FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Nathan J. Hoffman 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 01/01/2017 to 12/31/2017 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) Nathan J. Hoffman
(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: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	730	438	1,290	2,458	8
9	SNF/PED					9
10	ICF	4,167	9,858		14,025	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,897	10,296	1,290	16,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.26%

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

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started 1975

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1,290

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	301,823	22,330	10,147	334,300		334,300		334,300			1
2	Food Purchase		182,083		182,083		182,083	(9,273)	172,810			2
3	Housekeeping	225,175	20,239	2,105	247,519		247,519		247,519			3
4	Laundry		2,341		2,341		2,341		2,341			4
5	Heat and Other Utilities			107,522	107,522		107,522		107,522			5
6	Maintenance	70,889	29,728	59,026	159,643		159,643		159,643			6
7	Other (specify):*											7
8	TOTAL General Services	597,887	256,721	178,800	1,033,408		1,033,408	(9,273)	1,024,135			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,580,605	40,110	11,250	1,631,965	(1)	1,631,964		1,631,964			10
10a	Therapy		410	235,270	235,680		235,680		235,680			10a
11	Activities	102,501	9,845	725	113,071		113,071		113,071			11
12	Social Services	49,045	192	10,763	60,000		60,000		60,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,732,151	50,557	258,008	2,040,716	(1)	2,040,715		2,040,715			16
	C. General Administration											
17	Administrative	162,642			162,642		162,642		162,642			17
18	Directors Fees											18
19	Professional Services			61,343	61,343	(149)	61,194		61,194			19
20	Dues, Fees, Subscriptions & Promotions			4,804	4,804	7,461	12,265		12,265			20
21	Clerical & General Office Expenses	191,139	24,368	51,972	267,479	(7,312)	260,167	(287)	259,880			21
22	Employee Benefits & Payroll Taxes			640,684	640,684		640,684		640,684			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,310	52,310		52,310		52,310			26
27	Other (specify):*											27
28	TOTAL General Administration	353,781	24,368	811,113	1,189,262		1,189,262	(287)	1,188,975			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,683,819	331,646	1,247,921	4,263,386	(1)	4,263,385	(9,560)	4,253,825			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: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			155,929	155,929		155,929	(915)	155,014			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,994	21,994		21,994	(5)	21,989			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			177,923	177,923		177,923	(920)	177,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,959		26,959	1	26,960		26,960			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,284	125,284		125,284		125,284			42
43	Other (specify):*		11,944	316,479	328,423		328,423	(328,423)				43
44	TOTAL Special Cost Centers		38,903	441,763	480,666	1	480,667	(328,423)	152,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,683,819	370,549	1,867,607	4,921,975		4,921,975	(338,903)	4,583,072			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: 01/01/2017 Ending: 12/31/2017

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	(9,273)	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	(915)	30.3		9
10	Interest and Other Investment Income	(5)	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	(328,710)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (338,903)		$	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))	$ (338,903)		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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Apostolic Christian Church	x		Working Capital	none	various	$ 359,000	$ 50,000	n/a		$	1
2	Morton Community Bank		x	Long-term debt	7,000	2014	500,000	253,977	2019	0.0375	9,670	2
3					-							3
4					-					Interest offset	-5	4
5					-							5
	Working Capital											
6	Morton Community Bank		x	Working Capital	none	various		40,000	various	various	12,324	6
7					-						-	7
8					-							8
9	TOTAL Facility Related				7,000		$ 859,000	$ 343,977			$ 21,989	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	$ 343,977			$ 21,989	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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:		
2012		8
2013		9
2014		10
2015		11
2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 Nathan J. Hoffman

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 2016 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 2016.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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		583,641	6
7			1992	1992	129,607	4,469	30	4,320	(149)	112,171	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			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: 01/01/2017 Ending: 12/31/2017

