FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0021493

Facility Name: Apostolic Christian Home

Address: 1102 W Randolph Bx 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: 1975

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c(3)			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 01/01/2013 to 12/31/2013 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) 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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	365	119	1,775	2,259	8
9	SNF/PED					9
10	ICF	10,136	8,146		18,282	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,501	8,265	1,775	20,541	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.79%

D. How many bed-hold days during this year were paid by the Department? _____ (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 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 1975 NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1,775

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	325,325	26,248	7,747	359,320		359,320		359,320			1
2	Food Purchase		205,653		205,653		205,653	(8,625)	197,028			2
3	Housekeeping	245,922	30,470	9,664	286,056		286,056		286,056			3
4	Laundry		5,784		5,784		5,784		5,784			4
5	Heat and Other Utilities			97,381	97,381		97,381		97,381			5
6	Maintenance	69,815	41,893	44,368	156,076		156,076		156,076			6
7	Other (specify):*											7
8	TOTAL General Services	641,062	310,048	159,160	1,110,270		1,110,270	(8,625)	1,101,645			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,667,125	74,717	6,952	1,748,794		1,748,794		1,748,794			10
10a	Therapy	129,776	973	102,953	233,702		233,702		233,702			10a
11	Activities	102,663	14,564	502	117,729		117,729		117,729			11
12	Social Services	55,664	103	696	56,463		56,463		56,463			12
13	CNA Training					610	610		610			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,955,228	90,357	111,103	2,156,688	610	2,157,298		2,157,298			16
	C. General Administration											
17	Administrative	82,036			82,036		82,036		82,036			17
18	Directors Fees											18
19	Professional Services			89,518	89,518		89,518		89,518			19
20	Dues, Fees, Subscriptions & Promotions			3,689	3,689	3,124	6,813		6,813			20
21	Clerical & General Office Expenses	176,447	30,818	116,390	323,655	(3,734)	319,921		319,921			21
22	Employee Benefits & Payroll Taxes			599,410	599,410		599,410		599,410			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,060	42,060		42,060		42,060			26
27	Other (specify):*											27
28	TOTAL General Administration	258,483	30,818	851,067	1,140,368	(610)	1,139,758		1,139,758			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,854,773	431,223	1,121,330	4,407,326		4,407,326	(8,625)	4,398,701			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 of Roanoke #0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			178,741	178,741		178,741	(7,009)	171,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,928	11,928		11,928		11,928			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			190,669	190,669		190,669	(7,009)	183,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,689		78,689		78,689		78,689			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,272	149,272		149,272		149,272			42
43	Other (specify):*		14,440	305,197	319,637		319,637	(319,637)				43
44	TOTAL Special Cost Centers		93,129	454,469	547,598		547,598	(319,637)	227,961			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,854,773	524,352	1,766,468	5,145,593		5,145,593	(335,271)	4,810,322			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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	(8,625)	2.2		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	(7,009)	30.3		9
10	Interest and Other Investment Income		32.3		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		13		27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(319,637)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (335,271)		$	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))	$ (335,271)		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.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 [x] NO

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

1 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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Church	x		Coverage for State shortfall	n/a	various	$ 359,000	$ 100,000	n/a		$	1
2					-							2
3					-							3
4					-							4
5					-							5
	Working Capital											
6	Morton Community Bank		x	Working Capital	Various	Various		615,000	Various	0.0375	11,928	6
7					-						-	7
8					-							8
9	TOTAL Facility Related						$ 359,000	$ 715,000			$ 11,928	9
	B. Non-Facility Related*											
10	Commerce Bank		x	Building Loan	7,800	2000	875,000	24,697	2014	0.0417		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				7800		$ 875,000	$ 24,697			$	14
15	TOTALS (line 9+line14)						$ 1,234,000	$ 739,697			$ 11,928	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 Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2012 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2012 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2012.

Please complete the Real Estate Tax Statement below and include it in the 2013 cost report along with a copy of your 2012 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Roanoke 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 2012 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 2012.

