FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0006353

Facility Name: Apostolic Christian Skylines

Address: 7023 NE Skyline Dr (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 691-8091 Fax # (309) 683-2505

HFS ID Number:

Date of Initial License for Current Owners: 1966

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: Matt Feucht Telephone Number: (309) 691-8091
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 01/01/2014 to 12/31/2014 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) Matt Feucht
	(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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 2/25/2014

	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	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	10	Sheltered Care (SC)	2	1,170	5
6		ICF/DD 16 or Less			6
7	67	TOTALS	59	21,975	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	3,999	15,091	1,272	20,362	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	31	444		475	12
13	DD 16 OR LESS					13
14	TOTALS	4,030	15,535	1,272	20,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.82%

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)
Apartment, Assisted Living

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 1966 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1,272

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	320,809	11,849	6,870	339,528	(23,467)	316,061	(67,204)	248,857			1
2	Food Purchase		265,727		265,727	(18,366)	247,361	(40,419)	206,942			2
3	Housekeeping	111,839	24,660		136,499		136,499	(7,182)	129,317			3
4	Laundry	62,111	9,516		71,627		71,627		71,627			4
5	Heat and Other Utilities			175,099	175,099		175,099		175,099			5
6	Maintenance	167,719	39,563	74,145	281,427		281,427	(50,964)	230,463			6
7	Other (specify):*											7
8	TOTAL General Services	662,478	351,315	256,114	1,269,907	(41,833)	1,228,074	(165,769)	1,062,305			8
	B. Health Care and Programs											
9	Medical Director			938	938		938		938			9
10	Nursing and Medical Records	2,665,624	110,094	5,199	2,780,917	554	2,781,471	(230,397)	2,551,074			10
10a	Therapy		3,001	131,843	134,844		134,844		134,844			10a
11	Activities	169,814		5,375	175,189		175,189	(5,653)	169,536			11
12	Social Services	71,355		113	71,468		71,468	(1,320)	70,148			12
13	CNA Training					6,500	6,500		6,500			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,906,793	113,095	143,468	3,163,356	7,054	3,170,410	(237,370)	2,933,040			16
	C. General Administration											
17	Administrative	112,012			112,012		112,012	(10,447)	101,565			17
18	Directors Fees											18
19	Professional Services			36,494	36,494	3,000	39,494		39,494			19
20	Dues, Fees, Subscriptions & Promotions			35,684	35,684		35,684	(7,416)	28,268			20
21	Clerical & General Office Expenses	241,073	52,814	72,965	366,852	(10,055)	356,797	(94,853)	261,944			21
22	Employee Benefits & Payroll Taxes			870,923	870,923	41,833	912,756		912,756			22
23	Inservice Training & Education			12,006	12,006		12,006		12,006			23
24	Travel and Seminar			7,420	7,420		7,420		7,420			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,419	82,419		82,419		82,419			26
27	Other (specify):*											27
28	TOTAL General Administration	353,085	52,814	1,117,911	1,523,810	34,778	1,558,588	(112,716)	1,445,872			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,922,356	517,224	1,517,493	5,957,073	(1)	5,957,072	(515,855)	5,441,217			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 Skylines #0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			341,133	341,133		341,133	(114,381)	226,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,797	1,797		1,797	(1,656)	141			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			342,930	342,930		342,930	(116,037)	226,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,212	4,587	43,799	1	43,800		43,800			39
40	Barber and Beauty Shops			25,819	25,819		25,819		25,819			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,048	148,048		148,048		148,048			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		39,212	178,454	217,666	1	217,667		217,667			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,922,356	556,436	2,038,877	6,517,669		6,517,669	(631,892)	5,885,777			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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(40,419)	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	(4,134)	30.3		9
10	Interest and Other Investment Income	(1,656)	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	(1,540)	20.3		28
29	Other-Attach Schedule	(584,143)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (631,892)		$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	$ (631,892)		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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

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13	FROM R. E. TAX STATEMENT FOR 2013	$	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: 2013 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 2013 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2013.

