FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Ave (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: 3092841400 **Fax #** 3092667877

HFS ID Number:

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

Type of Ownership:

	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 01/01/2018 to 12/31/2018 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) Administrator & CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 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	2,722	30,246	1,555	34,523	8
9	SNF/PED					9
10	ICF		4,355		4,355	10
11	ICF/DD					11
12	SC		3,224		3,224	12
13	DD 16 OR LESS					13
14	TOTALS	2,722	37,825	1,555	42,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.12%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
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 04/01/2008

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

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 1,555

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: 01/01/2018 Ending: 12/31/2018

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	711,680	49,918		761,598		761,598		761,598			1
2	Food Purchase		425,200		425,200	(17,225)	407,975	(39,682)	368,293			2
3	Housekeeping	157,262	48,331		205,593		205,593		205,593			3
4	Laundry	91,977	16,069		108,046		108,046	(2,473)	105,573			4
5	Heat and Other Utilities			185,400	185,400		185,400		185,400			5
6	Maintenance	221,589	79,884	280,775	582,248	(39,611)	542,637		542,637			6
7	Other (specify):*			23,017	23,017		23,017		23,017			7
8	TOTAL General Services	1,182,508	619,402	489,192	2,291,102	(56,836)	2,234,266	(42,155)	2,192,111			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,485,233	259,448	23,342	4,768,023		4,768,023		4,768,023			10
10a	Therapy			424,758	424,758		424,758		424,758			10a
11	Activities	226,715			226,715		226,715	(45)	226,670			11
12	Social Services	216,064		60	216,124		216,124		216,124			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,928,012	259,448	460,160	5,647,620		5,647,620	(45)	5,647,575			16
	C. General Administration											
17	Administrative	199,322			199,322		199,322	(30,300)	169,022			17
18	Directors Fees											18
19	Professional Services			37,467	37,467		37,467	(5,027)	32,440			19
20	Dues, Fees, Subscriptions & Promotions			55,274	55,274		55,274	(30,854)	24,420			20
21	Clerical & General Office Expenses	343,253	27,240	157,043	527,536		527,536	(3,533)	524,003			21
22	Employee Benefits & Payroll Taxes			1,508,572	1,508,572	17,225	1,525,797	(22,925)	1,502,872			22
23	Inservice Training & Education											23
24	Travel and Seminar			39,779	39,779	(2,064)	37,715	(4,754)	32,961			24
25	Other Admin. Staff Transportation			3,470	3,470	2,064	5,534	(3,034)	2,500			25
26	Insurance-Prop.Liab.Malpractice			106,339	106,339		106,339		106,339			26
27	Other (specify):*											27
28	TOTAL General Administration	542,575	27,240	1,907,944	2,477,759	17,225	2,494,984	(100,427)	2,394,557			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,653,095	906,090	2,857,296	10,416,481	(39,611)	10,376,870	(142,627)	10,234,243			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: 01/01/2018 Ending: 12/31/2018

