

		FOR BHF USE				

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**2020**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2020)

**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><b>I. IDPH License ID Number:</b> <u>0012328</u></p> <p><b>Facility Name:</b> <u>Apostolic Chr Home of Eureka</u></p> <p><b>Address:</b> <u>610 Cruger</u> <u>Eureka</u> <u>61530</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Woodford</u></p> <p><b>Telephone Number:</b> <u>(309) 467-2311</u> Fax # <u>(309) 467-2584</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1966</u></p> <p><b>Type of Ownership:</b></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:  <b>Name:</b> <u>Kimberly S. Joos</u> <b>Telephone Number:</b> <u>(309) 467-2311</u>  <b>Email Address:</b> _____</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Date) _____            (Type or Print Name) <u>Kimberly S. Joos</u>            (Title) <u>Administrator</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Date) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Kimberly S. Joos</u> (Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<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						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>Kimberly S. Joos</u> (Title) <u>Administrator</u>							
<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	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	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	9	Sheltered Care (SC)	9	3,294	5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	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	3,691	25,066	348	29,105	8
9	SNF/PED					9
10	ICF	443	999		1,442	10
11	ICF/DD					11
12	SC		2,649		2,649	12
13	DD 16 OR LESS					13
14	TOTALS	4,134	28,714	348	33,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.21%

D. How many bed reserve days during this year were paid by the Department? \_\_\_\_\_ (Do not include bed reserve 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, Duplex, Condominium

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 100 and days of care provided 348

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRAU  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020  
 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	488,738	20,654	15,670	525,062		525,062		525,062		1
2	Food Purchase		294,063		294,063		294,063	(17,902)	276,161		2
3	Housekeeping	184,105	41,946	6,063	232,114		232,114	(5,663)	226,451		3
4	Laundry	160,896	10,189	3,335	174,420		174,420		174,420		4
5	Heat and Other Utilities			244,155	244,155		244,155	(57,600)	186,555		5
6	Maintenance	178,776	10,996	85,980	275,752		275,752	(31,920)	243,832		6
7	Other (specify):*										7
8	TOTAL General Services	1,012,515	377,848	355,203	1,745,566		1,745,566	(113,085)	1,632,481		8
<b>B. Health Care and Programs</b>											
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	3,602,759	185,914	230,692	4,019,365	29,438	4,048,803		4,048,803		10
10a	Therapy	86,176	1,320	163,972	251,468		251,468	(24,538)	226,930		10a
11	Activities	205,160	3,289	6,711	215,160		215,160	(347)	214,813		11
12	Social Services	88,807	31	7,313	96,151		96,151		96,151		12
13	CNA Training					20,431	20,431		20,431		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,982,902	190,554	413,488	4,586,944	49,869	4,636,813	(24,885)	4,611,928		16
<b>C. General Administration</b>											
17	Administrative	246,862			246,862		246,862	(26,766)	220,096		17
18	Directors Fees										18
19	Professional Services			24,599	24,599		24,599		24,599		19
20	Dues, Fees, Subscriptions & Promotions			108,967	108,967	2,557	111,524	(32,798)	78,726		20
21	Clerical & General Office Expenses	188,399	8,487	125,065	321,951	(6,493)	315,458	(20,835)	294,623		21
22	Employee Benefits & Payroll Taxes			1,024,465	1,024,465		1,024,465	(19,688)	1,004,777		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,212	3,212	3,936	7,148		7,148		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			132,199	132,199		132,199	(22,525)	109,674		26
27	Other (specify):*										27
28	TOTAL General Administration	435,261	8,487	1,418,507	1,862,255		1,862,255	(122,612)	1,739,643		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,430,678	576,889	2,187,198	8,194,765	49,869	8,244,634	(260,582)	7,984,052		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 Eureka #0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

## 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	
30	D. Ownership											
	Depreciation			663,281	663,281		663,281	(154,322)	508,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			29,195	29,195		29,195	(29,195)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			692,476	692,476		692,476	(183,517)	508,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,709	1,601	94,310	(49,869)	44,441		44,441			39
40	Barber and Beauty Shops			8,755	8,755		8,755		8,755			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,979	243,979		243,979		243,979			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		92,709	254,335	347,044	(49,869)	297,175		297,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,430,678	669,598	3,134,009	9,234,285		9,234,285	(444,099)	8,790,186			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 Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(15,333)	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	(10,062)	30.3		9
10 Interest and Other Investment Income		32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(418,704)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (444,099)		\$	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			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (444,099)		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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

