

		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.

<p>I. IDPH License ID Number: <u>0006353</u></p> <p>Facility Name: <u>Apostolic Christian Skylines</u></p> <p>Address: <u>7023 N E Skyline Dr</u> <u>Peoria</u> <u>61614</u> <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 691-8091</u> Fax # <u>(309) 683-2505</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1966</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Matt Feucht</u> Telephone Number: <u>(309) 691-8091</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <div style="border: 1px solid black; padding: 2px;">Officer or Administrator of Provider</div> </td> <td style="border: none;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>Matt Feucht</u> (Title) <u>Administrator</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <div style="border: 1px solid black; padding: 2px;">Paid Preparer</div> </td> <td style="border: none;"> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # () </td> </tr> </table> <p align="right"> 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 </p>	<div style="border: 1px solid black; padding: 2px;">Officer or Administrator of Provider</div>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Matt Feucht</u> (Title) <u>Administrator</u>	<div style="border: 1px solid black; padding: 2px;">Paid Preparer</div>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
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<div style="border: 1px solid black; padding: 2px;">Officer or Administrator of Provider</div>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Matt Feucht</u> (Title) <u>Administrator</u>							
<div style="border: 1px solid black; padding: 2px;">Paid Preparer</div>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Skylines

0006353 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 2/25/2016

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,862	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)		110	5
6		ICF/DD 16 or Less			6
7	59	TOTALS	57	20,972	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	2,040	16,995	841	19,876	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		55		55	12
13	DD 16 OR LESS					13
14	TOTALS	2,040	17,050	841	19,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.04%

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 NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES 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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 57 and days of care provided 841

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAU MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	Dietary	358,553	23,961	7,758	390,272	(14,119)	376,153	(65,964)	310,189		1
2	Food Purchase		260,949		260,949	(9,440)	251,509	(58,866)	192,643		2
3	Housekeeping	127,765	24,704		152,469		152,469	(7,524)	144,945		3
4	Laundry	49,207	11,309		60,516		60,516		60,516		4
5	Heat and Other Utilities			173,662	173,662		173,662		173,662		5
6	Maintenance	175,114	39,187	86,642	300,943		300,943	(62,569)	238,374		6
7	Other (specify):*										7
8	TOTAL General Services	710,639	360,110	268,062	1,338,811	(23,559)	1,315,252	(194,923)	1,120,329		8
	B. Health Care and Programs										
9	Medical Director			5,313	5,313		5,313		5,313		9
10	Nursing and Medical Records	2,788,381	169,064	47,642	3,005,087	(1)	3,005,086	(226,192)	2,778,894		10
10a	Therapy	125,029	3,293	111,693	240,015		240,015		240,015		10a
11	Activities	165,081		7,579	172,660		172,660	(5,358)	167,302		11
12	Social Services	79,433		2,175	81,608		81,608	(1,436)	80,172		12
13	CNA Training					2,000	2,000		2,000		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,157,924	172,357	174,402	3,504,683	1,999	3,506,682	(232,986)	3,273,696		16
	C. General Administration										
17	Administrative	119,647			119,647		119,647	(11,331)	108,316		17
18	Directors Fees										18
19	Professional Services			50,131	50,131	(1,850)	48,281		48,281		19
20	Dues, Fees, Subscriptions & Promotions			84,927	84,927		84,927	(10,495)	74,432		20
21	Clerical & General Office Expenses	284,042	66,436	67,179	417,657	(150)	417,507	(102,880)	314,627		21
22	Employee Benefits & Payroll Taxes			895,711	895,711	23,559	919,270		919,270		22
23	Inservice Training & Education			10,500	10,500		10,500		10,500		23
24	Travel and Seminar			8,578	8,578		8,578		8,578		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,743	75,743		75,743		75,743		26
27	Other (specify):*										27
28	TOTAL General Administration	403,689	66,436	1,192,769	1,662,894	21,559	1,684,453	(124,706)	1,559,747		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,272,252	598,903	1,635,233	6,506,388	(1)	6,506,387	(552,615)	5,953,772		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: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			367,637	367,637		367,637	(126,131)	241,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20	20		20	(20)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			367,657	367,657		367,657	(126,151)	241,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,688	4,649	45,337	1	45,338		45,338			39
40	Barber and Beauty Shops			22,728	22,728		22,728		22,728			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,709	146,709		146,709		146,709			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		40,688	174,086	214,774	1	214,775		214,775			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,272,252	639,591	2,176,976	7,088,819		7,088,819	(678,766)	6,410,053			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: 01/01/2016 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.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(58,866)	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	(3,756)	30.3		9
10 Interest and Other Investment Income	(20)	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
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising	(1,965)	20.3		28
29 Other-Attach Schedule	(614,159)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (678,766)		\$	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	2	
	Amount	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
(sum of SUBTOTALS (A) and (B))			
37 TOTAL ADJUSTMENTS	\$ (678,766)		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	2	3	4	
	Yes	No	Amount	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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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: 01/01/2016 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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