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			681,509	681,509		681,509		681,509			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					39,611	39,611		39,611			35
36	Other (specify):*											36
37	**TOTAL Ownership**			681,509	681,509	39,611	721,120		721,120			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			114,150	114,150		114,150		114,150			39
40	Barber and Beauty Shops	24,757	6,454		31,211		31,211		31,211			40
41	Coffee and Gift Shops			54,779	54,779		54,779	(54,779)				41
42	Provider Participation Fee			290,090	290,090		290,090		290,090			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	24,757	6,454	459,019	490,230		490,230	(54,779)	435,451			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,677,852	912,544	3,997,824	11,588,220		11,588,220	(197,406)	11,390,814			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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allwable Seminar	$ (1,932)	24	1
2	Non Allowable Dues and Subscriptions	(16,044)	20	2
3	Promotions and Yellow Pages	(14,555)	20	3
4	Employee Meal Income	(13,228)	22	4
5	Guest Meal Income	(6,526)	2	5
6	Misc Expense	(1,676)	21	6
7	Misc Income	(1,857)	21	7
8	Auto Expense	(3,034)	25	8
9	Professional Fees for Medicare and corporation	(5,027)	19	9
10	Meals on Wheels Expense	(33,156)	2	10
11	Sunshine Cart Income	(45)	11	11
12	POM management Fee	(30,300)	17	12
13	Travel out of State	(2,822)	24	13
14	Penalties	(255)	20	14
15	Interest Income Pension	(4,719)	22	15
16	Non Operating Expense	(54,779)	41	16
17	Private Pay Laundry	(2,473)	4	17
18	Excess Life Insurance	(4,978)	22	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**	(197,406)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(39,682)	0	0	0	0	0	0	0	0	0	0	(39,682)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,473)	0	0	0	0	0	0	0	0	0	0	(2,473)	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**	(42,155)	0	0	0	0	0	0	0	0	0	0	(42,155)	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	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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**	(45)	0	0	0	0	0	0	0	0	0	0	(45)	16
	C. General Administration													
17	Administrative	(30,300)	0	0	0	0	0	0	0	0	0	0	(30,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,027)	0	0	0	0	0	0	0	0	0	0	(5,027)	19
20	Fees, Subscriptions & Promotions	(30,854)	0	0	0	0	0	0	0	0	0	0	(30,854)	20
21	Clerical & General Office Expenses	(3,533)	0	0	0	0	0	0	0	0	0	0	(3,533)	21
22	Employee Benefits & Payroll Taxes	(22,925)	0	0	0	0	0	0	0	0	0	0	(22,925)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,754)	0	0	0	0	0	0	0	0	0	0	(4,754)	24
25	Other Admin. Staff Transportation	(3,034)	0	0	0	0	0	0	0	0	0	0	(3,034)	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**	(100,427)	0	0	0	0	0	0	0	0	0	0	(100,427)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(142,627)	0	0	0	0	0	0	0	0	0	0	(142,627)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor # 0047167 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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	(54,779)	0	0	0	0	0	0	0	0	0	0	(54,779)	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**	(54,779)	0	0	0	0	0	0	0	0	0	0	(54,779)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(197,406)	0	0	0	0	0	0	0	0	0	0	(197,406)	45

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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: 01/01/2018 Ending: 12/31/2018

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	Joe Zimmerman, Pres	BOD						1
2	Gary Psinas, V Pres	BOD						2
3	Brian Bahr	BOD						3
4	John Dill, Sec/Treas	BOD						4
5	Curt Tanner Asst Secretary/ Treasurer	BOD						5
6	John Knobloch	BOD						6
7	Dan Wagenbach	BOD						7
8								8
9								9
10								10
11								11
12								12
13								13
14	All Directors are volunteers, and receive no compensation							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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 2/31/2018

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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	facility	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: 01/01/2018 Ending: 12/31/2018