**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		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2					-							2
3					-							3
4					-							4
5					-							5
	<b>Working Capital</b>											
6					-							6
7					-							7
8					-							8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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 Eureka

# 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:	2015 _____	8	<table border="1"> <thead> <tr> <th colspan="3">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2019</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> </tbody> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2019	\$	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 2019	\$			13																		
14	PLUS APPEAL COST FROM LINE 5	\$			14																		
15	LESS REFUND FROM LINE 6	\$			15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
	2016 _____	9																					
	2017 _____	10																					
	2018 _____	11																					
	2019 _____	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.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford  
 FACILITY IDPH LICENSE NUMBER 0012328  
 CONTACT PERSON REGARDING THIS REPORT Kimberly S. Joos  
 TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,259 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire Resistance Number of Stories Two

C. 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).

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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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>63,500</u>	<u>1963</u>	<u>\$ 58,945</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>63,500</b>		<b>\$ 58,945</b>	<b>3</b>

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62		1966	1966	\$ 488,404	\$	40	\$		\$ 488,404	4
5	38		1975	1975	605,234		40			605,234	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	1,028,441	6
7	4		1994	1994	226,582	3,954	39	5,810	1,856	151,150	7
8				1989	3,512		20			3,512	8
	Improvement Type**										
9	Building & land improvements - '67 - '90			1967	222,229		40			222,229	9
10	Building & land improvements - '92			1992	16,565		20			16,565	10
11	Building & land improvements - '93			1993	4,470		20			4,470	11
12	Office Addition			1994	57,234	1,431	39	1,468	37	39,149	12
13	Building & land improvements - '94			1994	24,711		20			24,711	13
14	Building & land improvements - '95			1995	53,207		20			53,207	14
15	Building & land improvements - '96			1996	47,626		20			47,626	15
16	Building & land improvements - '97			1997	3,535		10			3,535	16
17	Hall Remodeling			1997	16,641		20			16,641	17
18	Building & land improvements - '98			1998	7,862		10			7,862	18
19	Building & land improvements - '99			1999	26,225		10			26,225	19
20	Generator & Building			2000	303,007	7,579	40	7,575	(4)	158,492	20
21	Building & land improvements - '00			2000	14,076		10			14,076	21
22	Air conditioner			2001	9,725	486	20	486		9,436	22
23	Building & land improvements - '01			2001	5,314		10			5,314	23
24	New dumpster door			2002	928	46	20	46		863	24
25	Flooring for 2002 addition and remodel			2002	85,333	4,267	20	4,267		76,806	25
26	2002 addition and remodel			2002	2,247,842	56,196	40	56,196		1,011,528	26
27	Landscaping for 2002 addition			2002	198,700	9,935	20	9,935		178,830	27
28	Building & land improvements - '02			2002	35,098		10			35,098	28
29	Electrical work addition			2003	8,185	205	40	205		3,657	29
30	Addition painting			2003	5,289	132	40	132		2,344	30
31	Remodel breakroom			2003	3,085		20	154	154	2,734	31
32	Steel Doors			2003	1,095	55	20	55		958	32
33	Oxygen room exhaust fan			2003	2,062	52	40	52		901	33
34	Building & land improvements - '03			2003	7,367		10			7,367	34
35	Door alert system			2004	1,342		10			1,342	35
36	Smoke detectors, roller latches, fire window			2004	8,913		13			8,913	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 Home of Eureka# 0012328

Report Period Beginning:

01/01/2020 Ending:12/31/2020

## 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 Life safety, wall repair, carpeting	2004	\$ 9,202	\$ 288	15		\$ (288)	\$ 9,202	37
38 Handrails	2004	1,472		10			1,472	38
39 Roofing	2004	6,500	325	20	325		5,391	39
40 Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		39,362	40
41 Carpeting room 255-257, office renovations	2004	13,647		20	682	682	10,970	41
42 Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	240	17	491	251	7,856	42
43 Water softener for kitchen	2005	3,708		10			3,708	43
44 Cabinet for dining	2005	719		10			719	44
45 ADON office remodel	2005	1,841	92	20	92		1,457	45
46 Living room remodel	2005	1,615		20	81	81	1,283	46
47 Door for laundry room	2005	536	27	20	27		425	47
48 Water lines for water softener	2005	780	39	20	39		608	48
49 Central air conditioning unit	2005	4,902	245	20	245		3,799	49
50 Remodel tub rooms	2005	47,940	2,397	20	2,397		36,960	50
51 Kitchen hood and light fixtures	2005	9,076	454	20	454		6,962	51
52 Replace floor in walk-in cooler	2005	2,160	108	20	108		1,647	52
53 Doors for east hall room	2005	1,280	64	20	64		965	53
54 Wall carpet and corner guards	2005	2,278	52	15	137	85	2,278	54
55 Hot water delivery system	2006	2,142		10			2,142	55
56 Carpeting	2006	969		10			969	56
57 Storage area	2006	1,228		10			1,228	57
58 Plumbing & electrical for dishwasher	2006	1,089		10			1,089	58
59 Soffit work	2006	4,268		10			4,268	59
60 Floor & wall tiling	2006	13,669	683	20	683		9,676	60
61 West entrance automatic door	2006	1,736		10			1,736	61
62 Sheltered care and tub room renovations	2006	16,029	801	20	801		11,282	62
63 Automatic door	2007	4,979		10			4,979	63
64 Drywall in stairwell	2007	1,973	99	20	99		1,370	64
65 Sprinkler system	2007	802	40	20	40		554	65
66 Fireproofing of stairwell	2007	1,951	98	20	98		1,339	66
67 Carpeting & cabinets rm 200	2007	2,172		10			2,172	67
68 Fire panel	2007	2,311		10			2,311	68
69 Flooring rooms 134, 135, 136	2007	5,628		10			5,628	69
70 TOTAL (lines 4 thru 69)		\$ 6,488,176	\$ 130,828		\$ 134,658	\$ 3,830	\$ 4,443,427	70

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	
1	Totals from Page 12A, Carried Forward	\$ 6,488,176	\$ 130,828		\$ 134,658	\$ 3,830	\$ 4,443,427	1
2	Flooring in quad	2007 52,194	2,610	20	2,610		34,366	2
3	Front entrance hallway renovations	2007 2,374		10			2,374	3
4	Exterior quad soffit replacement	2007 10,400	520	20	520		6,847	4
5	Smoke detectors	2007 569		10			569	5
6	Flooring	2007 2,910		10			2,910	6
7	Sprinkler system	2007 10,644	533	20	532	(1)	6,916	7
8	Fire grid ceiling	2008 1,725	86	20	86		1,111	8
9	Cabinetry in laundry	2008 561		10			561	9
10	Sprinkler system	2008 19,429	971	20	971		12,544	10
11	Air conditioning system	2008 2,300	115	20	115		1,409	11
12	Wood flooring install	2008 9,647		10			9,647	12
13	Doors for stairwell	2008 2,472		10			2,472	13
14	Phone system install	2008 26,715		10			26,715	14
15	Draperies	2008 1,568		10			1,568	15
16	Tub for upstairs w.s. room	2009		10				16
17	Sprinklers, fire damper updates w/caulking	2009 13,436	113	12	1,120	1,007	13,259	17
18	Flooring rms 109,110,111,112	2009 5,800		10			5,800	18
19	Auto doors, elevator & phone, walls, floors east rms.	2009 267,524	13,146	20	13,376	230	154,978	19
20	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009 15,716		10			15,716	20
21	Cabinets kitchen, water line n. hall & wing	2009 4,711	146	16	294	148	3,308	21
22	Tub for upstairs east south room	2010	897	10		(897)		22
23	Overhead & auto doors lawnshop & upeast entrance	2010 5,345	267	10	261	(6)	5,345	23
24	Blinds, flooring, walls for 214-220, utility, nurse station	2010 482,556	24,128	20	24,128		253,443	24
25	Flooring & wall tiles for upeast south hall spa rm	2010 7,140	357	10	354	(3)	7,140	25
26	Flooring, walls, ceiling upeast library	2010 5,632	282	10	377	95	5,632	26
27	Flooring, walls, ceiling for 101-108	2010 42,719	2,136	10	2,843	707	42,719	27
28	A/C for main kitchen	2010 4,250	213	20	213		2,184	28
29	Gutter coverings south & north sides	2010 3,475	231	15	232	1	2,378	29
30	Water heaters	2010 4,343		10	400	400	4,343	30
31	Flooring for downstairs E & W + nurse station	2011 42,244	2,112	20	2,112		20,941	31
32	Repair boiler & zone valves 214 - 220	2011 4,461	446	10	446		4,422	32
33	Vinyl flooring for 245 & 249	2011 4,494	449	10	449		4,191	33
34	TOTAL (lines 1 thru 33)	\$ 7,545,530	\$ 180,586		\$ 186,097	\$ 5,511	\$ 5,099,235	34

