15	53		656	11
12	650--MPR Remodel	2005	14,256	950	15	950		11,880	12
13	651--North Living Room Floor	2005	4,649	310	15	310		3,874	13
14	652--North Snack Room Remodeling	2005	1,452	97	15	97		1,210	14
15	653--Office Remodeling	2005	1,447	96	15	96		1,206	15
16	654--South Snack Room Refrigerator	2005	469		7			469	16
17	655--South Snack Room Remodeling	2005	9,127	608	15	608		7,606	17
18	656--Speech Room Floor	2005	641	43	15	43		534	18
19	680--Driveway Repavement	2005	50,323	3,355	15	3,355		41,936	19
20	681--Concrete to Picnic Area	2005	9,858	657	15	657		8,215	20
21	682--Concrete Pad for Dumpster	2005	806	54	15	54		672	21
22	692--Concrete leveling	2006	1,170	78	15	78		897	22
23	693--Sprinkler heads - bathroom closet	2006	1,082	72	15	72		830	23
24	695--Cabinets and Countertops	2006	680	45	15	45		522	24
25	706--Phone system	2006	1,756	117	15	117		1,346	25
26	707--Electronic Door repairs	2006	3,245	216	15	216		2,488	26
27	770--Concrete	2006	920	61	15	61		705	27
28	716--Bathroom remodel - 500 wing	2006	13,305	887	15	887		10,201	28
29	721--Laundry room remodel	2006	5,261	351	15	351		4,034	29
30	724--Door locks-South End	2006	687	46	15	46		526	30
31	735--North sick room	2006	3,557	237	15	237		2,727	31
32	740--Kitchen piping	2006	875	58	15	58		671	32
33	755--OT/PT office renovation	2006	287	19	15	19		220	33
34	TOTAL (lines 1 thru 33)		\$ 2,774,062	\$ 57,507		\$ 57,507	\$	\$ 2,524,117	34

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

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,774,062	\$ 57,507		\$ 57,507		\$ 2,524,117	1
2	697--Iron Fence for Rear Courtyard	2006	4,088	273	15	273		3,134	2
3	759--New driveway at Bus Garage	2006	5,130	342	15	342		3,933	3
4	762--North Courtyard Landscaping	2006	910	61	15	61		697	4
5	943--Roof Project	2010	18,642	165	15	165		1,156	5
6	801--Garage Doors - 4	2007	5,000	333	15	333		3,500	6
7	804--Bus Garage Renovations	2007	6,500	433	15	433		4,550	7
8	791--North Snack Room Remodeling	2007	5,476	365	15	365		3,833	8
9	796--Office Moves	2007	2,556	170	15	170		1,789	9
10	809--PT Outlet	2007	658	44	15	44		461	10
11	811--Floor and Cabinets N. Treatment	2007	22,292	1,486	15	1,486		15,605	11
12	814--North Treatment Room - Plumbing	2007	1,825	122	15	122		1,278	12
13	821--Office Move	2007	11,808	787	15	787		8,266	13
14	826--Damper - Heat and Air Conditioning	2007	61	4	15	4		43	14
15	831--Donated - New Concrete Sidewalk	2007	1,385	92	15	92		970	15
16	832--Landscaping - Donations	2007	600	40	15	40		420	16
17	833--2 Donated Wheelchairs and Dynavox	2007	1,000	67	15	67		700	17
18	836--Contributions - Landscaping - Time and Labor	2007	2,010	134	15	134		1,407	18
19	837--Contributions - Labor for N. Treatment Room	2007	39	3	15	3		27	19
20	786--Courtyard Landscaping	2007	9,283	619	15	619		6,498	20
21	790--Front Courtyard - Sidewalk	2007	1,950	130	15	130		1,365	21
22	824--Light Poles	2007	954	64	15	64		668	22
23	841--OT/PT Remodeling (flooring and painting)	2008	8,992	599	15	599		5,995	23
24	842--MPR Courtyard Door	2008	11,354	757	15	757		7,569	24
25	843--TR roof	2008	25,075	1,672	15	1,672		16,717	25
26	844--North Med Room remodeling (electrical)	2008	2,613	174	15	174		1,742	26
27	845--Hallway remodeling (Handrails and Wall coverings)	2008	2,233	149	15	149		1,489	27
28	846--South living room redecoration	2008	1,767	118	15	118		1,178	28
29	872--200 Wing Roof	2009	33,690	2,246	15	2,246		20,214	29
30	873--Air Conditioner (Roof Top)	2009	3,962		7			3,962	30
31	1216--New outlets for resident rooms	2017	5,341	356	15	356		356	31
32	874--Audio Visual Equipment	2009	7,084		7			7,084	32
33	945--Heat Tape Material - Gutters	2010	2,400	969	7	969		6,785	33
34	TOTAL (lines 1 thru 33)		\$ 2,980,740	\$ 70,281		\$ 70,281		\$ 2,657,508	34

