FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 B530 (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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	21,960	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	21,960	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	366	300	993	1,659	8
9	SNF/PED					9
10	ICF	6,099	9,751		15,850	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,465	10,051	993	17,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.73%

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 993

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	329,563	25,185	8,055	362,803		362,803		362,803			1
2	Food Purchase		192,505		192,505		192,505	(8,234)	184,271			2
3	Housekeeping	229,614	27,195	8,064	264,873		264,873		264,873			3
4	Laundry		3,618		3,618		3,618		3,618			4
5	Heat and Other Utilities			98,984	98,984		98,984		98,984			5
6	Maintenance	72,118	33,826	62,206	168,150		168,150		168,150			6
7	Other (specify):*											7
8	TOTAL General Services	631,295	282,329	177,309	1,090,933		1,090,933	(8,234)	1,082,699			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,706,945	71,062	9,593	1,787,600	1	1,787,601		1,787,601			10
10a	Therapy		2,260	135,843	138,103		138,103		138,103			10a
11	Activities	113,130	15,923	460	129,513		129,513		129,513			11
12	Social Services	59,003		1,513	60,516		60,516		60,516			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,879,078	89,245	147,409	2,115,732	1	2,115,733		2,115,733			16
	C. General Administration											
17	Administrative	91,921			91,921		91,921		91,921			17
18	Directors Fees											18
19	Professional Services			53,093	53,093		53,093		53,093			19
20	Dues, Fees, Subscriptions & Promotions			4,536	4,536	10,308	14,844		14,844			20
21	Clerical & General Office Expenses	187,613	29,502	104,060	321,175	(10,308)	310,867	(50)	310,817			21
22	Employee Benefits & Payroll Taxes			582,213	582,213		582,213		582,213			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,191	52,191		52,191		52,191			26
27	Other (specify):*											27
28	TOTAL General Administration	279,534	29,502	796,093	1,105,129		1,105,129	(50)	1,105,079			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,789,907	401,076	1,120,811	4,311,794	1	4,311,795	(8,284)	4,303,511			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: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			160,266	160,266		160,266	(1,655)	158,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,757	18,757		18,757		18,757			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			179,023	179,023		179,023	(1,655)	177,368			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,922		77,922	(1)	77,921		77,921			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,821	132,821		132,821		132,821			42
43	Other (specify):*		12,891	313,192	326,083		326,083	(326,083)				43
44	TOTAL Special Cost Centers		90,813	446,013	536,826	(1)	536,825	(326,083)	210,742			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,789,907	491,889	1,745,847	5,027,643		5,027,643	(336,022)	4,691,621			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: 01/01/2016 Ending: 12/31/2016

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	(8,234)	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	(1,655)	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	(326,133)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (336,022)		$	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))	$ (336,022)		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	Physician Care		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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Apostolic Christian Church	x		Working Capital	none	various	$ 359,000	$ 50,000	n/a		$	1
2	Morton Community Bank		x	Long-term debt	7,000	2014	500,000	324,830	2019	0.0375	10,725	2
3					-							3
4					-							4
5					-							5
	Working Capital											
6	Morton Community Bank		x	Working Capital	none	various		403,000	various	various	8,032	6
7					-						-	7
8					-							8
9	TOTAL Facility Related				7,000		$ 859,000	$ 777,830			$ 18,757	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 859,000	$ 777,830			$ 18,757	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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:		
2011		8
2012		9
2013		10
2014		11
2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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		561,265	6
7			1992	1992	129,607	4,469	30	4,320	(149)	107,851	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			36,135	26
27	Building & land improvements - '94			1994	14,661		20			14,661	27
28	Building & land improvements - '95			1995	30,372		20			30,372	28
29	Building & land improvements - '96			1996	5,114		20			5,114	29
30	Building & land improvements - '97			1997	28,536		20	1,426	1,426	28,536	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: 01/01/2016 Ending: 12/31/2016