Please complete the Real Estate Tax Statement below and include it in the 2014 cost report along with a copy of your 2013 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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matt Feucht

TELEPHONE (309) 691-8091 FAX #: (309) 683-2505

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,400 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories Two

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).

Apartments & Assisted Living: 18,850 sq. ft., 3 Independent Living Units & 33 Assisted Living Units.
Duplexes: 1,150 sq. ft. per unit, 16 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	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	29		1966	1965	$ 348,310	$ 2,194	40	$ 5,222	$ 3,028	$ 348,310	4
5	21		1971	1970	396,963	9,924	40	9,924		361,236	5
6	16		1985	1985	750,000	18,750	40	18,750		472,500	6
7	3		1989	1988	205,070	5,127	40	5,127		112,791	7
8	17		1995	1995	870,388	21,760	40	21,760		396,029	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		325,347	9
10	Shelter care remodel			1974	6,594	165	40	165		6,360	10
11	Fire prevention system			1977	23,804		25	629	629	23,804	11
12	Dining room addition			1978	38,922	973	40	973		36,361	12
13	Fire prevention system			1979	35,330		25			35,330	13
14	Windows replacement			1981	23,820		25			23,820	14
15	Kitchen remodel			1982	21,631	541	40	541		19,406	15
16	Energy conservation			1983	8,413		15			8,413	16
17	Shelter care remodel			1984	7,742	194	40	194		6,778	17
18	Cabinets			1986	1,618		15			1,618	18
19	Air conditioning units			1987	6,427		10			6,427	19
20	Physical therapy remodel			1989	11,503	288	40	288		9,270	20
21	Office Addition			1991	50,297	1,257	40	1,257		38,725	21
22	New roof			1993	14,210		10			14,210	22
23	Room remodel			1994	5,154	206	25	206		4,403	23
24	Front entrance, front office, ceiling back hall			1996	62,294	3,115	20	3,115		56,067	24
25	Guttering System			1996	89,096	3,564	25	3,564		64,151	25
26	Fencing, soffit/facia, new door			1997	28,036	1,121	25	1,121		19,388	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978	332	15	332		3,923	28
29	Flooring, lighting, wall covering			2000	97,127		5			97,127	29
30	Flooring, lighting, wall covering			2001	28,745		5			28,745	30
31	Lobby windows			2001	3,577	143	25	143		2,146	31
32	Blacktopping			2001	13,967		8			13,967	32
33	Balcony repair			2001	6,605	544	20	330	(214)	5,692	33
34	Insulation installation			2001	9,970	665	15	665		7,584	34
35	Lawn sprinkler system			2001		643	15		(643)		35
36	Air Conditioning Unit			2001	2,178		10	44	44	2,178	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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Locks	2002	$ 691	$ 35	20	$ 35	$	$ 394	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	9,371	38
39	Flooring, wall covering	2002	9,786		5			9,786	39
40	Balcony repair	2002	7,403	370	20	370		4,758	40
41	Carpeting in dining room	2002	5,446		5			5,446	41
42	Water heater	2002	4,197		10	190	190	4,197	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		256	20		(256)		44
45	Air Conditioning unit	2003	1,700	85	20	85		981	45
46	Sewer system upgrade	2003		256	20		(256)		46
47	Countertops in kitchen	2003	6,594		15	440	440	4,553	47
48	Carpeting	2004	5,878		5			5,878	48
49	Wiremesh	2004	1,825	122	15	122		1,220	49
50	Sewer system upgrade	2004		360	20		(360)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		1,334	51
52	Water heater	2004	7,646	510	10	765	255	7,267	52
53	Rewiring	2004	1,327	66	20	66		605	53
54	Roofing	2005	4,858	486	10	486		4,657	54
55	Tub room remodel	2005	3,855	154	25	154		1,450	55
56	Carpeting	2005	2,128		5			2,128	56
57	Alarm system	2005	2,357	157	15	157		1,439	57
58	External water carryoff system	2005	512	21	25	20	(1)	180	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	77,396	59
60	Door latches	2006	7,110	178	40	178		1,574	60
61	Automatic Doors	2006	2,886	192	15	192		1,633	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		2,777	62
63	Fire safety improvements	2007	19,182	480	40	480		3,377	63
64	Garage	2007	5,944	149	40	149		1,052	64
65	Locks	2007		69	10		(69)		65
66	Office expansion - social services	2007	2,346	59	40	59		465	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		13,985	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		2,083	68
69	Wood door	2007		63	15		(63)		69
70	TOTAL (lines 4 thru 69)		$ 4,583,249	$ 108,928		$ 110,485	$ 1,557	$ 2,810,153	70

