FOR BHF USE

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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.

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

I. IDPH License ID Number: 0021493

Facility Name: APOSTOLIC CHRISTIAN HOME

Address: 1102 WEST RANDOLPH, P O BOX 530 (Number) ROANOKE (City) 61561 (Zip Code)

County: WOODFORD

Telephone Number: 309-923-2071 **Fax #** 309-923-7919

HFS ID Number:

Date of Initial License for Current Owners: 05/05/1975

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 503C			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RICHARD D ISAIA **Telephone Number:** 309-923-2071
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 04/07/2011

(Type or Print Name) RICHARD D ISAIA

(Title) ADMINISTRATOR

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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 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	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	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	10,495	8,176	1,649	20,320	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,495	8,176	1,649	20,320	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.26%

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

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

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 05/05/1975

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 32 and days of care provided 1,649

Medicare Intermediary WISCONSIN PHYSICIAN SERVICE (WPS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	270,763	21,821	20,627	313,211		313,211		313,211			1
2	Food Purchase		161,171		161,171		161,171	(10,404)	150,767			2
3	Housekeeping	141,383	4,166	2,790	148,339		148,339		148,339			3
4	Laundry	75,140	6,195	367	81,702		81,702		81,702			4
5	Heat and Other Utilities			78,781	78,781		78,781		78,781			5
6	Maintenance	65,634	20,523	34,227	120,384		120,384		120,384			6
7	Other (specify):*		6,926	149,199	156,125		156,125	(156,125)				7
8	TOTAL General Services	552,920	220,802	285,991	1,059,713		1,059,713	(166,529)	893,184			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,542,699	188,411	89,436	1,820,546		1,820,546		1,820,546			10
10a	Therapy	109,543	2,441	11,670	123,654		123,654		123,654			10a
11	Activities	90,863	8,765	(52)	99,576		99,576		99,576			11
12	Social Services	41,129	291	519	41,939		41,939		41,939			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,784,234	199,908	101,573	2,085,715		2,085,715		2,085,715			16
	C. General Administration											
17	Administrative	76,159			76,159		76,159		76,159			17
18	Directors Fees											18
19	Professional Services			23,334	23,334		23,334		23,334			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	157,650	21,165	31,398	210,213		210,213	(7,295)	202,918			21
22	Employee Benefits & Payroll Taxes			491,052	491,052		491,052		491,052			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			34,092	34,092		34,092		34,092			26
27	Other (specify):*											27
28	TOTAL General Administration	233,809	21,165	579,876	834,850		834,850	(7,295)	827,555			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,570,963	441,875	967,440	3,980,278		3,980,278	(173,824)	3,806,454			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 HOME #0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			334,928	334,928		334,928	(163,386)	171,542			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,276	15,276		15,276	(15,276)				32
33	Real Estate Taxes			620	620		620	(620)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			350,824	350,824		350,824	(179,282)	171,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			7,446	7,446		7,446		7,446			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,398	33,398		33,398		33,398			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,844	40,844		40,844		40,844			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,570,963	441,875	1,359,108	4,371,946		4,371,946	(353,106)	4,018,840			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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,404)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,295)	21		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	(15,276)	32		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)**	$ (32,975)		$	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	(320,131)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (320,131)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (353,106)		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	X		47,875	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 47,875		47

APOSTOLIC CHRISTIAN HOME

ID# 0021493

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON-ALLOWABLE REAL ESTATE TAXES	$ (620)	33	1
2	COUNTRY VIEW EXPENSES	(119,987)	7	2
3	COUNTRY VIEW DEPRECIATION	(39,639)	30	3
4	DUPLEX EXPENSES	(36,138)	7	4
5	DUPLEX DEPRECIATION	(123,747)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	(320,131)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,404)	0	0	0	0	0	0	0	0	0	0	(10,404)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(156,125)	0	0	0	0	0	0	0	0	0	0	(156,125)	7
8	**TOTAL General Services**	(166,529)	0	0	0	0	0	0	0	0	0	0	(166,529)	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	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	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,295)	0	0	0	0	0	0	0	0	0	0	(7,295)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	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**	(7,295)	0	0	0	0	0	0	0	0	0	0	(7,295)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,824)	0	0	0	0	0	0	0	0	0	0	(173,824)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(163,386)	0	0	0	0	0	0	0	0	0	0	(163,386)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,276)	0	0	0	0	0	0	0	0	0	0	(15,276)	32
33	Real Estate Taxes	(620)	0	0	0	0	0	0	0	0	0	0	(620)	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**	(179,282)	0	0	0	0	0	0	0	0	0	0	(179,282)	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)**	(353,106)	0	0	0	0	0	0	0	0	0	0	(353,106)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	NONE					