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		7			728	43
44	Dining Room Insulation	2006	850		7			850	44
45	Floor Joist	2006	1,010		7			1,010	45
46	Furnace and Ductwork	2006	1,305		7			1,305	46
47	Generator	2006	2,496		7			2,496	47
48	Sprinkler Update	2006	960		7			960	48
49	Tub	2006	14,095		7			14,095	49
50	Activity Window Coverings	2006	558		7			558	50
51	Electrical Wiring	2006	389		7			389	51
52	Canopy Sprinkler Repair	2006	4,866		7			4,866	52
53	Retaining wall, Rm12 plaster, door latches, draperies	2006			7				53
54	Sprinkler system & plumbing upgrade	2006			7				54
55	South elevator improvement & wallguards	2006			5				55
56	Basement doors	2007	2,605		7			2,605	56
57	Water lines and sidewalks	2007	3,300		7			3,300	57
58	North end fire dampers	2007	11,784		7			11,784	58
59	Kitchen plumbing, electrical, carpentry, flooring, insulation	2007	93,241		7			93,241	59
60	Kitchen sinks	2007	4,179		5			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			7				66
67	Kitchen hot water heater piping	2008			7				67
68	Kitchen doors	2008	12,848		7			12,848	68
69	Room 9 west flooring	2008			7				69
70	TOTAL (lines 4 thru 69)		$ 2,707,270	$ 26,845		$ 28,122	$ 1,277	$ 2,575,493	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: 01/01/2016 Ending: 12/31/2016

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	$ 26,845		$ 28,122	$ 1,277	$ 2,575,493	1
2	South basement wall, lighting, sink & vanity	2008	3,404		7			3,404	2
3	Sprinkler system upgrade	2008			7				3
4	Basement sewer & plumbing system repair	2008	10,354		7			10,354	4
5	Maintenance garage sewer hook-up	2008			7				5
6	Water heater upgrade	2008	10,898		5			10,898	6
7	Elevator and pole light	2008	4,153		5			4,153	7
8	Kitchen grease trap replacement	2008	3,972		5			3,972	8
9	East & West end flooring	2008	12,916		5			12,916	9
10	Door replacements	2008			5				10
11	Northeast exit sidewalk replacement	2008	18,726	1,622	10	1,873	251	15,297	11
12	Front sewer line installation and repair	2008	4,216	422	10	422		3,446	12
13	Sprinkler system upgrade	2009	3,288		5			3,288	13
14	Water heaters, fresh air hook-up, door upgrade w/ramps	2009	12,302		5			12,302	14
15	Wiring/installation of digital cable system	2009			5				15
16	Roofing project	2009	72,252	2,297	30	2,408	111	17,463	16
17	Kitchen cabinets, countertop, plumbing	2009	2,798		5			2,798	17
18	Nurse station & med rm counter top, insulation	2010	9,407		5			9,407	18
19	Sprinkler system upgrade	2010	13,072		5			13,072	19
20	Doors, openers, exit lighting	2010	3,783		5			3,783	20
21	Furnace, air conditioners, disposal	2010	6,475		5			6,475	21
22	Asphalt parking lot	2010	20,152	2,015	10	2,015		12,427	22
23	Basement ceiling drywall & rm 11 carpeting	2011	4,912	491	10	491		2,743	23
24	Basement ceiling drywall & rewiring	2011		423	5		(423)		24
25	Resident rm wall mounted box holders	2011	3,422	342	5	684	342	3,420	25
26	Water heater	2011	6,999	700	5	225	(475)	6,999	26
27	West flooring, furnace, electrical, ceiling	2011	18,658	1,881	5	3,106	1,225	18,658	27
28	West Doors	2011	61,657	6,166	10	6,166		30,830	28
29	Wall mounted nursing stations	2011		649	5		(649)		29
30	West air conditioner	2012	3,914	783	5	783		3,394	30
31	West room signage, plumbing, electrical, sprinklers, curtains, wall mou	2012	5,880	3,604	5	1,176	(2,428)	5,393	31
32	West & basement floors, walls, ceiling, electrical, plumbing	2012	133,422	13,474	10	13,342	(132)	56,731	32
33	West & east floors, walls, ceiling, electrical, plumbing	2012	17,854	1,786	10	1,785	(1)	7,438	33
34	TOTAL (lines 1 thru 33)		$ 3,176,156	$ 63,500		$ 62,598	$ (902)	$ 2,856,554	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: 01/01/2016 Ending: 12/31/2016