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		\$ 7,545,530	\$ 180,586		\$ 186,097	\$ 5,511	\$ 5,099,235	1
2	Bus garage and mezzanine	2011	112,089	3,963	30	3,736	(227)	34,248	2
3	Water heater for kitchen	2011	5,769		10	577	577	5,193	3
4	Fire alarm kit/lndr, DW wall, chr rail, window trim, security cam lvg m	2012	13,097	1,081	5		(1,081)	13,097	4
5	Flooring:120,125,122,126,239,124,Breakroom,Entrance,Kitchen	2012	46,149	4,616	10	4,615	(1)	38,463	5
6	Front entrance wall, window, door, ceiling, wiring, A/C, signage	2012	872,571	43,569	20	43,629	60	363,615	6
7	Laundry A/C, walls	2012	8,510	851	10	851		7,092	7
8	Mixing Valve for kitchen, laundry, resident rooms	2013	5,019	502	10	502		3,935	8
9	HL room - painting, wall board, lights	2013	5,859	586	10	586		4,543	9
10	Main Kitchen dishroom flooring	2013	2,937	294	10	294		2,255	10
11	Vinyl wood flooring for upstairs family & activity room	2013	13,757	1,376	10	1,376		10,439	11
12	Convert fire alarms to chimes	2013	9,565	957	10	957		7,181	12
13	Vinyl wood flooring for Room #123 & #247	2013	5,247	525	10	525		3,850	13
14	Air conditioning unit for Social Service office	2013	2,550	255	10	255		1,870	14
15	Tile & carpet flooring for UW hallways & SS Office	2013	32,389	1,702	20	1,619	(83)	11,741	15
16	UW nurses station walls, closet, cabinetry, countertop	2013	10,221	1,022	10	1,022		7,241	16
17	Boiler Replacement	2013	154,265	15,426	10	15,427	1	107,989	17
18	Flooring & bathroom tile work UE rooms 201-209	2013	41,832	4,183	10	4,183		29,281	18
19	Concrete to replace asphalt at entrance	2013	10,680	534	20	534		4,051	19
20	Concrete portion of parking lot	2013	5,940	297	20	297		2,104	20
21	Vinyl & carpet flooring for Rms 131, 127, 129, 121, 241, 224	2014	12,706	1,166	10	1,271	105	8,789	21
22	Controller for boiler	2014	2,796		5			2,796	22
23	Adjust-a-sink & electrical for beauty shop	2014	4,758	77	5		(77)	4,758	23
24	Air conditioning condensing unit for beauty shop	2014	3,450	345	10	345		2,302	24
25	Awning for courtyard west door	2014	2,861		5			2,861	25
26	Courtyard brick patio and landscaping	2014	47,424	2,949	20	2,371	(578)	15,019	26
27	Concrete main parking lot	2014	18,200	910	20	910		5,612	27
28	Expansion of rooms 201-212-HVAC, Carpentry, Electrical, Plumbing,	2014	691,032	34,660	20	34,552	(108)	233,344	28
29	Flooring in commons, kitchen, baths, storage, hallways	2014	39,895	1,995	20	1,995		12,139	29
30	Dining & Kitchen cabinetry & counter top, carpentry, electrical	2014	66,432	3,322	20	3,322		20,214	30
31	Palatium Care nurse call system	2015	105,024	11,284	10	10,502	(782)	61,315	31
32	Vinyl wood flooring rm:237,241,256,242,246,254,255,259,128,130,258,dinin	2015	34,803	3,480	10	3,480		19,154	32
33	Autodoors rm: dining, break, break	2015	12,595	1,259	10	1,260	1	7,038	33
34	TOTAL (lines 1 thru 33)		\$ 9,945,952	\$ 323,772		\$ 327,090	\$ 3,318	\$ 6,152,764	34