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 4,583,249	$ 108,928		$ 110,485	$ 1,557	$ 2,810,153	1
2	Air conditioner compressor	2007	8,418	842	10	842		6,085	2
3	Sprinklers	2007		62	20		(62)		3
4	Maglock outswing door	2007	1,173	117	10	117		930	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		4,473	5
6	Heat exchangers	2007	8,455	423	20	423		3,231	6
7	Disposer 3 hp	2007	3,472	347	10	347		2,566	7
8	Door monitoring unit	2007		110	10		(110)		8
9	Sprinkler-kitchen; flooring-306; fire safety improvs	2008	58,524	1,799	48	1,219	(580)	7,648	9
10	Walkway and snow melt	2008	5,357	357	15	357		2,240	10
11	Septic field St. Luke Ct	2008		268	50		(268)		11
12	Iron guard hand railings	2008	6,781	452	15	452		2,755	12
13	Commercial disposal	2008		149	10		(149)		13
14	Rm flooring, wall	2008	6,604	165	40	165		990	14
15	Internet wiring	2009	4,849	242	20	242		1,351	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		3,071	16
17	Water heater	2009	13,950	930	20	698	(232)	3,568	17
18	Air conditioning units	2009	2,673	267	25	107	(160)	636	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		1,991	19
20	Dining room walls	2009	5,391	216	40	135	(81)	767	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	294	20	316	22	1,881	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		910	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		1,504	23
24	Senior TV hook-up	2009		13	20		(13)		24
25	Salem architectural	2009	3,392	136	25	136		748	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		5,418	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		1,895	27
28	Flooring Salem lounge	2009	14,443	578	25	578		2,986	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		3,802	29
30	Social room tv cabinetry	2009		50	20		(50)		30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		555	31
32	Maglock outswing door, sensor push bars	2009	2,999	182	20	150	(32)	899	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	2,900	33
34	TOTAL (lines 1 thru 33)		$ 4,849,774	$ 122,033		$ 121,532	$ (501)	$ 2,875,953	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 4,849,774	$ 122,033		$ 121,532	$ (501)	$ 2,875,953	1
2	Roofing, flooring rm 226	2009		878	15		(878)		2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	1,095	10	1,094	(1)	4,598	3
4	Elevator repair	2010	12,698	635	10	1,270	635	6,089	4
5	Salem flooring, baseboards	2010	13,507	593	25	540	(53)	2,432	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		744	6
7	Nurses Station	2010	2,533	101	10	253	152	1,054	7
8	Flooring Canaan room	2010		174	5		(174)		8
9	Dining room flooring	2010		48	15		(48)		9
10	New burner boiler 1	2010	12,225	489	25	489		2,055	10
11	Commercial water heater	2010	4,900	327	15	327		1,354	11
12	Surveillance hardware & smoke detector	2010	5,421	497	10	542	45	2,305	12
13	Rebuild \ replace heat exchangers	2010	4,129	275	15	275		1,123	13
14	Zion & Galilee tubs, fire safety wall	2011		2,824	10		(2,824)		14
15	South bath plumbing piping & fixtures	2011	6,824	273	25	273		987	15
16	Judea bath walls, floor, doors, plumbing, drapes	2011	62,271	1,559	25	2,491	932	8,306	16
17	Activity room walls, ceiling, flooring, electrical, plumbing.	2011		732	40		(732)		17
18	Laundry room plumbing, electrical, walls, ceiling.	2011	6,030	151	40	151		479	18
19	Drinking fountain and air conditioning unit	2012	2,495	210	10	250	40	744	19
20	Showers and valves	2012	4,823	193	25	193		551	20
21	Elevator starter and door	2012	5,504	221	25	220	(1)	581	21
22	Therapy rm sprinklers, plumbing, walls, ceiling	2012	22,029	936	25	881	(55)	2,324	22
23	Dining room air conditioner	2012	10,212	681	15	681		1,748	23
24	Beauty shop flooring, walls	2012	3,654	146	25	146		356	24
25	Dining rm addition:walls, electrical, plumbing, ceilings	2012	507,333	12,683	40	12,683		29,605	25
26	Door protectors	2012	4,403	440	10	440		1,161	26
27	Walk in freezer dining rm addition	2012	35,435	2,478	15	2,362	(116)	5,514	27
28	Disposal in dining rm addition	2012		442	10		(442)		28
29	Dining rm:walls, doors, flooring, electrical, plumbing, ceilings	2013	88,266	2,265	40	2,207	(58)	3,585	29