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	$ 63,500		$ 62,598	$ (902)	$ 2,856,554	1
2	South floors, walls, ceiling, electrical, plumbing	2013	9,750	975	10	975		3,817	2
3	Water line replacement west side	2013	13,456	1,346	10	1,346		4,377	3
4	Dining Room a/c unit and pad	2013	4,274	855	5	855		3,066	4
5	Door locks	2013	4,809	962	5	962		3,047	5
6	Concrete N.E. loading area	2014	36,506	1,825	20	1,825		3,955	6
7	Elevator door restrictor, heat detector, call box	2014	5,121	1,025	5	1,024	(1)	2,820	7
8	Sprinkler piping and spray heads	2014	14,177	2,835	5	2,835		6,859	8
9	Security system wiring & affixed hardware	2014	15,456	3,091	5	3,091		6,182	9
10	Rms 21 & 15, conference rm flooring	2014	6,634	1,327	5	1,327		3,210	10
11	N.E. elevator control board	2015	3,761	752	5	752		1,440	11
12	Compressor sprinkler system & tamper switches	2015	2,822	565	5	564	(1)	1,037	12
13	Generator auto governor & power meter	2015	8,163	1,633	5	1,633		2,863	13
14	Electrical outlet replacement	2015	22,548	2,255	10	2,255		3,768	14
15	Door alarm system	2015	4,691	938	5	938		1,411	15
16	Sprinkler system	2015	10,777	2,155	5	2,155		2,155	16
17	Tub room water heater	2015	7,750	1,550	5	1,550		1,941	17
18	N.E., N.W., S.W. Furnaces & HVAC systems	2015	33,452	4,990	5	6,690	1,700	7,808	18
19	Lobby fireplace	2015	17,336	2,104	10	1,734	(370)	1,734	19
20	Generator auto governor	2016	2,703	270	5	453	183	453	20
21	Wall speakers	2016	3,764	376	5	441	65	441	21
22	Fire alarm system	2016	15,081	754	10	632	(122)	632	22
23	Water softner	2016	4,033	403	5	203	(200)	203	23
24	Office air conditioner	2016	4,227	423	5	213	(210)	213	24
25	Sprinkler system	2016	18,238	1,824	5		(1,824)		25
26	4 large windows & 3 sills: lobby, activity, tub rms	2016	15,750	394	20	397	3	397	26
27	Rms E7-E9;W2;W10;W14;W19 & east hall flooring project	2016	29,647	2,965	5	2,989	24	2,989	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,491,082	$ 102,092		$ 100,437	$ (1,655)	$ 2,923,372	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: 01/01/2016 Ending: 12/31/2016