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



STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		\$ 9,945,952	\$ 323,772		\$ 327,090	\$ 3,318	\$ 6,152,764	1
2	Elevator shunt trip	2015	7,460	746	10	746		3,855	2
3	UW dry sprinkler system	2015	68,200	3,410	20	3,410		17,620	3
4	Gas line main kitchen	2015	3,157	316	10	316		1,607	4
5	Energy project: VFD's, Zone dampers, Zone valves - air handlers	2015	50,760	5,076	10	5,076		25,380	5
6	Electrical outlets in rooms, nurse station, therapy	2015	3,313	391	10	331	(60)	1,655	6
7	Vinyl wood flooring rm:251,260,244,248,238	2016	12,853	1,285	10	1,285		5,679	7
8	Sound system & wiring - activity & dining	2016	7,827	782	10	783	1	3,850	8
9	A/C nursing admin	2016	8,754	875	10	875		3,941	9
10	Smoke detectors & circuit panels	2016	8,048	805	10	805		3,220	10
11	Concrete drive, leveling, repairs	2016	33,386	1,842	20	1,669	(173)	7,655	11
12	DE lighting & door - rm 109-112 & supply	2016	4,199	420	10	420		1,820	12
13	Water heater for kitchens	2017	8,063	806	10	806		2,418	13
14	Vinyl floor Rm #250, Therapy Rm, West entry	2017	13,465	2,433	5	2,693	260	9,658	14
15	16 H/C units Rms: 120-131; 245-250; dining; tub	2017	50,313	3,354	15	3,354		10,347	15
16	Water heater - old boiler room	2018	8,953	895	10	895		1,790	16
17	Security system main doors; wiring, wall/ceiling domes.	2018	6,170	1,234	5	1,234		2,674	17
18	Water heater - new mechanical room	2018	3,900	780	5	780		1,821	18
19	Upstairs west resident room lighting Room 236-259	2018	10,800	1,080	10	1,080		2,974	19
20	Wood floor: Up dining, sm dining, office, sm sitting rm.	2018	19,771	2,131	10	1,977	(154)	5,281	20
21	Vinyl floor: Upstairs and downstairs hallways	2018	18,350	1,835	10	1,835		4,902	21
22	Dining & kitchen:carpentry,plumbing,elec,paint,cabinetry	2018	64,590	4,306	15	4,306		11,502	22
23	5 PTAC units: Upstairs sitting rm: rms 236,238,240,242	2018	29,650	1,977	15	1,977		4,122	23
24	Security cameras for HL doors and Dumpster door	2019	3,260	652	5	652		925	24
25	Doors: main kitchen, up west nurse station, courtyard.	2019	9,633	909	10	963	54	1,689	25
26	Flooring: rms 252,236,therapy,south breakroom&hallway,1st floor dining&ac	2019	47,413	4,742	10	4,741	(1)	5,936	26
27	Painting west entrance, dw hall, room 130	2019	10,395	1,040	10	1,040		1,040	27
28	PTAC units room 128 & 244, tranquility room	2019	6,118	408	15	408		511	28
29	Can lights in rooms: 127-129, 131-137	2019	5,416	542	10	542		860	29
30	Break room electrical, walls, painting, ducting, cabinets, counters, sink	2019	24,319	2,432	10	2,432		2,432	30
31	Therapy & activity: plumbing, heat & cool, ducting, walls, drainage, electrical	2019	721,328	36,066	20	36,066		36,066	31
32	Landscaping therapy addition	2019	6,328	633	10	633		845	32
33	Down West tv wall mounts:Rms 120,122,124,126	2020	4,587	459	5	842	383	842	33
34	TOTAL (lines 1 thru 33)		\$ 11,226,731	\$ 408,434		\$ 412,062	\$ 3,628	\$ 6,337,681	34