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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		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	NONE								$		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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	APOSTOLIC CHRISTIAN	X		COVERAGE FOR STATE	NONE	Various	$ 359,000	$ 250,000	unknown		$	1
2	CHURCH			SHORTFALL								2
3												3
4												4
5												5
	Working Capital											
6	MORTON COMMUNITY		X	WORKING CAPITAL	Various	Various			unknown	5.0000		6
7	BANK			STATE SHORTFALL								7
8												8
9	TOTAL Facility Related						$ 359,000	$ 250,000			$	9
	B. Non-Facility Related*											
10	COMMERCE BANK		X	COUNTRY VIEW LOAN	$7,800.00	03/28/00	875,000	285,051			15,276	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$7,800.00		$ 875,000	$ 285,051			$ 15,276	14
15	TOTALS (line 9+line14)						$ 1,234,000	$ 535,051			$ 15,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** 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 HOME # 0021493 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

ALL REAL ESTATE TAXES ARE NON-ALLOWABLE AND ARE ADJUSTED OUT ON SCHEDULE V.

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTIAN HOME COUNTY WOODFORD

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT RICHARD D ISAIA

TELEPHONE 309-923-2071 FAX #: 309-923-7919

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) 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	$	$ NONE

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,601 B. General Construction Type: Exterior BRICK Frame BLOCK & WOOD Number of Stories ONE

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).

APOSTOLIC CHRISTIAN HOME OF ROANOKE DUPLEXES - 20 UNITS

APOSTOLIC CHRISTIAN HOME OF ROANOKE COUNTRY VIEW APARTMENTS - INDEPENDENT LIVING APARTMENTS - 14 UNITS

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	BLDG. & GROUNDS	100,000	1975	$ 35,875	1
2					2
3	TOTALS	100,000		$ 35,875	3

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1975	1958	$ 202,000	$	30	$	$	$ 202,000	4
5			1976	1976	22,708		30			22,708	5
6			1991	1991	671,286	22,376	30	22,376		427,009	6
7			1992	1992	129,607	4,469	30	4,469		82,676	7
8											8
	Improvement Type**										
9	Land & Bldg Improvements			1976	105,004						9
10				1977	6,591						10
11				1978	10,960						11
12				1979	9,124						12
13				1980	8,166						13
14				1981	6,506						14
15				1982	18,087						15
16				1983	36,023						16
17				1984	12,947						17
18				1985	13,333		VARIOUS			577,013	18
19				1986	8,595						19
20				1987	87,248						20
21				1988	43,526						21
22				1989	64,604						22
23				1990	11,217						23
24				1991	3,700						24
25				1992	5,410						25
26				1993	36,135						26
27				1994	14,661						27
28				1995	30,372						28
29	Soiled Utility Remodeling			1996	680					680	29
30	Fixed TV Monitoring System			1996	278					278	30
31	Remodel 14 East			1996	2,781					2,781	31
32	New Sidewalk			1996	1,375					1,375	32
33	Room Remodeling (9,21,17)			1997	11,487					11,487	33
34	Room Remodeling (11,8,10,19,5,6)			1997	17,049					17,049	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE ALARM SYSTEM COSTS	1998	$ 12,671	$	7	$	$	$ 12,671	37
38	ROOM REMODELING (3,12,14)	1998	13,953		7			13,953	38
39	GAS LINE WORK	1998	1,033		7			1,033	39
40	PARKING LOT	1998	19,397		7			19,397	40
41	COURTYARD	1998	15,971		7			15,971	41
42	FIRE ALARM SYSTEM COSTS	1999	87,698		7			87,698	42
43	CALL LIGHT SYSTEM COSTS	1999	40,500		7			40,500	43
44	EAST ROOM REMODELING	1999	23,345		7			23,345	44
45	PT RESTROOM REMODELING	1999	605		7			605	45
46	MULTI-PURPOSE ROOM REMODELING	1999	1,438		7			1,438	46
47	SPRINKLER SYSTEM ADDITIONS	1999	3,166		7			3,166	47
48	STORM SEWER WORK	1999	2,396		7			2,396	48
49	DOOR ALARM SYSTEM	1999	2,075		7			2,075	49
50	WEST STATION ARCHITECT FEES	1999	4,742		7			4,742	50
51	EAST SIDE STATION REMODELING	2000	43,536		7			43,536	51
52	WEST SIDE STATION	2000	4,637		7			4,637	52
53	CALL LIGHT SYSTEM COSTS	2000	11,500		7			11,500	53
54	DOOR ALARM SYSTEM REMODEL	2000	2,093		7			2,093	54
55	RESIDENT ROOM REMODEL	2000	7,066		7			7,066	55
56	LANDSCAPING	2000	3,152		7			3,152	56
57	WATER MAIN EXTENSION	2000	1,675		7			1,675	57
58	SPRINKLER WORK	2001	19,622		7			19,622	58
59	NURSING AND SOCIAL SERVICE OFFICES	2001	1,587		7			1,587	59
60	NEW PARKING AREA	2001	2,363		7			2,363	60
61	ROOM REMODELING (12W)	2001	2,612		7			2,612	61
62	NEW WATER LINES	2001	4,581		7			4,581	62
63	ROOM REMODELED (8W)	2001	3,422		7			3,422	63
64	TUB ROOM ROOF	2001	27,941		7			27,941	64
65	WEST TUB REMODEL	2001	25,454		7			25,454	65
66	EAST HALL REMODEL	2001	23,052		7			23,052	66
67	EAST PARK AREA	2001	1,687		7			1,687	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,006,430	$ 26,845		$ 26,845	$	$ 1,760,026	70