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: 01/01/2016 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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: 01/01/2016 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	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2015</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		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
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																				
	2012	9																					
	2013	10																					
	2014	11																					
	2015	12																					

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Skylines# 0006353

Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,400 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories TwoC. Does the Operating Entity? (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? (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 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	<u>Nursing Home</u>	<u>200,000</u>	<u>1964</u>	<u>\$ 743</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>200,000</u>		<u>\$ 743</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	29	1966	1965	\$ 348,310	\$	40	\$	\$	\$ 348,310	4
5	21	1971	1970	396,963	9,924	40	9,924		381,084	5
6	16	1985	1985	750,000	18,750	40	18,750		510,000	6
7	3	1989	1988	205,070	5,127	40	5,127		123,045	7
8	17	1995	1995	870,388	21,760	40	21,760		439,549	8
	Improvement Type**									
9	17 bed room addition		1996	793,538	19,838	40	19,838		365,023	9
10	Shelter care remodel		1974	6,594		40	69	69	6,594	10
11	Fire prevention system		1977	23,804		25			23,804	11
12	Dining room addition		1978	38,922	615	40	973	358	38,307	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		20,488	15
16	Energy conservation		1983	8,413		15			8,413	16
17	Shelter care remodel		1984	7,742	194	40	194		7,166	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		9,846	20
21	Office Addition		1991	50,297	1,257	40	1,257		41,239	21
22	New roof		1993	14,210		10			14,210	22
23	Room remodel		1994	5,154	206	25	206		4,815	23
24	Front entrance, front office, ceiling back hall		1996	62,294		20	3,112	3,112	62,294	24
25	Guttering System		1996	89,096	3,564	25	3,564		71,279	25
26	Fencing, soffit/facia, new door		1997	28,036	1,121	25	1,121		21,630	26
27	Flooring, lighting, wall covering		1998	88,061		5			88,061	27
28	Door & fire alarms		2000	4,978	332	15	332		4,587	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		2,432	31
32	Blacktopping		2001	13,967		8			13,967	32
33	Balcony repair		2001	6,605	544	20	330	(214)	6,352	33
34	Insulation installation		2001	9,970	665	15	665		8,914	34
35	Lawn sprinkler system		2001		643	15		(643)		35
36	Air Conditioning Unit		2001	2,178		10			2,178	36

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Apostolic Christian Skylines# 0006353