	(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 x 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Duplex 20 Units
Apostolic Christian Home of Roanoke Independent Living 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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	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		494,137	6
7			1992	1992	129,607	4,469	30	4,320	(149)	94,891	7
8											8
	Improvement Type**										
9	Building & land improvements - '76			1976	105,004		20			105,004	9
10	Building & land improvements - '77			1977	6,591		20			6,591	10
11	Building & land improvements - '78			1978	10,960		20			10,960	11
12	Building & land improvements - '79			1979	9,124		20			9,124	12
13	Building & land improvements - '80			1980	8,166		20			8,166	13
14	Building & land improvements - '81			1981	6,506		20			6,506	14
15	Building & land improvements - '82			1982	18,087		20			18,087	15
16	Building & land improvements - '83			1983	36,023		20			36,023	16
17	Building & land improvements - '84			1984	12,947		20			12,947	17
18	Building & land improvements - '85			1985	13,333		20			13,333	18
19	Building & land improvements - '86			1986	8,595		20			8,595	19
20	Building & land improvements - '87			1987	87,248		20			87,248	20
21	Building & land improvements - '88			1988	43,526		20			43,526	21
22	Building & land improvements - '89			1989	64,604		20			64,604	22
23	Building & land improvements - '90			1990	11,217		20			11,217	23
24	Building & land improvements - '91			1991	3,700		20			3,700	24
25	Building & land improvements - '92			1992	5,410		20			5,410	25
26	Building & land improvements - '93			1993	36,135		20	1,806	1,806	36,135	26
27	Building & land improvements - '94			1994	14,661		20	733	733	14,661	27
28	Building & land improvements - '95			1995	30,372		20	1,519	1,519	28,854	28
29	Building & land improvements - '96			1996	5,114		20	256	256	4,603	29
30	Building & land improvements - '97			1997	28,536		20	1,427	1,427	24,256	30
31	Building & land improvements - '98			1998	63,025		7			63,025	31
32	Building & land improvements - '99			1999	165,965		7			165,965	32
33	Building & land improvements - '00			2000	73,659		7			73,659	33
34	Building & land improvements - '01			2001	112,321		7			112,321	34
35	Building & land improvements - '02			2002	274,745		7			274,745	35
36	Building & land improvements - '03			2003	58,837		7			58,837	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Building & land improvements - '04	2004	$ 111,862	$	7	$	$	$ 111,862	37
38	New Flooring (18W)	2005	1,750		7			1,750	38
39	Drywall State Survey	2005	8,016		7			8,016	39
40	Air Conditioner Relocation	2005	448		7			448	40
41	West Side Plumbing	2005	4,108		7			4,108	41
42	Dining Remodel	2005	67,687		7			67,687	42
43	Water Piping	2006	728	52	7	19	(33)	728	43
44	Dining Room Insulation	2006	850	61	7	42	(19)	850	44
45	Floor Joist	2006	1,010	165	7	53	(112)	1,010	45
46	Furnace and Ductwork	2006	1,305		7	70	70	1,305	46
47	Generator	2006	2,496		7	70	70	2,496	47
48	Sprinkler Update	2006	960		7	29	29	960	48
49	Tub	2006	14,095		7	494	494	14,095	49
50	Activity Window Coverings	2006	558		7	22	22	558	50
51	Electrical Wiring	2006	389		7			389	51
52	Canopy Sprinkler Repair	2006	4,866	348	7	405	57	4,866	52
53	Retaining wall, Rm12 plaster, door latches, draperies	2006		116	7		(116)		53
54	Sprinkler system & plumbing upgrade	2006		240	7		(240)		54
55	South elevator improvement & wallguards	2006			5				55
56	Basement doors	2007	2,605	372	7	372		2,573	56
57	Water lines and sidewalks	2007	3,300	792	7	471	(321)	2,984	57
58	North end fire dampers	2007	11,784	1,683	7	1,683		10,379	58
59	Kitchen plumbing, electrical, carpentry, flooring, insulation	2007	93,241	13,162	7	13,320	158	82,146	59
60	Kitchen sinks	2007	4,179	418	5		(418)	4,179	60
61	Dining room cabinetry	2007	4,375		5			4,375	61
62	Kitchen air conditioning	2007	2,500		5			2,500	62
63	Elevator wiring	2007	4,720		5			4,720	63
64	Wallguards	2007	6,578		5			6,578	64
65	Kitchen lighting fixtures and ramps	2007			5				65
66	Exit light upgrade	2008		156	7		(156)		66
67	Kitchen hot water heater piping	2008		237	7		(237)		67
68	Kitchen doors	2008	12,848	1,835	7	1,835		10,558	68
69	Room 9 west flooring	2008		327	7		(327)		69
70	TOTAL (lines 4 thru 69)		$ 2,707,270	$ 46,809		$ 51,322	$ 4,513	$ 2,473,958	70