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,006,430	$ 26,845		$ 26,845	$	$ 1,760,026	1
2	VINYL FLOORING - HSKG	2002	1,001		7			1,001	2
3	NURSING OFFICE	2002	1,068		7			1,068	3
4	EAST HALL REMODEL	2002	12,749		7			12,749	4
5	DELAYED EGRESS LOCK	2002	1,934		7			1,934	5
6	ROOM 5 REMODEL	2002	2,999		7			2,999	6
7	ROOM REMODEL	2002	3,173		7			3,173	7
8	WATER LINE REPAIRS	2002	15,959		7			15,959	8
9	TUB ROOM REMODEL	2002	235,862		7			235,862	9
10	WEST NURSES STATION	2003	21,472	1,536	7	1,536		21,472	10
11	WATER LINE REPAIRS	2003	4,424	316	7	316		4,424	11
12	ROOM REMODEL - 2 ROOMS	2003	3,808	278	7	278		3,808	12
13	NORTH CEILING REPAIR	2003	2,980	217	7	217		2,980	13
14	MIXING VALVES	2003	679	49	7	49		679	14
15	BASEMENT STAIRS	2003	6,956	495	7	495		6,956	15
16	CANOPY SPRINKLER	2003	1,425	100	7	100		1,425	16
17	ALARM SYSTEMS	2003	3,017	216	7	216		3,017	17
18	MECHANICAL ROOM WORK	2003	2,907	210	7	210		2,907	18
19	SPRINKLER IMPROVEMENTS	2003	6,428	461	7	461		6,428	19
20	LANDSCAPING SIDEWALK	2003	4,741		7			4,741	20
21	DRYWALL REPAIR/FIRE DRYWALL	2004	13,476	1,925	7	1,925		12,512	21
22	FIRE DAMPERS	2004	2,100	300	7	300		1,950	22
23	EXIT LIGHTS	2004	4,011	573	7	573		3,724	23
24	DRAIN LINES - EAST WING	2004	1,504	214	7	214		1,391	24
25	ELEVATOR WORK	2004	8,359	1,194	7	1,194		7,761	25
26	CONCRETE EXIT	2004	850	121	7	121		787	26
27	NORTH BASEMENT IMPROVEMENTS	2004	15,554	2,222	7	2,222		14,443	27
28	FENCING	2004	10,980	1,569	7	1,569		10,198	28
29	PLUMBING UPDATE	2004	3,949	564	7	564		3,666	29
30	KITCHEN FLOOR	2004	3,713	530	7	530		3,445	30
31	GENERATOR SHED - ELECTRIC	2004	2,380	340	7	340		2,210	31
32	BASEMENT ELECTRIC PANELS	2004	1,056	150	7	150		975	32
33	WEST HALL & DINING ROOM	2004	6,600	943	7	943		6,129	33
34	TOTAL (lines 1 thru 33)		$ 2,414,544	$ 41,368		$ 41,368	$	$ 2,162,799	34