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

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,980,740	\$ 70,281		\$ 70,281	\$	\$ 2,657,508	1
2	875--Hallway remodeling (Handrails and Wall coverings)	2009	47,652	3,177	15	3,177		28,591	2
3	876--Laundry Water Heater	2009	4,895		7			4,895	3
4	877--Lighting Project	2009	24,448		7			24,448	4
5	878--MPR Windows	2009	7,632	509	15	509		4,579	5
6	879--North Med Room remodeling (cabinets)	2009	1,237	82	15	82		742	6
7	881--Sprinkler Main Valve Replacement	2009	6,750	1,467	20	1,467		11,733	7
8	924--Repair Asphalt in Front Drive	2009	4,361	291	15	291		2,326	8
9	12--1972 Additions	1972	157		40			157	9
10	13--1973 Additions	1973	1,051		40			1,051	10
11	14--1973 Additions	1973	1,326		40			1,326	11
12	964--Kitchen/Laundry Area Roof Replacement	2010	13,742	2,278	15	2,278		15,946	12
13	976--500 Wing Roof Replacement	2011	15,095	337	15	337		3,037	13
14	982--Kitchen Roof	2011	13,742	1,243	15	1,243		9,942	14
15	985--Roof repairs with HVAC units	2011	2,478		15			2,400	15
16	987--100 Wing Roof Replacement	2011	14,540	916	15	916		7,329	16
17	990--North end Rooftop HVAC units	2011	34,170	1,006	15	1,006		7,044	17
18	880--Roof-Central Suppl, Dining, South Nursing	2009	22,000	916	15	916		6,413	18
19	1003--400 and 600 Wings Roof	2012	33,795	845	40	845		5,069	19
20	1004--Tempstar condenser	2012	2	167	15	167		1,000	20
21	1016--MPR Offices - Electrical / IT	2013	5,578	372	15	372		1,859	21
22	1018--Floor Covering (food prep, hall, storage)	2013	4,563	652	7	652		3,259	22
23	1021--Rheem furnace and a/c	2013	6,964	464	15	464		2,321	23
24	1022--Rheem Furnace and Gas Piping	2013	8,747	583	15	583		2,916	24
25	714--Bathroom remodeling 400 wing	2006	9,659	644	15	644		7,405	25
26	1087--IT Wiring for office changes	2014	2,729	273	10	273		1,092	26
27	1096--Landscaping - Brick Edging	2014	11,107	740	15	740		2,962	27
28	1097--Main Hallway Flooring	2014	30,000	2,000	15	2,000		8,000	28
29	1104--MPR Offices Wall construction	2014	5,850	195	30	195		780	29
30	1109--Roof for MPR	2014	13,349	667	20	667		2,670	30
31	1110--Roof for MPR - Rerun gas lines	2014	2,285	152	15	152		609	31
32	1118--Heated Bus Garage Door & Opener	2015	3,165	211	15	211		633	32
33	1119--Nurse Stations - Design, Cabinets, Installed	2015	46,816	3,121	15	3,121		9,363	33
34	TOTAL (lines 1 thru 33)		\$ 3,380,625	\$ 93,589		\$ 93,589	\$	\$ 2,839,405	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,380,625	\$ 93,589		\$ 93,589	\$	\$ 2,839,405	1
2	1119--Nurse Stations - Design, Cabinets, Installed	2015	46,816	3,121	15	3,121		9,363	2
3	1120--Stainless Steel Door Plates	2015	5,720	381	15	381		1,144	3
4	1121--TR Main Hallways & 18 TR Resident Rooms Flooring	2015	42,898	2,860	15	2,860		8,580	4
5	1152--Ceiling tiles--replacement	2015	2,819	188	15	188		564	5
6	1154--RTU System-Roof Top Unit w/Economizer	2015	8,024	535	15	535		1,605	6
7	1158--TR Handrails	2015	9,451	630	15	630		1,890	7
8	1160--TR CUH9350524 Chromalox 5KW Ceiling Htr	2015	7,194	480	15	480		1,439	8
9	1161--TR MPR Ceiling	2015	5,539	369	15	369		1,108	9
10	1168--Soiled Util,Housekpg,Dr Exam rms floorcover	2015	3,226	215	15	215		645	10
11	767--Concrete	2006	18,800	1,253	15	1,253		14,413	11
12	691--Picnic area landscaping	2006	1,660	111	15	111		1,273	12
13	1186--Concrete area in front of bus garage	2016	7,080	472	15	472		944	13
14	1229--Window Treatment - Solar	2017	9,648	965	10	965		965	14
15	1230--TR - LS Building Products- New Roof	2017	5,550	222	25	222		222	15
16	1237--TR - Kaiser Electrical - Interior LED Lighting Upgrade	2017	88,050	5,870	15	5,870		5,870	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,643,100	\$ 111,261		\$ 111,261	\$	\$ 2,889,430	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 569,183	\$ 54,727	\$ 54,727	\$	12.00	\$ 254,011	71
72	Current Year Purchases	83,545	10,725	10,725		3.00	12,013	72
73	Fully Depreciated Assets	1,140,656	12,318	12,318		9.00	1,140,656	73
74						8.00		74
75	TOTALS	\$ 1,793,384	\$ 77,770	\$ 77,770	\$		\$ 1,406,680	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,469,711	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,031	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)	\$ 4,296,110	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	Fully depreciated vehicles	\$ 88,216	\$	\$ 88,216	86
87	Capitalized repairs	47,640	5,032	23,930	87
88	Vehicle Equipment	60,026	4,860	20,385	88
89	Vehicles	393,914	39,707	208,694	89
90	Disposed Assets	84,082		84,082	90
91	TOTALS	\$ 673,878	\$ 49,599	\$ 425,307	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 Apos Christian Timber Ridge