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	Building & land improvements - '05	2005	82,009		7			82,009	38
39	Building & land improvements - '06	2006	22,391		7			22,391	39
40	Building & land improvements - '06	2006	4,866		7			4,866	40
41	Building & land improvements - '07	2007	133,282		7			133,282	41
42	Kitchen doors	2008	12,848		7			12,848	42
43	South basement wall, lighting, sink & vanity	2008	3,404		7			3,404	43
44	Basement sewer & plumbing system repair	2008	10,354		7			10,354	44
45	Water heater upgrade	2008	10,898		5			10,898	45
46	Elevator and pole light	2008	4,153		5			4,153	46
47	Kitchen grease trap replacement	2008	3,972		5			3,972	47
48	East & West end flooring	2008	12,916		5			12,916	48
49	Northeast exit sidewalk replacement	2008	18,726	1,622	10	1,873	251	17,170	49
50	Front sewer line installation and repair	2008	4,216	422	10	422		3,868	50
51	Sprinkler system upgrade	2009	3,288		5			3,288	51
52	Water heaters, fresh air hook-up, door upgrade w/ramps	2009	12,302		5			12,302	52
53	Roofing project	2009	72,252	2,297	30	2,408	111	19,871	53
54	Kitchen cabinets, countertop, plumbing	2009	2,798		5			2,798	54
55	Nurse station & med rm counter top, insulation	2010	9,407		5			9,407	55
56	Sprinkler system upgrade	2010	13,072		5			13,072	56
57	Doors, openers, exit lighting	2010	3,783		5			3,783	57
58	Furnace, air conditioners, disposal	2010	6,475		5			6,475	58
59	Asphalt parking lot	2010	20,152	2,015	10	2,015		14,442	59
60	Basement ceiling drywall & rm 11 carpeting	2011	4,912	391	10	491	100	3,234	60
61	Resident rm wall mounted box holders	2011	3,422		5	2	2	3,422	61
62	Water heater	2011	6,999		5			6,999	62
63	West flooring, furnace, electrical, ceiling	2011	18,658	1,250	5		(1,250)	18,658	63
64	West Doors	2011	61,657	6,166	10	6,166		36,996	64
65	West air conditioner	2012	3,914	391	5	520	129	3,914	65
66	West room signage, plumbing, electrical, sprinklers, curtains, wall mou	2012	5,880	1,801	5	487	(1,314)	5,880	66
67	West & basement floors, walls, ceiling, electrical, plumbing	2012	133,422	13,474	10	13,342	(132)	70,073	67
68	West & east floors, walls, ceiling, electrical, plumbing	2012	17,854	1,786	10	1,785	(1)	9,223	68
69	South floors, walls, ceiling, electrical, plumbing	2013	9,750	975	10	975		4,792	69
70	TOTAL (lines 4 thru 69)		$ 3,185,906	$ 59,435		$ 57,182	$ (2,253)	$ 2,917,553	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: 01/01/2017 Ending: 12/31/2017

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		$ 3,185,906	$ 59,435		$ 57,182	$ (2,253)	$ 2,917,553	1
2	Water line replacement west side	2013	13,456	1,346	10	1,346		5,723	2
3	Dining Room a/c unit and pad	2013	4,274	855	5	855		3,921	3
4	Door locks	2013	4,809	962	5	962		4,009	4
5	Concrete N.E. loading area	2014	36,506	1,825	20	1,825		5,780	5
6	Elevator door restrictor, heat detector, call box	2014	5,121	1,025	5	1,024	(1)	3,844	6
7	Sprinkler piping and spray heads	2014	14,177	2,835	5	2,835		9,694	7
8	Security system wiring & affixed hardware	2014	15,456	3,091	5	3,091		9,273	8
9	Rms 21 & 15, conference rm flooring	2014	6,634	1,327	5	1,327		4,537	9
10	N.E. elevator control board	2015	3,761	752	5	752		2,192	10
11	Compressor sprinkler system & tamper switches	2015	2,822	565	5	564	(1)	1,601	11
12	Generator auto governor & power meter	2015	8,163	1,633	5	1,633		4,496	12
13	Electrical outlet replacement	2015	22,548	2,255	10	2,255		6,023	13
14	Door alarm system	2015	4,691	938	5	938		2,349	14
15	Sprinkler system	2015	10,777	2,155	5	2,155		4,310	15
16	Tub room water heater	2015	7,750	1,550	5	1,550		3,491	16
17	N.E., N.W., S.W. Furnaces & HVAC systems	2015	33,452	4,990	5	6,690	1,700	14,498	17
18	Lobby fireplace	2015	17,336	2,270	10	1,734	(536)	3,468	18
19	Generator auto governor	2016	2,703	541	5	541		994	19
20	Wall speakers	2016	3,764	753	5	753		1,194	20
21	Fire alarm system	2016	15,081	1,508	10	1,508		2,140	21
22	Water softner	2016	4,033	807	5	807		1,010	22
23	Office air conditioner	2016	4,227	845	5	845		1,058	23
24	Sprinkler system	2016	18,238	3,648	5	3,648		3,648	24
25	4 large windows & 3 sills: lobby, activity, tub rms	2016	15,750	787	20	788	1	1,185	25
26	Rms E7-E9;W2;W10;W14;W19 & east hall flooring project	2016	29,647	5,928	5	5,929	1	8,918	26
27	East 8 & West wing plumbing: fixture, water pipes, mixing valve	2017	4,017	101	20	34	(67)	34	27
28	Electrical junction boxes, outlet, lobby & entire facility	2017	7,215	361	10	544	183	544	28
29	Attic insulation batting: entire facility	2017	11,470	574	10	1,050	476	1,050	29
30	Dining room funace and condensing unit	2017	8,350	418	10		(418)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,522,134	$ 106,080		$ 105,165	$ (915)	$ 3,028,537	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: 01/01/2017 Ending: 12/31/2017