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,414,544	$ 41,368		$ 41,368	$	$ 2,162,799	1
2	KTICHEN STEAMER WIRING	2004	614	88	7	88		572	2
3	MAINTENANCE SHED	2004	34,020	4,860	7	4,860		31,590	3
4	CANOPY SPRINKLER REPAIR	2004	2,696	385	7	385		2,502	4
5	NEW FLOOR 18W	2005	1,750	250	7	250		1,375	5
6	DRYWALL STATE SURVEY	2005	8,016	1,145	7	1,145		6,297	6
7	AC RELOCATE	2005	448	64	7	64		352	7
8	WEST SIDE PLUMBING	2005	4,108	587	7	587		3,228	8
9	DINING REMODEL	2005	67,687	9,670	7	9,670		53,185	9
10	WATER LINE REPAIR	2006	728	104	7	104		468	10
11	DINING INSTALLATION	2006	850	121	7	121		545	11
12	WEST FLOOR JOIST WORK	2006	2,315	330	7	330		1,485	12
13	CANOPY UPGRADE SPRINKLER	2006	4,866	695	7	695		3,128	13
14	WEST STEPS RETAINING WALL	2006	700	100	7	100		450	14
15	SPRINKLER SYSTEM REPAIRS	2006	1,524	218	7	218		981	15
16	LAUNDRY PLUMING UPGRADE	2006	1,840	263	7	263		1,183	16
17	ROOM 12 REMODEL	2006	926	132	7	132		594	17
18	SIDEWALK	2007	1,008	144	7	144		504	18
19	WATER LINE REPAIRS	2007	3,300	471	7	471		1,649	19
20	NORTH END FIRE DAMPERS	2007	11,784	1,683	7	1,683		5,891	20
21	KITCHEN REMODEL	2007	92,132	13,084	7	13,084		45,709	21
22	WATER LINES WEST WING	2007	1,234	176	7	176		616	22
23	BASEMENT DOORS	2007	2,605	372	7	372		1,302	23
24	SiIDEWALK DOOR H	2008	16,218	1,622	10	1,622		4,055	24
25	FRONT SEWER REPAIR	2008	4,216	422	10	422		1,055	25
26	EXIT LIGHT UPGRADE	2008	1,089	156	7	156		389	26
27	REPIPING KITCHEN HOT WATER	2008	1,658	236	7	236		590	27
28	KITCHEN DOOORS	2008	12,848	1,835	7	1,835		4,587	28
29	ROOM 9 REMODEL	2008	2,289	327	7	327		817	29
30	SOUTH BASEMENT UPGRADE	2008	3,404	486	7	486		1,215	30
31	ACTIVITY CANOPY SPRINKLER	2008	1,295	185	7	185		462	31
32	BASEMENT SEWER IMPROVEMENT	2008	4,282	612	7	612		1,529	32
33	PLUMBING UPGRADE	2008	6,072	867	7	867		2,167	33
34	TOTAL (lines 1 thru 33)		$ 2,713,066	$ 83,058		$ 83,058	$	$ 2,343,271	34

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,713,066	$ 83,058		$ 83,058	$	$ 2,343,271	1
2	MAINT. GARAGE SEWER HOOK-UP	2008	1,075	153	7	153		382	2
3	PLUMBING UPGRADE	2009	368	52	7	52		78	3
4	ROOF PROJECT	2009	68,922	2,297	30	2,297		3,446	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,783,431	$ 85,560		$ 85,560	$	$ 2,347,177	34

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 360,803	$ 76,980	$ 76,980	$		$ 271,050	71
72	Current Year Purchases	113,600	7,359	7,359			7,359	72
73	Fully Depreciated Assets	846,520					846,520	73
74								74
75	TOTALS	$ 1,320,923	$ 84,339	$ 84,339	$		$ 1,124,929	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRIPS	FORD BUS	1999	$ 49,239	$	$	$		$ 49,239	76
77	RESIDENT TRIPS	FORD MONTANA	2005	12,500	1,250	1,250		5	12,500	77
78	RESIDENT TRIPS	BEAU VAN	2009	1,964	393	393		5	589	78
79										79
80	TOTALS			$ 63,703	$ 1,643	$ 1,643	$		$ 62,328	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)	$ 4,203,932	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 171,542	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,542	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)	$ 3,534,434	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	DUPLEXES	$ 2,722,801	$ 90,910	$ 955,030	86
87	COUNTRY VIEW APARTMENTS	1,097,269	23,426	267,402	87
88	DUPLEX FIXTURES	102,397	9,968	68,067	88
89	COUNTRY VIEW FURN & FIX	178,887	16,214	106,932	89
90	DUPLEX LAND IMPROVEMENTS	404,294	22,868	179,683	90
91	TOTALS	$ 4,505,648	$ 163,386	$ 1,577,114	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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	NONE	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 prescrpts							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.