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
1	Totals from Page 12A, Carried Forward		$ 2,707,270	$ 46,809		$ 51,322	$ 4,513	$ 2,473,958	1
2	South basement wall, lighting, sink & vanity	2008	3,404	486	7	486		2,756	2
3	Sprinkler system upgrade	2008		380	7		(380)		3
4	Basement sewer & plumbing system repair	2008	10,354	1,479	7	1,479		8,388	4
5	Maintenance garage sewer hook-up	2008		154	7		(154)		5
6	Water heater upgrade	2008	10,898	1,090	5	536	(554)	10,898	6
7	Elevator and pole light	2008	4,153	477	5	620	143	4,153	7
8	Kitchen grease trap replacement	2008	3,972	397	5	794	397	3,970	8
9	East & West end flooring	2008	12,916	1,467	5	418	(1,049)	12,916	9
10	Door replacements	2008		326	5		(326)		10
11	Northeast exit sidewalk replacement	2008	18,726	1,622	10	1,873	251	9,678	11
12	Front sewer line installation and repair	2008	4,216	422	10	422		2,180	12
13	Sprinkler system upgrade	2009	3,288	1,005	5	658	(347)	2,632	13
14	Water heaters, fresh air hook-up, door upgrade w/ramps	2009	12,302	3,262	5	2,460	(802)	11,492	14
15	Wiring/installation of digital cable system	2009		4,344	5		(4,344)		15
16	Roofing project	2009	72,252	2,297	30	2,408	111	10,239	16
17	Kitchen cabinets, countertop, plumbing	2009	2,798	560	5	560		2,709	17
18	Nurse station & med rm counter top, insulation	2010	9,407	2,264	5	1,881	(383)	6,746	18
19	Sprinkler system upgrade	2010	13,072	2,614	5	2,614		8,279	19
20	Doors, openers, exit lighting	2010	3,783	757	5	757		2,588	20
21	Furnace, air conditioners, disposal	2010	6,475	1,295	5	1,295		4,428	21
22	Asphalt parking lot	2010	20,152	2,015	10	2,015		6,382	22
23	Basement ceiling drywall & rm 11 carpeting	2011	4,912	591	10	491	(100)	1,270	23
24	Basement ceiling drywall & rewiring	2011		846	5		(846)		24
25	Resident rm wall mounted box holders	2011	3,422	684	5	684		1,368	25
26	Water heater	2011	6,999	1,400	5	1,400		3,974	26
27	West flooring, furnace, electrical, ceiling	2011	18,658	2,512	5	3,732	1,220	8,088	27
28	West Doors	2011	61,657	6,166	10	6,166		12,332	28
29	Wall mounted nursing stations	2011		1,297	5		(1,297)		29
30	West air conditioner	2012	3,914	783	5	783		1,045	30
31	West room signage, plumbing, electrical, sprinklers, curtains, wall mou	2012	5,880	3,604	5	1,176	(2,428)	1,865	31
32	West & basement floors, walls, ceiling, electrical, plumbing	2012	133,422	13,474	10	13,342	(132)	16,705	32
33	West & east floors, walls, ceiling, electrical, plumbing	2012	17,854	1,786	10	1,785	(1)	2,083	33
34	TOTAL (lines 1 thru 33)		$ 3,176,156	$ 108,665		$ 102,157	$ (6,508)	$ 2,633,122	34

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
1	Totals from Page 12B, Carried Forward		$ 3,176,156	$ 108,665		$ 102,157	$ (6,508)	$ 2,633,122	1
2	South floors, walls, ceiling, electrical, plumbing	2013	9,750	813	10	892	79	892	2
3	Water line replacement west side	2013	13,456	673	10	339	(334)	339	3
4	Dining Room a/c unit and pad	2013	4,274	427	5	501	74	501	4
5	Door locks	2013	4,809	481	5	161	(320)	161	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	TOTAL (lines 1 thru 33)		$ 3,208,445	$ 111,059		$ 104,050	$ (7,009)	$ 2,635,015	34

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 581,750	$ 56,283	$ 56,283	$	5	$ 286,268	71
72	Current Year Purchases	61,409	6,143	6,143		5	6,143	72
73	Fully Depreciated Assets	1,048,450					1,048,450	73
74								74
75	TOTALS	$ 1,691,609	$ 62,426	$ 62,426	$		$ 1,340,861	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 Transport	1999 Ford Bus	1999	$ 49,239	$	$	$	5	$ 49,239	76
77	Patient Transport	2005 Ford Montana	2005	12,500				5	12,500	77
78	Patient Transport	2009 Beau Van	2009	1,964	393	393		5	1,768	78
79	Patient Transport	2011 Dodge Caravan	2011	48,628	4,863	4,863		10	12,157	79
80	TOTALS			$ 112,331	$ 5,256	$ 5,256	$		$ 75,664	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,048,260	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,741	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,732	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,009)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,051,540	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	Various	$ 2,968,941	$ 105,852	$ 1,243,900	86
87	Country View Apartments	Various	1,099,505	23,538	337,793	87
88	Duplex Furniture & Fixtures	Various	216,074	23,908	120,108	88
89	Country View Furniture & Fixt	Various	244,946	24,919	175,967	89
90	Duplex Land & Improvements	Various	466,751	24,262	252,346	90
91	TOTALS		$ 4,996,217	$ 202,479	$ 2,130,114	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.