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	$ 313,512	$ 50,994	$ 50,994	$	5	$ 71,412	71
72	Current Year Purchases	10,864	1,087	1,087		5	1,087	72
73	Fully Depreciated Assets	1,441,239					1,441,239	73
74								74
75	TOTALS	$ 1,765,615	$ 52,081	$ 52,081	$		$ 1,513,738	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 Bus/'05 Van	various	$ 61,739	$	$	$	5	$ 61,739	76
77	Patient Transport	98 Bus	2015	6,149	1,230	1,230		5	1,540	77
78	Patient Transport	2009 Beau Van	2009	1,964				5	1,964	78
79	Patient Transport	2011 Dodge Caravan	2011	48,628	4,863	4,863		10	26,746	79
80	TOTALS			$ 118,480	$ 6,093	$ 6,093	$		$ 91,989	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)	$ 5,411,052	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,266	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,611	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,655)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,529,099	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	$ 3,060,324	$ 112,846	$ 1,578,339	86
87	Country View Apartments	Various	1,102,123	23,911	409,134	87
88	Duplex Furniture & Fixtures	Various	259,890	27,329	206,771	88
89	Country View Furniture & Fixt	Various	326,303	24,374	252,484	89
90	Duplex Land & Improvements	Various	466,751	21,160	320,731	90
91	TOTALS		$ 5,215,391	$ 209,620	$ 2,767,459	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 01/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	332	$ 17,920	$	332	$ 17,920	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		181	11,600		181	11,600	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		383	21,304		383	21,304	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				46,968		46,968	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					30,953		30,953	13
14	TOTAL			$	896	$ 50,824	$ 77,921	896	$ 128,745	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: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 12,033	$	1
2	Cash-Patient Deposits	162		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	737,061		3
4	Supply Inventory (priced at FIFO)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,194		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 798,450	$	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	7,921,499		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,418,863		16
17	Accumulated Depreciation (book methods)	(7,317,010)		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)	$ 3,087,978	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 3,886,428	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,399	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	162		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,353		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,632		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	106,037		36
37	Life Lease Deferred Income			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 550,583	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,153,129		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	2,149,405		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 3,302,534	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 3,853,117	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 33,311	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 3,886,428	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 469,304	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 469,304	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(873,646)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	437,653	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)	$ (435,993)	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)	$ 33,311	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	$ 4,113,594	1
2	Discounts and Allowances for all Levels	(671,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 3,442,153	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	265,734	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 265,734	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	19,612	13
14	Non-Patient Meals	8,234	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)	$ 27,846	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,270	28
28a	Non-Care Facility	413,994	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 418,264	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 4,153,997	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,090,933	31
32	Health Care	2,115,732	32
33	General Administration	1,105,129	33
	B. Capital Expense		
34	Ownership	179,023	34
	C. Ancillary Expense		
35	Special Cost Centers	404,005	35
36	Provider Participation Fee	132,821	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,027,643	40
41	Income before Income Taxes (line 30 minus line 40)**	(873,646)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (873,646)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (516,554)	44
45	Private Pay - Net Inpatient Revenue	3,701,565	45
46	Medicare - Net Inpatient Revenue	257,143	46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,442,153	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	1,912	2,080	$ 80,386	$ 38.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,148	12,984	395,318	30.45	3
4	Licensed Practical Nurses	5,110	5,543	140,776	25.40	4
5	CNAs & Orderlies	51,215	54,657	889,733	16.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,215	39,662	17.91	9
10	Activity Assistants	5,371	5,825	73,468	12.61	10
11	Social Service Workers	3,022	3,254	59,003	18.13	11
12	Dietician					12
13	Food Service Supervisor	1,815	2,080	53,680	25.81	13
14	Head Cook	8,093	8,493	119,668	14.09	14
15	Cook Helpers/Assistants	13,771	14,516	156,215	10.76	15
16	Dishwashers					16
17	Maintenance Workers	1,998	2,229	72,118	32.35	17
18	Housekeepers	17,204	18,398	229,614	12.48	18
19	Laundry					19
20	Administrator	1,830	2,110	91,921	43.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,590	9,697	187,613	19.35	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)	7,770	8,716	200,732	23.03	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,796	152,797	$ 2,789,907 *	$ 18.26	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	119	$ 6,512	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	71	4,467	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	399	10,852	10a.3	40
41	Occupational Therapy Consultant	2	156	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	7	460	11.3	44
45	Social Service Consultant	35	1,413	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	633	$ 23,860		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	20	459	10.3	52
53	TOTAL (lines 50 - 52)	20	$ 459		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.)			$ 91,921

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) (For legal fee disclosure, see page 39 of instructions)		$ 53,093

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,462
Unemployment Compensation Insurance	16,689
FICA Taxes	198,919
Employee Health Insurance	315,730
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis Immunization	
Employee Life/Disability	
Employee Physicals	7,528
Uniform Allowance	
Vacation allowance	(3,115)
Non-Care Employee Benefits	
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,213

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,308
Health Care Worker Background Check	435
(Indicate # of checks performed 15)	
Patient Background Checks 56	750
LeadingAge	3,201
Other Membership Dues \ Licenses	
CLIA	150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,844

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)	$

* Attach copy of IMRF notifications

**See instructions.

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. LeadingAge 3,201

(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. $ 40,855 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. $ 132,821
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. $ 8,234

(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. $ Zero

(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.