STATE OF ILLINOIS

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 392,819	$	1
2	Cash-Patient Deposits	222		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	226,201		3
4	Supply Inventory (priced at)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,340		6
7	Other Prepaid Expenses	3,864		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 661,446	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,603		13
14	Buildings, at Historical Cost	7,027,949		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,645,906		16
17	Accumulated Depreciation (book methods)	(5,114,015)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,684,443	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,345,889	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,449	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	222		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,477		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,790		31
32	Accrued Real Estate Taxes(Sch.IX-B)	660		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 250,598	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	713,350		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUPLEX EQUITY	2,314,460		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,027,810	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,278,408	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,067,481	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,345,889	$	48

*(See instructions.)

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 798,045	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 798,045	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,446)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	375,882	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)**	$ 269,436	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)**	$ 1,067,481	24 *

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,248,255	1
2	Discounts and Allowances for all Levels	(1,004,146)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,244,109	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,020	13
14	Non-Patient Meals	10,405	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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)**	$ 19,425	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,966	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,966	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,265,500	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,059,713	31
32	Health Care	2,085,715	32
33	General Administration	834,850	33
	B. Capital Expense		
34	Ownership	350,824	34
	C. Ancillary Expense		
35	Special Cost Centers	7,446	35
36	Provider Participation Fee	33,398	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,371,946	40
41	**Income before Income Taxes (line 30 minus line 40)****	(106,446)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (106,446)	43

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

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

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

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,024	2,160	$ 62,393	$ 28.89	1
2	Assistant Director of Nursing	1,480	1,695	44,907	26.49	2
3	Registered Nurses	13,310	14,338	393,898	27.47	3
4	Licensed Practical Nurses	6,342	6,852	163,062	23.80	4
5	CNAs & Orderlies	60,706	64,524	878,439	13.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,876	5,372	109,543	20.39	8
9	Activity Director	1,947	2,252	31,746	14.10	9
10	Activity Assistants	5,161	5,603	59,117	10.55	10
11	Social Service Workers	3,200	3,422	41,129	12.02	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,160	43,518	20.15	13
14	Head Cook	7,609	8,245	98,466	11.94	14
15	Cook Helpers/Assistants	12,510	13,236	128,779	9.73	15
16	Dishwashers					16
17	Maintenance Workers	2,161	2,465	65,634	26.63	17
18	Housekeepers	11,159	11,983	111,586	9.31	18
19	Laundry	6,126	6,701	75,140	11.21	19
20	Administrator	1,928	2,160	76,159	35.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,483	10,434	157,650	15.11	24
25	Vocational Instruction					25
26	Academic Instruction					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					31
32	Other Health Care(specify)					32
33	Other(specify) HSKG. SUPER	1,758	2,061	29,797	14.46	33
34	TOTAL (lines 1 - 33)	153,697	165,663	$ 2,570,963 *	$ 15.52	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				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		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 HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RICHARD D ISAIA	ADMIN.	0.00	$ 76,159
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,159

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
HEALTH OUTCOMES	COMP. SERVICES	$ 7,096
HEINOLD-BANWART	ACCTG. SERVICES	6,363
BOB REIN-CPA	ACCTG. SERVICES	2,821
ROUTE 24-COMPUTER	COMP. SERVICES	2,551
HOWARD & HOWARD	LEGAL SERVICES	3,578
MICHAEL ARENDS	COMP. SERVICES	275
BENEFIT PLAN ASSOC.	LEGAL SERVICES	650
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,334

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,602
Unemployment Compensation Insurance	2,597
FICA Taxes	184,682
Employee Health Insurance	241,171
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 491,052

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NONE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. **AAHSA $1179, LSN $3102**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,961** 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. $ **33,398**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **10,404**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **NONE**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NONE**
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. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.