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Locks	2002	\$ 691	\$ 35	20	\$ 35	\$	\$ 464	37
38 Flooring, tub, wall covering	2002	14,570	728	20	729	1	10,829	38
39 Flooring, wall covering	2002	9,786		5			9,786	39
40 Balcony repair	2002	7,403	370	20	370		5,498	40
41 Carpeting in dining room	2002	5,446		5			5,446	41
42 Water heater	2002	4,197		10			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		1,151	45
46 Sewer system upgrade	2003		256	20		(256)		46
47 Countertops in kitchen	2003	6,594		15	440	440	5,433	47
48 Carpeting	2004	5,878		5			5,878	48
49 Wiremesh	2004	1,825	122	15	122		1,464	49
50 Sewer system upgrade	2004		360	20		(360)		50
51 Electrical panel upgrade	2004	2,068	138	15	138		1,610	51
52 Water heater	2004	7,646	127	10		(127)	7,646	52
53 Rewiring	2004	1,327	66	20	66		737	53
54 Roofing	2005	4,858		10			4,858	54
55 Tub room remodel	2005	3,855	154	25	154		1,758	55
56 Carpeting	2005	2,128		5			2,128	56
57 Alarm system	2005	2,357	157	15	157		1,753	57
58 External water carryoff system	2005	512	21	25	20	(1)	220	58
59 Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	95,604	59
60 Door latches	2006	7,110	178	40	178		1,930	60
61 Automatic Doors	2006	2,886	192	15	192		2,017	61
62 Walk-in Cooler upgrades	2006	3,135	52	10	44	(8)	3,135	62
63 Fire safety improvements	2007	19,182	480	40	480		4,337	63
64 Garage	2007	5,944	149	40	149		1,350	64
65 Locks	2007		69	10		(69)		65
66 Office expansion - social services	2007	2,346	59	40	59		583	66
67 Elevator jack replacement	2007	35,560	1,778	20	1,778		17,541	67
68 Fire hydrant - sprinkler heads	2007	5,719	286	20	286		2,655	68
69 Wood door	2007		63	15		(63)		69
70 TOTAL (lines 4 thru 69)		\$ 4,583,249	\$ 101,965		\$ 102,780	\$ 815	\$ 3,016,662	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Apostolic Christian Skylines# 0006353

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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,583,249	\$ 101,965		\$ 102,780	\$ 815	\$ 3,016,662	1
2	Air conditioner compressor	2007	8,418	842	10	842		7,769	2
3	Sprinklers	2007		62	20		(62)		3
4	Maglock outswing door	2007	1,173	117	10	117		1,164	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		5,633	5
6	Heat exchangers	2007	8,455	423	20	423		4,077	6
7	Disposer 3 hp	2007	3,472	347	10	347		3,260	7
8	Door monitoring unit	2007		110	10		(110)		8
9	Sprinkler-kitchen; flooring-306; fire safety improvs	2008	58,524	1,520	48	1,219	(301)	10,086	9
10	Walkway and snow melt	2008	5,357	357	15	357		2,954	10
11	Septic field St. Luke Ct	2008		268	50		(268)		11
12	Iron guard hand railings	2008	6,781	452	15	452		3,659	12
13	Commercial disposal	2008		149	10		(149)		13
14	Rm flooring, wall	2008	6,604	165	40	165		1,320	14
15	Internet wiring	2009	4,849	242	20	242		1,835	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		4,241	16
17	Water heater	2009	13,950	930	20	698	(232)	4,964	17
18	Air conditioning units	2009	2,673	267	25	107	(160)	850	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		2,715	19
20	Dining room walls	2009	5,391	216	40	135	(81)	1,037	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	294	20	316	22	2,513	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		1,222	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		2,058	23
24	Senior TV hook-up	2009		13	20		(13)		24
25	Salem architectural	2009	3,392	136	25	136		1,020	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		7,482	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		2,617	27
28	Flooring Salem lounge	2009	14,443	578	25	578		4,142	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		5,322	29
30	Social room tv cabinetry	2009		50	20		(50)		30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		777	31
32	Maglock outswing door, sensor push bars	2009	2,999	182	20	150	(32)	1,199	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	3,978	33
34	TOTAL (lines 1 thru 33)		\$ 4,849,774	\$ 114,791		\$ 113,827	\$ (964)	\$ 3,104,556	34