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	$ 14,231,596	$ 355,790	40	$ 355,790	$	$ 3,824,743	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Site preparation and grading			2008	395,786						9
10	Remote unattached storage building			2008	207,121	5,178	20	5,178		55,664	10
11	Road and parking area			2008	194,661	9,733	20	9,733		104,630	11
12	Brick Edging and Landscaping			2008	10,923	546	15	546		5,782	12
13	New Sidewalk			2009	8,245	550	20	550		5,133	13
14	Concrete drainage ways for stormwater			2009	10,656	533	15	533		4,885	14
15	Additional Heat Pump for Spa area			2009	7,020	468	15	468		4,524	15
16	Additional Lighting			2009	9,232	615	15	615		5,945	16
17	New Ventilators in Spa area			2009	6,791	453	15	453		4,349	17
18	Additional Smoke Devices			2009	2,667	178	15	178		1,750	18
19	Additional Door Holders			2009	2,758	184	20	184		1,717	19
20	Courtyard concrete finish			2010	11,808	590	37	590		5,163	20
21	Re keying all doors			2010	9,980	270	37	270		2,340	21
22	Smokedoors			2010	10,570	286	37	286		2,455	22
23	New Trees			2010	5,000	135	36	135		1,114	23
24	New Trees			2011	3,900	108	12	108		792	24
25	Linoleum in laundry room			2011	7,667	639	12	639		5,005	25
26	Paneling in patient rooms			2011	9,550	796	35	796		6,036	26
27	Geo Thermal Retrocommissioning			2012	357,300	10,209	35	10,209		69,761	27
28	Enclose Porches in resident living rooms			2012	25,892	740	35	740		4,563	28
29	Lighting Upgrade on exterior doors			2012	3,402	97	35	97		590	29
30	Air Filters			2013	3,000	86	35	86		509	30
31	Air Conditioning Reconfiguration			2013	48,300	1,380	35	1,380		7,590	31
32	Automatic Doors for four outside entrances			2013	23,651	676	35	676		3,777	32
33	Kick Resistant Panel			2013	5,630	161	34	161		885	33
34	Heat Pump			2014	5,418	159	34	159		769	34
35	LED Oustide Lighting			2014	10,113	297	34	297		1,411	35
36	Paneling in patient rooms			2014	10,000	294	34	294		1,372	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: 01/01/2018 Ending: 12/31/2018

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	$	$ 1,016	37
38	Revise electrical outlets	2014	18,900	556	34	556		2,270	38
39	Hearing Loop	2015	6,985	218	32	218		854	39
40	ID Card System	2015	6,665	208	32	208		798	40
41	Paneling Rm 532, 605, 607, 614, 712, 204, 211, 312,406, 410, 412	2015	7,118	222	32	222		796	41
42	Water Softener	2015	20,000	625	32	625		2,135	42
43	Bathroom Flooring	2015	8,801	275	32	275		917	43
44	Paneling Rm 514, 528, 718, 720, 711, 528, Haircare area	2016	6,955	224	31	224		560	44
45	Nurse Call Addition	2016	5,770	186	31	186		419	45
46	Building addition which connects Pine and Spruce wings together	2017	1,206,374	38,915	31	38,915		77,830	46
47	Panelam Rm 304 ,311 ,323 ,418 ,520 ,713 ,714 ,604	2017	6,975	233	30	233		427	47
48	Vinyl Flooring Rm 222, 303, 409, 607, 608, 612, 713, 719, 925, 928	2017	10,073	336	30	336		560	48
49	New Roof Entire Building	2017	936,561	31,219	30	31,219		44,227	49
50	Replace Concrete in Employee and Visitor Parking Lots	2017	612,479	20,416	30	20,416		25,520	50
51	Electronic Door for Employee Corridor	2017	4,308	144	30	144		168	51
52	River Rock placed around building edge	2017	10,300	343	30	343		372	52
53	Brick edging along west parking lot sidewalk	2018	5,700	158	30	158		158	53
54	New Sprinkler System whole facility	2018	306,178	15,309	15	15,309		15,309	54
55	Panelam Rm 223, 303, 325, 409, 515, 519,	2018	3,850	86	30	86		86	55
56	Sidewalk Repairs in egress areas leading away from building	2018	7,970	177	30	177		177	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)		$ 18,838,719	$ 501,240		$ 501,240	$	$ 4,307,853	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: 01/01/2018 Ending: 12/31/2018

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	$ 2,475,858	$ 165,805	$ 165,805	$	4--15	$ 1,761,159	71
72	Current Year Purchases	97,805	6,710	6,710			6,710	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,573,663	$ 172,515	$ 172,515	$		$ 1,767,869	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	2017 Dodge Grand Caravan	2017	$ 38,037	$ 5,434	$ 5,434	$	7	$ 9,057	76
77	Machinery			8,720					8,720	77
78	Patient Transportation	Chevy Express Passenger Van	2010	24,149					24,149	78
79	Patient Transportation	2009 Dodge Braun	2011	32,500	2,321	2,321			32,500	79
80	TOTALS			$ 103,406	$ 7,755	$ 7,755	$		$ 74,426	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)	$ 21,918,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 681,510	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 681,510	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)	$ 6,150,148	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: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 39,611 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	Ford 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: 01/01/2018 Ending: 12/31/2018