0016220

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,450 Description: Oygen Concentrators - \$2,450

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	1,222	2,895		4,117
3	Classroom Wages (a)	6,460	16,320		22,780
4	Clinical Wages (b)	3,230	32,640		35,870
5	In-House Trainer Wages (c)	2,899	29,291		32,190
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 13,811	\$ 81,146	\$	\$ 94,957
10	SUM OF line 9, col. 1 and 2 (e)	\$ 94,957			

C. CONTRACTUAL INCOME

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

\$ 45,589

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	45
2. From other facilities (f)	33
DROP-OUTS	
1. From this facility	19
2. From other facilities (f)	
TOTAL TRAINED	97

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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 **Apos Christian Timber Ridge**

0016220

Report Period Beginning: **7/1/2016**

Ending:

6/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 97,625	\$ 98,975	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,101,039	2,438,591	3
4	Supply Inventory (priced at)	30,543	31,510	4
5	Short-Term Investments	4,035,175	4,035,175	5
6	Prepaid Insurance		20,990	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	678	678	8
9	Other(specify):	938,427	939,389	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,203,487	\$ 7,565,308	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,227	550,863	13
14	Buildings, at Historical Cost	3,216,970	8,027,151	14
15	Leasehold Improvements, at Historical Cost	722,125	1,007,539	15
16	Equipment, at Historical Cost	1,837,858	2,640,480	16
17	Accumulated Depreciation (book methods)	(3,772,965)	(6,216,698)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,121)	20
21	Restricted Funds	11,872,431	11,872,431	21
22	Other Long-Term Assets (specify):	131,626	131,626	22
23	Other(specify): Investment in Other Facilities	11,829,195	11,829,195	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,870,467	\$ 29,842,587	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,073,954	\$ 37,407,895	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 377,451	\$ 408,450	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	475,000	475,000	29
30	Accrued Salaries Payable	415,205	682,055	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	226,802	359,886	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rounding			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,494,458	\$ 1,926,429	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	Capital Lease	14,377	14,377	43
44	Investment from Other Facilities		11,829,195	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 14,377	\$ 11,843,572	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,508,835	\$ 13,770,001	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,565,119	\$ 23,637,894	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,073,954	\$ 37,407,895	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 29,209,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 29,209,444	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,355,675	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)	\$ 2,355,675	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)	\$ 31,565,119	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apos Christian Timber Ridge