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

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,849,774	\$ 114,791		\$ 113,827	\$ (964)	\$ 3,104,556	1
2	Roofing, flooring rm 226	2009		404	15		(404)		2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	1,095	10	1,094	(1)	6,786	3
4	Elevator repair	2010	12,698	635	10	1,270	635	8,629	4
5	Salem flooring, baseboards	2010	13,507	593	25	540	(53)	3,512	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		1,094	6
7	Nurses Station	2010	2,533	101	10	253	152	1,560	7
8	Flooring Canaan room	2010			5				8
9	Dining room flooring	2010		48	15		(48)		9
10	New burner boiler 1	2010	12,225	489	25	489		3,033	10
11	Commercial water heater	2010	4,900	327	15	327		2,008	11
12	Surveillance hardware & smoke detector	2010	5,421	497	10	542	45	3,389	12
13	Rebuild \ replace heat exchangers	2010	4,129	275	15	275		1,673	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		1,533	15
16	Judea bath walls, floor, doors, plumbing, drapes	2011	62,271	1,559	25	2,491	932	13,288	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		781	18
19	Drinking fountain and air conditioning unit	2012	2,495	210	10	250	40	1,244	19
20	Showers and valves	2012	4,823	193	25	193		937	20
21	Elevator starter and door	2012	5,504	221	25	220	(1)	1,021	21
22	Therapy rm sprinklers, plumbing, walls, ceiling	2012	22,029	936	25	881	(55)	4,086	22
23	Dining room air conditioner	2012	10,212	681	15	681		3,110	23
24	Beauty shop flooring, walls	2012	3,654	146	25	146		648	24
25	Dining rm addition:walls, electrical, plumbing, ceilings	2012	507,333	12,683	40	12,683		54,971	25
26	Door protectors	2012	4,403	440	10	440		2,041	26
27	Walk in freezer dining rm addition	2012	35,435	2,478	15	2,362	(116)	10,238	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)	7,999	29
30	30 ton chiller complete with installation	2013	33,263	2,218	15	2,218		8,325	30
31	Dining Room project complete	2013	21,859	601	40	546	(55)	2,183	31
32	100 gallon water heater	2013	12,788	1,279	10	1,279		4,356	32
33	Security cameras and access control	2013	14,350	1,435	10	1,435		4,887	33
34	TOTAL (lines 1 thru 33)		\$ 5,762,039	\$ 151,197		\$ 147,248	\$ (3,949)	\$ 3,257,888	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:

01/01/2016

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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,762,039	\$ 151,197		\$ 147,248	\$ (3,949)	\$ 3,257,888	1
2	Humidification system - Salem	2015	8,156	816	10	816		1,520	2
3	Fire alarm system	2015	22,038	1,469	15	1,469		2,701	3
4	Security camera nursing home B	2015	3,275	328	10	328		460	4
5	Roofing Salem	2015	4,381	176	25	175	(1)	246	5
6	100 & 81 gallon water heaters nursing center	2016	17,610	1,468	10	1,467	(1)	1,467	6
7	Nursing center pneumatic control system air dryer	2016	3,307	138	10	131	(7)	131	7
8	Zion hall: wallpaper,paint,drywall,light fixtures,sprinkler,rails,wall protectors,carpet	2016	92,779	3,093	25	3,101	8	3,101	8
9	Galilee hall: ceiling tile,wallpaper,paint,light fixtures,sprinkler,rails,wall protectors,carpet	2016	92,682	3,089	25	3,098	9	3,098	9
10	Galilee nurse stn:studs&drywall,ceiling,paint,flooring,wainscot,sprinkler,plumbing,duct,electrical	2016	101,360	3,379	25	3,388	9	3,388	10
11	Salem bath project nurse center	2016	18,183	707	15	761	54	761	11
12	Walk in cooler: condenser,evaporator,electronic controls,piping	2016	6,790	264	15	272	8	272	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,132,600	\$ 166,124		\$ 162,254	\$ (3,870)	\$ 3,275,033	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: 01/01/2016 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	\$ 816,973	\$ 60,678	\$ 60,678	\$	Various	\$ 471,261	71
72	Current Year Purchases	48,160	4,086	4,086		Various	4,086	72
73	Fully Depreciated Assets	626,008					626,008	73
74								74
75	TOTALS	\$ 1,491,141	\$ 64,764	\$ 64,764	\$		\$ 1,101,355	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; '06 Ford Van	2005	\$ 95,175	\$	\$	\$	5	\$ 95,175	76
77	Maintenance	02 John Deere	2005	6,475				3	6,475	77
78	Patient Transport	15 Doge Van	2015	39,933	5,705	5,705		7	8,159	78
79	Patient Transport	16 Ford Bus	2016	66,200	8,669	8,783	114	7	8,783	79
80	TOTALS			\$ 207,783	\$ 14,374	\$ 14,488	\$ 114		\$ 118,592	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)	\$ 7,832,267	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,262	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 241,506	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,756)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,494,980	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	\$ 2,782,879	\$ 89,639	\$ 1,363,797	86
87	Equipment Various	309,056	24,974	218,712	87
88	Vehicle Various	42,154	2,843	27,940	88
89	Land Various	112,446			89
90	Duplexes Various	1,870,391	4,919	12,220	90
91	TOTALS	\$ 5,116,926	\$ 122,375	\$ 1,622,669	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 59,097	92
93			93
94			94
95		\$ 59,097	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES 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

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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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		2,000		2,000
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,000	\$	\$ 2,000
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,000		

- (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.

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

- (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.

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	\$ 857,396	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 658)	606,886		3
4	Supply Inventory (priced at FIFO)	22,002		4
5	Short-Term Investments	80,257		5
6	Prepaid Insurance	191,567		6
7	Other Prepaid Expenses	36,394		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,794,502	\$	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	10,829,458		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,112,217		16
17	Accumulated Depreciation (book methods)	(6,259,131)		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	59,097		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,854,830	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,649,332	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 215,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,331		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)	\$ 359,642	\$	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	1,758,293		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,758,293	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,117,935	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,531,397	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,649,332	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,389,477	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>	21,834	4
5	<u>Rounding</u>		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,411,311	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	120,086	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)	\$ 120,086	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)	\$ 6,531,397	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines# 0006353Report Period Beginning: 01/01/2016Ending: 12/31/2016

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,733,548	1
2	Discounts and Allowances for all Levels	(207,482)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,526,066	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	166,383	6
7	Oxygen	19,973	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 186,356	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	320	12
13	Barber and Beauty Care	23,866	13
14	Non-Patient Meals	58,920	14
15	Telephone, Television and Radio	8,040	15
16	Rental of Facility Space		16
17	Sale of Drugs	33,310	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,121	19
20	Radiology and X-Ray	689	20
21	Other Medical Services	907,003	21
22	Laundry	1,122	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,036,391	23
D. Non-Operating Revenue			
24	Contributions	347,250	24
25	Interest and Other Investment Income***	1,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 348,566	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	53,425	27
28	Non-Care Facility	25,831	28
28a	Miscellaneous Income	32,270	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 111,526	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,208,905	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,338,811	31
32	Health Care	3,504,683	32
33	General Administration	1,662,894	33
B. Capital Expense			
34	Ownership	367,657	34
C. Ancillary Expense			
35	Special Cost Centers	68,065	35
36	Provider Participation Fee	146,709	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,088,819	40
41	Income before Income Taxes (line 30 minus line 40)**	120,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 120,086	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 231,317	44
45	Private Pay - Net Inpatient Revenue	5,078,696	45
46	Medicare - Net Inpatient Revenue	216,053	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,526,066	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.