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 [x] 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 [x] 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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] 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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	x
HOURS PER CNA	40

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		610		610
8	CNA Competency Tests				
9	TOTALS	$	$ 610	$	$ 610
10	SUM OF line 9, col. 1 and 2 (e)	$ 610			

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

(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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	189	$ 14,824	$	189	$ 14,824	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		162	10,394		162	10,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		224	17,416		224	17,416	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				40,323		40,323	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care	39.2								12
13	Other (specify): Medical Supplies	39.2					38,366		38,366	13
14	TOTAL			$	575	$ 42,634	$ 78,689	575	$ 121,323	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 Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	$ 10,048	$	1
2	Cash-Patient Deposits	347		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	793,253		3
4	Supply Inventory (priced at FIFO)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,594		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 837,242	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,626		13
14	Buildings, at Historical Cost	7,730,651		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,995,920		16
17	Accumulated Depreciation (book methods)	(6,193,699)		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)	$ 3,597,498	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 4,434,740	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,514	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	347		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,007		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,728		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,958		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	215,254		36
37	Life Lease Deferred Income			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 741,808	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	917,996		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	2,165,054		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 3,083,050	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 3,824,858	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 609,882	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 4,434,740	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,053,825	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(203,126)	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 850,699	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(676,858)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	436,041	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)	$ (240,817)	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)	$ 609,882	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 4,790,071	1
2	Discounts and Allowances for all Levels	(1,058,518)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 3,731,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	269,450	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 269,450	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	17,977	13
14	Non-Patient Meals	8,625	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)	$ 26,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,084	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 26,084	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,535	28
28a	Non-Care Facility	410,511	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 415,046	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 4,468,735	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,110,270	31
32	Health Care	2,156,688	32
33	General Administration	1,140,368	33
	B. Capital Expense		
34	Ownership	190,669	34
	C. Ancillary Expense		
35	Special Cost Centers	398,326	35
36	Provider Participation Fee	149,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,145,593	40
41	Income before Income Taxes (line 30 minus line 40)**	(676,858)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (676,858)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (924,316)	44
45	Private Pay - Net Inpatient Revenue	4,231,761	45
46	Medicare - Net Inpatient Revenue	424,108	46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,731,553	49

* 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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1,838	2,080	$ 69,334	$ 33.33	1
2	Assistant Director of Nursing	1,613	1,835	55,444	30.21	2
3	Registered Nurses	11,051	11,670	334,438	28.66	3
4	Licensed Practical Nurses	8,652	9,285	229,966	24.77	4
5	CNAs & Orderlies	63,994	68,056	977,943	14.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,984	5,435	129,776	23.88	8
9	Activity Director	1,957	2,232	36,715	16.45	9
10	Activity Assistants	5,072	5,433	65,948	12.14	10
11	Social Service Workers	3,217	3,459	55,664	16.09	11
12	Dietician					12
13	Food Service Supervisor	1,816	2,080	49,158	23.63	13
14	Head Cook	7,610	8,274	109,087	13.18	14
15	Cook Helpers/Assistants	14,969	15,760	167,080	10.60	15
16	Dishwashers					16
17	Maintenance Workers	2,051	2,296	69,815	30.41	17
18	Housekeepers	19,027	20,757	245,922	11.85	18
19	Laundry					19
20	Administrator	1,809	2,080	82,036	39.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,260	10,192	176,447	17.31	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)					33
34	TOTAL (lines 1 - 33)	158,920	170,924	$ 2,854,773 *	$ 16.70	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	162	$ 7,271	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	86	5,618	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	10	644	10a.3	40
41	Occupational Therapy Consultant	1	64	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	518	10a.3	43
44	Activity Consultant	10	502	11.3	44
45	Social Service Consultant	14	696	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	291	$ 15,313		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides			10.3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See Schedule			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,036

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
		$
See Schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 89,518

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,237
Unemployment Compensation Insurance	183
FICA Taxes	210,354
Employee Health Insurance	311,488
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis Immunization	
Employee Life/Disability	
Employee Physicals	5,524
Uniform Allowance	332
Vacation allowance	10,292
Non-Care Employee Benefits	
TOTAL (agree to Schedule V, line 22, col.8)	$ 599,410

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	3,124
Health Care Worker Background Check	364
(Indicate # of checks performed 13)	
Patient Background Checks 50	500
Life Services Network Dues	2,825
Other Membership Dues \ Licenses	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,813

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 of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. Life Services Network Dues 2,825

(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. $ 38,366 Line 10.2

(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. $ 149,272
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. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 8,625

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? 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? No
Firm Name:

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

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