0016220

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,784,250	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,784,250	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	61,996	10
11	CNA Training Reimbursements	107,756	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	35,331	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 205,083	23
D. Non-Operating Revenue			
24	Contributions	3,364,778	24
25	Interest and Other Investment Income***	506,081	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,870,859	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Developmental Training Income</u>	471,900	28
28a	<u>Gain/Loss on Sale of Assets</u>	9,587	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 481,487	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,341,679	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,058,967	31
32	Health Care	4,074,694	32
33	General Administration	1,403,558	33
B. Capital Expense			
34	Ownership	216,575	34
C. Ancillary Expense			
35	Special Cost Centers	3,734	35
36	Provider Participation Fee	228,476	36
D. Other Expenses (specify):			
37	<u>Rounding</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,986,004	40
41	Income before Income Taxes (line 30 minus line 40)**	2,355,675	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,355,675	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) <u>ICF-ID/DD</u>	4,784,250	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,784,250	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Apos Christian Timber Ridge

0016220

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,784	2,086	\$ 80,782	\$ 38.73	1
2	Assistant Director of Nursing	2,022	2,227	76,985	34.57	2
3	Registered Nurses	19,919	21,819	641,667	29.41	3
4	Licensed Practical Nurses	15,490	17,083	456,689	26.73	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,373	6,028	95,169	15.79	8
9	Activity Director	1,773	2,086	47,704	22.87	9
10	Activity Assistants	17,930	19,193	241,092	12.56	10
11	Social Service Workers	2,113	2,278	83,295	36.56	11
12	Dietician					12
13	Food Service Supervisor	1,809	2,086	60,395	28.95	13
14	Head Cook	6,424	7,582	99,863	13.17	14
15	Cook Helpers/Assistants	11,624	12,250	127,898	10.44	15
16	Dishwashers					16
17	Maintenance Workers	4,846	6,040	106,532	17.64	17
18	Housekeepers	9,753	11,642	133,096	11.43	18
19	Laundry	8,003	8,668	104,617	12.07	19
20	Administrator	888	1,143	64,225	56.19	20
21	Assistant Administrator	291	553	27,708	50.10	21
22	Other Administrative	1,705	2,477	62,519	25.24	22
23	Office Manager	306	597	13,398	22.44	23
24	Clerical	298	485	7,257	14.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,217	5,816	109,092	18.76	28
29	Resident Services Coordinator	2,121	2,461	57,426	23.33	29
30	Habilitation Aides (DD Homes)	102,537	111,723	1,466,961	13.13	30
31	Medical Records					31
32	Other Health Care(specify)	7,729	8,561	179,283	20.94	32
33	Other(specify)	6,983	8,059	123,139	15.28	33
34	TOTAL (lines 1 - 33)	236,938	262,943	\$ 4,466,792 *	\$ 16.99	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	120	\$ 5,466	1-3	35
36	Medical Director	Flat Fee	787	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	4,274	10-3	39
40	Physical Therapy Consultant	23	1,506	10-3	40
41	Occupational Therapy Consultant	30	1,971	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	166	12,164	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist Consultant</u>			12-3	46
47	<u>Dental Consultant</u>			10a-3	47
48	<u>Psychiatrist Consultant</u>	20	4,463	10a-3	48
49	TOTAL (lines 35 - 48)	359	\$ 30,631		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	39	1,221	10-3	51
52	Certified Nurse Assistants/Aides	1,433	27,694	10a-3	52
53	TOTAL (lines 50 - 52)	1,472	\$ 28,914		53

Facility Name & ID Number Apos Christian Timber Ridge# 0016220Report Period Beginning: 7/1/2016Ending: 6/30/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$4,218, Don Moss & Assoc - \$2,400, Institute on Public Policy - \$6,800
- (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? N/A
- (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? N/A
- (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? 9.1 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,722 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. \$ 230,455
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 388 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No, they have been adjusted out.
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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 66,155
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Koch Consultants, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Schedule V - Costs Center Expenses

Lines	Description	Amount
1	Day Program Costs	16,435
43	Facility Bulletin / Newsletter	3,734
36	Investment Management Fees	92,420
36	Interest Expense	15,367
15	Bad Debt	-
27	Dental costs	4,096
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	(97)
	Other Expenses	131,955