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	$ 324,376	$ 41,880	$ 41,880	$	5	$ 113,292	71
72	Current Year Purchases	29,228	1,876	1,876		5	1,876	72
73	Fully Depreciated Assets	1,380,095					1,380,095	73
74								74
75	TOTALS	$ 1,733,699	$ 43,756	$ 43,756	$		$ 1,495,263	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	05 Van	2005	$ 12,500	$	$	$	5	$ 12,500	76
77	Patient Transport	98 Bus	2015	6,149	1,230	1,230		5	2,770	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	31,609	79
80	TOTALS			$ 69,241	$ 6,093	$ 6,093	$		$ 48,843	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)	$ 5,360,949	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 155,929	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 155,014	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (915)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,572,643	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	$ 3,124,047	$ 115,605	$ 1,694,148	86
87	Country View Apartments	Various	1,102,123	23,911	433,045	87
88	Duplex Furniture & Fixtures	Various	271,840	23,336	229,903	88
89	Country View Furniture & Fixt	Various	340,837	23,354	275,838	89
90	Duplex Land & Improvements	Various	470,518	18,671	339,401	90
91	TOTALS		$ 5,309,365	$ 204,877	$ 2,972,335	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: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 01/01/2017 Ending: 12/31/2017

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	505	$ 29,680	$	505	$ 29,680	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		117	8,103		117	8,103	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		472	27,725		472	27,725	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				10,913		10,913	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					16,047		16,047	13
14	TOTAL			$	1,094	$ 65,508	$ 26,960	1,094	$ 92,468	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: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 8,874	$	1
2	Cash-Patient Deposits	291		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	398,546		3
4	Supply Inventory (priced at FIFO)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,807		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)	$ 450,518	$	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	8,004,956		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,489,659		16
17	Accumulated Depreciation (book methods)	(7,677,816)		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)	$ 2,881,425	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 3,331,943	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 234,753	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	291		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,917		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,062		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	129,826		36
37	Life Lease Deferred Income			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 467,849	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	519,275		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	2,187,952		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 2,707,227	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 3,175,076	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 156,867	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 3,331,943	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 33,311	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)	$ 33,311	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(638,573)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	762,129	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)	$ 123,556	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)	$ 156,867	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 3,996,994	1
2	Discounts and Allowances for all Levels	(537,619)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 3,459,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	356,445	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 356,445	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	20,941	13
14	Non-Patient Meals	9,273	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)	$ 30,214	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 5	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,477	28
28a	Non-Care Facility	433,886	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 437,363	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 4,283,402	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,033,408	31
32	Health Care	2,040,716	32
33	General Administration	1,189,262	33
	B. Capital Expense		
34	Ownership	177,923	34
	C. Ancillary Expense		
35	Special Cost Centers	355,382	35
36	Provider Participation Fee	125,284	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 4,921,975	40
41	Income before Income Taxes (line 30 minus line 40)**	(638,573)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (638,573)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (359,626)	44
45	Private Pay - Net Inpatient Revenue	3,427,140	45
46	Medicare - Net Inpatient Revenue	391,862	46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,459,375	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	1,940	2,136	$ 80,509	$ 37.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,162	12,846	396,228	30.84	3
4	Licensed Practical Nurses	4,771	5,130	136,636	26.63	4
5	CNAs & Orderlies	42,879	45,968	768,513	16.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,826	2,175	37,762	17.36	9
10	Activity Assistants	4,849	5,104	64,739	12.68	10
11	Social Service Workers	2,612	2,940	49,045	16.68	11
12	Dietician					12
13	Food Service Supervisor	1,879	2,080	54,437	26.17	13
14	Head Cook	7,915	8,391	118,574	14.13	14
15	Cook Helpers/Assistants	10,769	11,374	128,812	11.33	15
16	Dishwashers					16
17	Maintenance Workers	1,970	2,231	70,889	31.77	17
18	Housekeepers	16,823	18,366	225,175	12.26	18
19	Laundry					19
20	Administrator	1,040	1,208	42,866	35.49	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	119,776	115.17	22
23	Office Manager					23
24	Clerical	9,079	10,183	191,139	18.77	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)	7,674	8,694	198,719	22.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,228	139,866	$ 2,683,819 *	$ 19.19	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	144	$ 7,868	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	58	3,668	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	156	4,941	10a.3	40
41	Occupational Therapy Consultant	1	75	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	16	10a.3	43
44	Activity Consultant	8	513	11.3	44
45	Social Service Consultant	266	10,658	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	633	$ 27,739		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	307	6,351	10.3	52
53	TOTAL (lines 50 - 52)	307	$ 6,351		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.)			$ 162,642

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)		$ 61,343

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,693
Unemployment Compensation Insurance	16,748
FICA Taxes	193,178
Employee Health Insurance	352,613
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis Immunization	
Employee Life/Disability	
Employee Physicals	8,260
Uniform Allowance	
Vacation allowance	21,192
Non-Care Employee Benefits	
TOTAL (agree to Schedule V, line 22, col.8)	$ 640,684

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,479
Health Care Worker Background Check	232
(Indicate # of checks performed 8)	
Patient Background Checks 76	750
LeadingAge	4,804
Other Membership Dues \ Licenses	
CLIA	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,265

G. Schedule of Travel and Seminar**

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

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LeadingAge 4,804

(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. $ 31,402 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. $ 125,284
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. $ 9,273

(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.