30	30 ton chiller complete with installation	2013	33,263	2,218	15	2,218		3,889	30
31	Dining Room project complete	2013	21,859	601	40	546	(55)	1,091	31
32	100 gallon water heater	2013	12,788	1,279	10	1,279		1,798	32
33	Security cameras and access control	2013	14,350	1,435	10	1,435		2,017	33
34	TOTAL (lines 1 thru 33)		$ 5,762,039	$ 159,087		$ 154,953	$ (4,134)	$ 2,962,443	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 1,089,853	$ 77,932	$ 77,932	$	Various	$ 647,413	71
72	Current Year Purchases	6,779	467	467		Various	467	72
73	Fully Depreciated Assets	315,442					315,442	73
74								74
75	TOTALS	$ 1,412,074	$ 78,399	$ 78,399	$		$ 963,322	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	99 Ford Bus	2005	$ 58,988	$	$	$	4	$ 58,988	76
77	Maintenance	02 John Deere	2005	6,475				3	6,475	77
78										78
79	Patient Transport	06 Ford Van	2006	36,187				5	36,187	79
80	TOTALS			$ 101,650	$	$	$		$ 101,650	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)	$ 7,276,506	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 237,486	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 233,352	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,134)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,027,415	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	Building	Various	$ 2,508,380	$ 73,986	$ 1,189,027	86
87	Equipment	Various	274,329	25,839	173,322	87
88	Vehicle	Various	22,254	1,015	49,120	88
89	Land	Various	112,446			89
90	Duplexes	Various	1,830,475	2,807	2,807	90
91	TOTALS		$ 4,747,884	$ 103,647	$ 1,414,276	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	$ 470,417	92
93			93
94			94
95		$ 470,417	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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 6,500	$ 6,500
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	$	$	$ 6,500	$ 6,500
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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	$	440	$ 23,890	$	440	$ 23,890	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		703	44,981		703	44,981	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		355	20,244		355	20,244	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				34,665		34,665	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					4,547		4,547	13
14	TOTAL			$	1,498	$ 89,115	$ 39,212	1,498	$ 128,327	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 Skylines # 0006353 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 425,114	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	612,490		3
4	Supply Inventory (priced at FIFO)	20,006		4
5	Short-Term Investments	151,648		5
6	Prepaid Insurance	116,594		6
7	Other Prepaid Expenses	78,478		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,404,330	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	10,158,148		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,854,782		16
17	Accumulated Depreciation (book methods)	(5,536,983)		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): Construction In Progress			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 6,589,136	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 7,993,466	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 269,735	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,437		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 354,172	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingency Payable	1,772,923		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 1,772,923	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 2,127,095	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 5,866,371	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 7,993,466	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 5,790,907	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(28,491)	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 5,762,416	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,955	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 103,955	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)	$ 5,866,371	24 *