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	$		$ 36,219	$		$ 36,219	1
2	Licensed Speech and Language Development Therapist		hrs			38,821			38,821	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			62,307			62,307	4
5	Physician Care		visits			4,891			4,891	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			97,466			97,466	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/Xray					11,793			11,793	13
14	TOTAL			$		$ 251,497	$		$ 251,497	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 1,053,808	$	1
2	Cash-Patient Deposits	5,473		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,830)	614,832		3
4	Supply Inventory (priced at)	97,959		4
5	Short-Term Investments	2,995,272		5
6	Prepaid Insurance	122,256		6
7	Other Prepaid Expenses	31,507		7
8	Accounts Receivable (owners or related parties)	96,951		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,018,058	$	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	14,231,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,677,068		16
17	Accumulated Depreciation (book methods)	(6,150,142)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,550,431		21
22	Other Long-Term Assets (specify):	856,711		22
23	Other(specify): Building Additions & Imp	3,776,064		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,344,538	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,362,596	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,110	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,473		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	612,129		30
31	Accrued Taxes Payable (excluding real estate taxes)	99,422		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	Insurance Payable	135,045		36
37	Pension Payable	384,711		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,301,890	$	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)**	$ 1,301,890	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 23,060,706	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,362,596	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 22,430,756	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 22,430,756	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	629,950	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)**	$ 629,950	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)**	$ 23,060,706	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	$ 11,649,952	1
2	Discounts and Allowances for all Levels	(629,637)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,020,315	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	550,678	6
7	Oxygen	52,799	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 603,477	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	40,712	13
14	Non-Patient Meals	47,757	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	71,231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,539	19
20	Radiology and X-Ray		20
21	Other Medical Services	184,953	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 366,192	23
	D. Non-Operating Revenue		
24	Contributions	122,780	24
25	Interest and Other Investment Income***	68,456	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 191,236	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	See SS2	36,950	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,950	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,218,170	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,291,102	31
32	Health Care	5,647,620	32
33	General Administration	2,477,759	33
	B. Capital Expense		
34	Ownership	681,509	34
	C. Ancillary Expense		
35	Special Cost Centers	200,140	35
36	Provider Participation Fee	290,090	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,588,220	40
41	**Income before Income Taxes (line 30 minus line 40)****	629,950	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 629,950	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 384,937	44
45	Private Pay - Net Inpatient Revenue	10,248,947	45
46	Medicare - Net Inpatient Revenue	386,431	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,020,315	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	1,928	2,140	$ 95,812	$ 44.77	1
2	Assistant Director of Nursing	2,743	2,963	115,882	39.11	2
3	Registered Nurses	41,634	45,240	1,421,589	31.42	3
4	Licensed Practical Nurses	16,858	18,696	475,172	25.42	4
5	CNAs & Orderlies	120,496	140,099	2,055,665	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,935	2,012	35,626	17.71	9
10	Activity Assistants	13,203	14,204	191,089	13.45	10
11	Social Service Workers	5,908	7,464	131,550	17.62	11
12	Dietician	1,481	1,680	38,498	22.92	12
13	Food Service Supervisor	1,960	2,195	79,519	36.23	13
14	Head Cook	6,149	6,780	102,827	15.17	14
15	Cook Helpers/Assistants	43,287	45,127	490,836	10.88	15
16	Dishwashers					16
17	Maintenance Workers	8,680	9,599	221,589	23.08	17
18	Housekeepers	11,882	14,621	157,262	10.76	18
19	Laundry	7,833	8,504	91,977	10.82	19
20	Administrator	1,928	2,480	129,821	52.35	20
21	Assistant Administrator	1,888	2,376	69,501	29.25	21
22	Other Administrative	3,025	3,848	84,514	21.96	22
23	Office Manager					23
24	Clerical	11,293	12,583	317,324	25.22	24
25	Vocational Instruction					25
26	Academic Instruction	1,555	1,777	50,671	28.51	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,681	11,861	199,971	16.86	31
32	Other Health C: Dir Memory Care	1,891	2,173	70,471	32.43	32
33	Other(specify) Hair Care/Vol Dir	2,356	2,571	50,686	19.71	33
34	TOTAL (lines 1 - 33)	320,594	360,993	$ 6,677,852 *	$ 18.50	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				36
37	Medical Records Consultant	39	2,812	10--3	37
38	Nurse Consultant	346	20,000	10--3	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)	385	$ 22,812		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