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 12D, Carried Forward		\$ 11,226,731	\$ 408,434		\$ 412,062	\$ 3,628	\$ 6,337,681	1
2	Heat/Cool units rooms 224 - 231	2020	35,704	1,786	10	1,800	14	1,800	2
3	Flooring down west main entryway	2020	6,053	303	10	507	204	507	3
4	Fire alarm entire facility less new therapy, dining, activity	2020	11,089	554	10	930	376	930	4
5	Room/directional signage entire facility less rms 201-220	2020	7,503	751	5	880	129	880	5
6	Sound speakers in ceiling of front office	2020	3,557	178	10	179	1	179	6
7	Window.plumbing.carpentry.cabinetry down west Bistro	2020	15,212	988	10	383	(605)	383	7
8	100 gallon water heater old mechanical room	2020	9,358	936	5	313	(623)	313	8
9	Window coverings therapy room	2020	2,781	278	5	466	188	466	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,317,988	\$ 414,208		\$ 417,520	\$ 3,312	\$ 6,343,139	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	\$ 705,403	\$ 74,026	\$ 74,026	\$	5	\$ 333,074	71
72	Current Year Purchases	132,234	13,223	13,223		5	13,223	72
73	Fully Depreciated Assets	1,109,076					1,109,076	73
74								74
75	TOTALS	\$ 1,946,713	\$ 87,249	\$ 87,249	\$		\$ 1,455,373	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 Chevy bus/17 E350 bus	2005/2018	\$ 111,744	\$ 13,124	\$	(13,124)	10	\$ 111,744	76
77	Patient Transport	14 Dodge Caravan	2015	36,443	3,644	3,644		10	20,042	77
78	Patient Transport	Chevy 07 Van	2008	35,100		(250)	(250)	10	35,100	78
79	Maintenance	13 Nissan Pickup	2016	14,509	2,902	2,902		5	12,824	79
80	TOTALS			\$ 197,796	\$ 19,670	\$ 6,296	\$ (13,374)		\$ 179,710	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)	\$ 13,521,442	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 521,127	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 511,065	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,062)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,978,222	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	Apartments Various	\$ 576,031	\$ 13,332	\$ 451,118	86
87	Condos Various	1,645,707	54,152	1,208,462	87
88	Duplexes Various	1,924,116	71,877	1,182,143	88
89	Rental Units Various	762,323	2,367	25,202	89
90	Garages Various	36,768	426	35,795	90
91	TOTALS	\$ 4,944,945	\$ 142,154	\$ 2,902,720	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 49,155	92
93			93
94			94
95		\$ 49,155	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>      </u> /2021	\$ <u>      </u>
13.	<u>      </u> /2022	\$ <u>      </u>
14.	<u>      </u> /2023	\$ <u>      </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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input 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>
--	---	--

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)		1,311		1,311
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		17,695		17,695
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,425		1,425
9	TOTALS	\$	\$ 20,431	\$	\$ 20,431
10	SUM OF line 9, col. 1 and 2 (e)	\$	20,431		

- (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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	22

- (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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	288	\$ 27,174	\$	288	\$ 27,174	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		111	7,707		111	7,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		324	30,640		324	30,640	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				26,327		26,327	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2					16,535		16,535	13
14	TOTAL			\$	723	\$ 65,521	\$ 42,861	723	\$ 108,382	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.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 7,127,591	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	186,833		3
4	Supply Inventory (priced at FIFO )	49,877		4
5	Short-Term Investments			5
6	Prepaid Insurance	123,696		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Assets</u>	10,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,497,997	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,026,056		13
14	Buildings, at Historical Cost	15,036,621		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,645,224		16
17	Accumulated Depreciation (book methods)	(11,019,123)		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): <u>Construction in Progress</u>	49,155		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,737,933	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,235,930	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 135,612	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	272,715		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,503		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	250,602		36
37	<u>Life Lease Deferred Income</u>	270,309		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 999,741	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Life Lease Equity</u>	2,803,473		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,803,473	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,803,214	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,432,716	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,235,930	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,125,729	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>		4
5	<u>Rounding</u>	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,125,730	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	1,306,986	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)	\$ 1,306,986	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 11,432,716	24 *

\* This must agree with page 17, line 47.



## STATE OF ILLINOIS

Page 19

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2020Ending: 12/31/2020

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,512,058	1
2	Discounts and Allowances for all Levels	(423,812)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,088,246	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	286,040	6
7	Oxygen	24,677	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 310,717	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	1,095,500	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,646	13
14	Non-Patient Meals	15,333	14
15	Telephone, Television and Radio	11,305	15
16	Rental of Facility Space		16
17	Sale of Drugs	49,146	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,796	19
20	Radiology and X-Ray		20
21	Other Medical Services	116,011	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,301,737	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,296,430	24
25	Interest and Other Investment Income***	132,093	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,428,523	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	26,407	28
28a	Non-Care Facility	385,641	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 412,048	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,541,271	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,745,566	31
32	Health Care	4,586,944	32
33	General Administration	1,862,255	33
<b>B. Capital Expense</b>			
34	Ownership	692,476	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	103,065	35
36	Provider Participation Fee	243,979	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,234,285	40
41	Income before Income Taxes (line 30 minus line 40)**	1,306,986	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,306,986	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 602,162	44
45	Private Pay - Net Inpatient Revenue	6,473,868	45
46	Medicare - Net Inpatient Revenue	12,217	46
47	Other-(specify) <u>Rounding</u>	(1)	47
48	Other-(specify) <u>Rounding</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,088,246	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