* This must agree with page 17, line 47.

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,646,826	1
2	Discounts and Allowances for all Levels	(470,417)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,176,409	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,530	6
7	Oxygen	22,658	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 255,188	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	312	12
13	Barber and Beauty Care	27,923	13
14	Non-Patient Meals	40,449	14
15	Telephone, Television and Radio	10,035	15
16	Rental of Facility Space		16
17	Sale of Drugs	30,092	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,594	19
20	Radiology and X-Ray	3,323	20
21	Other Medical Services	657,316	21
22	Laundry	893	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 773,937	23
	D. Non-Operating Revenue		
24	Contributions	375,779	24
25	Interest and Other Investment Income***	1,826	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 377,605	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Facility	5,337	28
28a	Miscellaneous Income	33,148	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 38,485	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 6,621,624	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,269,907	31
32	Health Care	3,163,356	32
33	General Administration	1,523,810	33
	B. Capital Expense		
34	Ownership	342,930	34
	C. Ancillary Expense		
35	Special Cost Centers	69,618	35
36	Provider Participation Fee	148,048	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 6,517,669	40
41	Income before Income Taxes (line 30 minus line 40)**	103,955	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 103,955	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 438,607	44
45	Private Pay - Net Inpatient Revenue	4,432,496	45
46	Medicare - Net Inpatient Revenue	305,307	46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,176,409	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 67,272	$ 32.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,064	19,326	526,970	27.27	3
4	Licensed Practical Nurses	13,103	14,012	329,144	23.49	4
5	CNAs & Orderlies	68,031	72,168	993,844	13.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,080	36,066	17.34	9
10	Activity Assistants	10,854	11,489	131,015	11.40	10
11	Social Service Workers	3,540	3,819	70,035	18.34	11
12	Dietician					12
13	Food Service Supervisor	3,642	4,009	84,394	21.05	13
14	Head Cook	6,500	6,821	90,982	13.34	14
15	Cook Helpers/Assistants	6,406	7,179	78,229	10.90	15
16	Dishwashers					16
17	Maintenance Workers	7,085	7,803	142,311	18.24	17
18	Housekeepers	9,142	9,760	104,657	10.72	18
19	Laundry	5,039	5,439	62,111	11.42	19
20	Administrator	1,742	1,886	101,565	53.85	20
21	Assistant Administrator	1,385	1,529	59,529	38.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,447	5,753	109,315	19.00	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	2,279	2,481	46,695	18.82	31
32	Other Health Care(specify)	33,206	33,343	471,302	14.13	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,439	210,977	$ 3,505,436 *	$ 16.62	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	172	$ 6,870	1.3	35
36	Medical Director	8	938	9.3	36
37	Medical Records Consultant	34	2,453	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	41	3,300	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	8	563	11.3	44
45	Social Service Consultant	3	113	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	$ 14,237		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

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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.)			$ 112,012

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.)		$ 36,494

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,327
Unemployment Compensation Insurance	1,230
FICA Taxes	291,402
Employee Health Insurance	379,763
Employee Meals	41,833
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan & Administration	70,716
Employee Physical	13,385
Employee Incentives	13,975
Uniform Allowance	125
Non-Care	
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 912,756

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	$ 5,207
Advertising: Employee Recruitment	21,580
Health Care Worker Background Check	30
(Indicate # of checks performed 3)	
Patient Background Checks 36	360
Life Services Network Dues	5,810
Publications	1,162
Licenses	1,190
Other Membership Dues	345
Non-Care	
Less: Public Relations Expense	( )
Non-allowable advertising	(5,876)
Yellow page advertising	(1,540)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,582
Seminar Expense	4,838
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,420

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 5,810

(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? 6

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 38,382 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. $ 148,048
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. $ 41,833 Has any meal income been offset against related costs? Yes Indicate the amount. $ 40,419

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.