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaiser	Administrator		$ 129,821
Jeremiah Psinas	COO		69,501
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 199,322

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	$ 25,000
Benckendorf & Benckendorf	Legal	423
Heyl Royster	Legal	336
Management Performance Ass	Legal	500
FGMK	Medicare	4,268
Principle Financial Group	Pension Adm	3,000
Heinold Banwart	Salary Survey	2,137
Personnel Planners	UC Manager	1,803
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 37,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,829
Unemployment Compensation Insurance	1,511
FICA Taxes	494,839
Employee Health Insurance	472,127
Employee Meals	3,997
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Rental	9,575
Disability	372
Employee Relations	15,352
Employee Hiring Training	16,394
Tuition Reimbursement	9,749
Pension contributions	375,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,502,872

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,119
Health Care Worker Background Check	
(Indicate # of checks performed 31)	893
Patient Background Checks 94	930
Motion Picture License	1,180
IL Aging Svc Network	9,690
Tazewell Cty Health Permit	350
ACA PCORI Fee	258
Other Dues	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,420

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Tazewell County Food course	490
Seminars Misc names	1,206
In-State Travel	7,958
INHAA	200
Alzheimers Association class	921
Wound Treatment Assoc classes	1,075
Seminar Expense	0
Relias Learning for all staff	16,532
Annual convention	3,490
IL Activity Professionals classes	1,089
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,961

**See instructions.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. **IL aging services network $9690**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **47,686** 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 fo
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 Departmen
during this cost report period. $ **290,090**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **17,225** Has any meal income been offset against
related costs? **Y** Indicate the amount. $ **13,228**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No, vehicles are used only for resident needs**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

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

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

(19) 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

SS1
Legal Fees

Name	Description	Payment	Allowable	Non Allowable	Reclassified
Benckendorf and Benckendorf	By Law and Corporate work	423		423	
Heyl Royster Voelker & Allen	Payroll consulting	336		336	
Management Performance Associates	Compliance program work	500	500		
Total for Legal Fees		1259	500	759	

Travel and Seminar

Vehicle Reimbursements	Perform assessments in Hospital	2064			
Vehicle Reimbursements	Reclassified	-2064			To line 25
Out of State Travel	Raleigh NC	1306		1306	
Out of State Travel	Minneapolis MN	1367		1367	
Midwest Accounting Showcase	Chicago, IL	1053		1053	
Relias Learning	Seminar in Raleigh NC	149		149	
Hospital Healthcare Compensation Sv	Salary and Wage survey	580		580	
Univ of IL tax school	Tax Seminar	299		299	
From Schedule XIX-G		32961	32961	0	
Total Travel Seminar		37715	32961	4754	

SS2

APOSTOLIC CHRISTIAN RESTMOR #23952 12/31/2018

SCHEDULE XVII PAGE 19
LINE 28a

Social Activities Income	2275	2586
Private Pay Laundry	2472	2895
Personal Supplies Income	0	9
Finance Charge	0	113
Sunshine Cart Income	45	63
Misc Income	255	17
Parkside Management Fee Income	30300	38100
Misc Income	1603	500
	36950	44283