Schedule V - Reclassifications

Lines	Description	Increase	Decrease
6	Communication equipment rental	-	-
35	Communication equipment rental	-	-
32	Interest Expense	15,367	-
36	Interest Expense	-	15,367
11	Donated labor	-	-
1	Donated labor	-	-
4	Donated labor	272	-
6	Donated labor	3,758	-
21	Donated labor	470	-
10	Donated labor	-	-
10a	Donated labor	-	-
12	Donated labor	2,355	-
27	Donated labor	-	6,855
38	Medically necessary transportation	-	-
14	Medically necessary transportation	-	-
10a	Disability Pay to Benefits	-	-
22	Disability Pay to Benefits	-	-
13	Nurse aid trainer wages	52,632	-
1	Nurse aid trainer wages	-	434
6	Nurse aid trainer wages	-	612
10	Nurse aid trainer wages	-	47,306
10a	Nurse aid trainer wages	-	1,385
11	Nurse aid trainer wages	-	316
12	Nurse aid trainer wages	-	2,431
15	Nurse aid trainer wages	-	148
17	Nurse aid trainer wages	-	-
39	Dental costs	4,096	-
27	Dental costs	-	4,096
		78,950	78,950

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 31 visits	\$ 4,096
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Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	\$ 6,855
	Department	Time in Hours Time in Dollars
	Activities	- -
	Kitchen	- -
	Laundry	32.00 272
	Maintenance	375.75 3,758
	Nursing	- -
	PT/OT	- -
	Social Service Programs	277.00 2,355
	Office	55.25 470
	Totals	740.00 \$ 6,855

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - \$213.32 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Ben Knochel - \$0.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Paul Kelson - \$36.33 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Dennis Mott - \$85.47 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Bryan Stoller - \$34.89 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Kathy Woodruff - \$343.17 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Tim Steffen - \$0.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 9; Other Current Assets

A/R - N.A. Training	72,671
A/R - Bequests	246,000
A/R - Health Insurance	607,319
A/R - Employees	12,437
	938,427

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	11,829,195
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Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	471,900
Farm Income	-
Gain/(Loss) on Sale of Assets	2,996
Increase in Cash Value of Life Insurance	-
Miscellaneous	6,591
Cost to Market Adjustment on Investments	481,487

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	2,355,675
Income from related parties	(536,766)
Estimated excess for year, Form 990, p.1, line 18	1,818,909

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	4,466,792
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(4,466,792)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	4,466,792
Prior Year PTO Accrual	(187,501)
Current Year PTO Accrual	206,922
Prior Year Wage Accrual	193,482
Current Year Wage Accrual	(158,202)
Section 125 Wages not applicable to FICA taxes	(335,754)
Less: Wages over FICA taxation limit of SS Wages (\$0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilities	488,873
Add: ACCS Wages	-
Add: wages included in employee meal calculation	-
Cash basis salaries	4,674,613
FICA rate	7.650%
Calculated FICA	357,608
FICA per Sch XIX	357,608
Variance	(0)

Sch. XX - General Information

12. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	1,385
	Activities Director	316
	Day Program	148
	Head Cook	434
	Maintenance	612
	Nursing	47,306
	Soc. Serv. / QMRP	2,431
		52,632

14. A portion of office space is allocated to related entities based on number of beds.

16. Out of State Travel

Administration

Administrator	36
Assistant Administrator	23
	59

Board of Directors

Virgil Metzger (No out of State Travel)	-
Ben Knochel (No out of State Travel)	-
Paul Kelson (No out of State Travel)	-
Dennis Mott	226
Roger Beutel (No out of State Travel)	-
Bryan Stoller (No out of State Travel)	-
Kathy Woodruff	907
Ed Leman (No out of State Travel)	-
Tim Steffen (No out of State Travel)	-
Royce Scheiler (No out of State Travel)	-
Wendy Witzig (No out of State Travel)	-
	1,133

Nursing

None	-
	-

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Oakwood Estate #0033712

Linden Estate #0039305

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Bryan Stoller, Chairman

Virgil Metzger, Vice Chairman

Paul Kelson, Secretary/Treasurer

Kathy Woodruff, Director

Ed Leman, Director

Royce Scheiler, Director

Ben Knochel, Director

Wendy Sauder, Director (term began 05/20/2017)

Roger Beutel, Director (term began 5/20/2017)

Tim Steffen, Director (term ended 05/20/2017)

Dennis Mott, Director (term ended 05/20/2017)

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.