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

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,848	1,920	\$ 70,453	\$ 36.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,715	20,223	581,057	28.73	3
4	Licensed Practical Nurses	12,813	13,462	328,752	24.42	4
5	CNAs & Orderlies	63,061	66,706	949,986	14.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,484	5,973	125,029	20.93	8
9	Activity Director	1,965	2,040	37,333	18.30	9
10	Activity Assistants	9,327	9,875	125,337	12.69	10
11	Social Service Workers	3,707	4,128	77,997	18.89	11
12	Dietician					12
13	Food Service Supervisor	4,307	4,507	101,867	22.60	13
14	Head Cook	4,855	5,140	64,715	12.59	14
15	Cook Helpers/Assistants	8,792	9,636	126,007	13.08	15
16	Dishwashers					16
17	Maintenance Workers	6,508	7,068	139,765	19.77	17
18	Housekeepers	10,426	11,008	120,241	10.92	18
19	Laundry	4,488	4,719	49,207	10.43	19
20	Administrator	1,771	1,883	108,316	57.52	20
21	Assistant Administrator	1,454	1,502	67,482	44.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,479	6,927	137,941	19.91	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	1,949	2,147	44,450	20.70	31
32	Other Health Care(specify)	44,400	44,684	587,491	13.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,349	223,548	\$ 3,843,426 *	\$ 17.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	129	\$ 7,758	1.3	35
36	Medical Director	43	5,313	9.3	36
37	Medical Records Consultant	35	2,379	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	36	3,630	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	31	2,175	11.3	44
45	Social Service Consultant	31	2,175	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	\$ 23,430		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	109	\$ 5,573	10.3	50
51	Licensed Practical Nurses	715	31,969	10.3	51
52	Certified Nurse Assistants/Aides	162	4,091	10.3	52
53	TOTAL (lines 50 - 52)	986	\$ 41,633		53

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount	
_____	_____	_____	\$ _____	Workers' Compensation Insurance	\$ <u>62,165</u>	IDPH License Fee	\$ <u>3,903</u>		
_____	_____	_____	_____	Unemployment Compensation Insurance	<u>3,827</u>	Advertising: Employee Recruitment	<u>66,746</u>		
_____	_____	_____	_____	FICA Taxes	<u>321,164</u>	Health Care Worker Background Check	<u>275</u>		
_____	_____	_____	_____	Employee Health Insurance	<u>378,071</u>	(Indicate # of checks performed <u>9</u>)			
_____	_____	_____	_____	Employee Meals	<u>23,559</u>	Patient Background Checks	<u>55</u>		
See Schedule				Illinois Municipal Retirement Fund (IMRF)*		LeadingAge	<u>5,952</u>		
				401k Plan & Administration	<u>91,823</u>	Publications	<u>1,893</u>		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Physical	<u>13,235</u>	Licenses	<u>4,222</u>		
(List each licensed administrator separately.)			\$ <u>119,647</u>	Employee Incentives	<u>25,323</u>	Other Membership Dues	<u>1,386</u>		
B. Administrative - Other				Non-Care			Non-Care		
Description				Amount			Less: Public Relations Expense (_____)		
_____				_____			Non-allowable advertising (8,530)		
_____				_____			Yellow page advertising (1,965)		
_____				_____			TOTAL (agree to Sch. V, line 20, col. 8) \$ <u>74,432</u>		
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8) \$ <u>74,432</u>		
_____				_____			_____		
_____				_____			_____		
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_____				_____			_____		
_____				_____			_____		
_____				_____			_____		
See Schedule							Entertainment Expense (_____)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8) \$ <u>8,578</u>		
(For legal fee disclosure, see page 39 of instructions)				_____					
_____				_____					
\$ <u>50,131</u>									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines# 0006353Report Period Beginning: 01/01/2016Ending: 12/31/2016

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 5,952
- (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. \$ 49,597 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. \$ 146,709
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. \$ 23,559 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 58,866
- (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 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.