12/31/2020

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	2,080	2,080	\$ 101,897	\$ 48.99	1
2	Assistant Director of Nursing	1,948	2,008	74,712	37.21	2
3	Registered Nurses	26,502	28,664	1,230,853	42.94	3
4	Licensed Practical Nurses	13,363	15,037	409,916	27.26	4
5	CNAs & Orderlies	96,044	105,445	1,766,375	16.75	5
6	CNA Trainees	92	92	1,311	14.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,982	4,688	86,176	18.38	8
9	Activity Director	2,738	2,948	53,247	18.06	9
10	Activity Assistants	10,232	12,069	151,913	12.59	10
11	Social Service Workers	3,351	3,504	88,807	25.34	11
12	Dietician					12
13	Food Service Supervisor	3,376	3,459	74,399	21.51	13
14	Head Cook	4,251	4,587	80,321	17.51	14
15	Cook Helpers/Assistants	11,073	12,342	166,097	13.46	15
16	Dishwashers	11,573	13,584	167,921	12.36	16
17	Maintenance Workers	6,186	6,720	169,369	25.20	17
18	Housekeepers	11,572	12,692	178,442	14.06	18
19	Laundry	10,164	11,305	160,896	14.23	19
20	Administrator	1,854	1,854	119,881	64.66	20
21	Assistant Administrator	2,080	2,080	100,215	48.18	21
22	Other Administrative	7,675	8,511	116,073	13.64	22
23	Office Manager					23
24	Clerical	4,781	5,106	53,490	10.48	24
25	Vocational Instruction	498	498	17,695	35.53	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,415	259,273	\$ 5,370,006 *	\$ 20.71	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	145	\$ 7,887	1.3	35
36	Medical Director	24	4,800	9.3	36
37	Medical Records Consultant	34	2,345	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	79	7,860	10.3	39
40	Physical Therapy Consultant	11	735	10a.3	40
41	Occupational Therapy Consultant	9	608	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	28	10a.3	43
44	Activity Consultant	20	1,422	11.3	44
45	Social Service Consultant	11	786	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	333	\$ 26,471		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,375	\$ 69,064	10.3	50
51	Licensed Practical Nurses	212	8,977	10.3	51
52	Certified Nurse Assistants/Aides	2,050	65,794	10.3	52
53	TOTAL (lines 50 - 52)	3,637	\$ 143,835		53

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	\$ 56,355	IDPH License Fee	\$ 3,980		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	84,612		
				FICA Taxes	397,509	Health Care Worker Background Check	2,462		
				Employee Health Insurance	412,207	(Indicate # of checks performed <u>86</u> )			
				Employee Meals		Patient Background Checks <u>55</u>	550		
				Illinois Municipal Retirement Fund (IMRF)*		Leading Age	8,272		
				Hepatitis Immunization	348	Journal Star & Pantagraph Newspaper	498		
				Employee Life/Disability	8,586	Nursing Manuals & Oth Subscriptions	1,016		
				Employee Physicals	16,244	Other Membership Dues \ Licenses	9,909		
				Uniform Allowance & Other	227	Activity Manuals & Oth Subscriptions	225		
				Tax Deferred Annuity	127,308	Less: Public Relations Expense	( )		
				Non-Care Employee Benefits	(14,006)	Non-allowable advertising	(32,798)		
				Reclassifications & Rounding	(1)	Yellow page advertising	( )		
See Schedule									
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 246,862	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,004,777	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 78,726		
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	452	
							Seminar Expense	6,696	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 7,148	
(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)			\$ 24,599						
(For legal fee disclosure, see page 39 of instructions)									

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

## 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. Leading Age 8,272
- (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. \$ 49,848 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. \$ 243,979  
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. \$ 15,333
- (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.