		FOR BHF USE					

LL1

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.

I. IDPH License ID Number: 0006353

Facility Name: Apostolic Christian Skylines

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

County: Peoria

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

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

[x] VOLUNTARY,NON-PROFIT
- [x] Charitable Corp.
- [ ] Trust

IRS Exemption Code 501c(3)

[ ] PROPRIETARY
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [ ] "Sub-S" Corp.
- [ ] Limited Liability Co.
- [ ] Trust
- [ ] Other

[ ] GOVERNMENTAL
- [ ] State
- [ ] County
- [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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) Matthew J. Feucht
(Title) Executive Director

Paid Preparer
(Signed) ________ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Matthew J. Feucht Telephone Number: (309) 691-8091
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,862	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	57	TOTALS	57	20,862	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	1,938	15,617	1,007	18,562	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,938	15,617	1,007	18,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.98%

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, Assisted Living

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 1,007

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number: Apostolic Christian Skylines # 0006353 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	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	389,247	29,959	4,838	424,044	(6,089)	417,955	(83,827)	334,128			1
2	Food Purchase		299,206		299,206	(4,297)	294,909	(127,560)	167,349			2
3	Housekeeping	183,071	32,309		215,380		215,380	(4,096)	211,284			3
4	Laundry	71,010	12,028		83,038		83,038	(1,440)	81,598			4
5	Heat and Other Utilities			163,391	163,391		163,391		163,391			5
6	Maintenance	211,772	26,589	127,747	366,108		366,108	(128,315)	237,793			6
7	Other (specify):*											7
8	TOTAL General Services	855,100	400,091	295,976	1,551,167	(10,386)	1,540,781	(345,238)	1,195,543			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,641,023	96,527	85,680	2,823,230	(1)	2,823,229	(244,511)	2,578,718			10
10a	Therapy	91,998	1,758	210,399	304,155		304,155	(19,892)	284,263			10a
11	Activities	195,817		4,059	199,876		199,876	(16,213)	183,663			11
12	Social Services	132,877		1,027	133,904		133,904	(586)	133,318			12
13	CNA Training					1,519	1,519		1,519			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,061,715	98,285	316,165	3,476,165	1,518	3,477,683	(281,202)	3,196,481			16
	C. General Administration											
17	Administrative	149,290			149,290		149,290	(49,450)	99,840			17
18	Directors Fees											18
19	Professional Services			65,182	65,182	(403)	64,779		64,779			19
20	Dues, Fees, Subscriptions & Promotions			43,936	43,936		43,936	(8,143)	35,793			20
21	Clerical & General Office Expenses	446,644	83,509	55,542	585,695	(1,116)	584,579	(160,077)	424,502			21
22	Employee Benefits & Payroll Taxes			1,068,715	1,068,715	10,386	1,079,101		1,079,101			22
23	Inservice Training & Education			5,778	5,778		5,778		5,778			23
24	Travel and Seminar			1,323	1,323		1,323		1,323			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,339	99,339		99,339		99,339			26
27	Other (specify):*											27
28	TOTAL General Administration	595,934	83,509	1,339,815	2,019,258	8,867	2,028,125	(217,670)	1,810,455			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,512,749	581,885	1,951,956	7,046,590	(1)	7,046,589	(844,110)	6,202,479			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Skylines #0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			508,805	508,805		508,805	(198,739)	310,066			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184	184		184	(184)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			508,989	508,989		508,989	(198,923)	310,066			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,345	120,550	176,895	1	176,896		176,896			39
40	Barber and Beauty Shops			15,471	15,471		15,471		15,471			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,982	135,982		135,982		135,982			42
43	Other (specify):*	1,060,209	6,790	275,103	1,342,102		1,342,102		1,342,102			43
44	TOTAL Special Cost Centers	1,060,209	63,135	547,106	1,670,450	1	1,670,451		1,670,451			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,572,958	645,020	3,008,051	9,226,029		9,226,029	(1,043,033)	8,182,996			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(127,560)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,674	30.3		9
10	Interest and Other Investment Income	(184)	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	(2,025)	20.3		28
29	Other-Attach Schedule	(917,938)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (1,043,033)		$	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))	$ (1,043,033)		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 Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 [x]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2					-							2
3					-							3
4					-							4
5					-							5
	Working Capital											
6					-							6
7					-						-	7
8					-							8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.

Item			Line
1. Real Estate Tax accrual used on 2019 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:

Year	Amount	Line
2015		8
2016		9
2017		10
2018		11
2019		12

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Line	Description		Amount	Line
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

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 Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matthew J. Feucht

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

A. Summary of Real Estate Tax Cost

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments & Assisted Living: 18,850 sq. ft., 3 Independent Living Units & 33 Assisted Living Units.
Duplexes: 1,150 sq. ft. per unit, 16 Units.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1966	1965	$ 348,310	$	40	$	$	$ 348,310	4
5	21		1971	1970	396,963		40			396,963	5
6	16		1985	1985	750,000	18,750	40	18,750		585,000	6
7	3		1989	1988	205,070	5,127	40	5,127		143,553	7
8	17		1995	1995	870,388	21,760	40	21,760		526,589	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		444,375	9
10	Shelter care remodel			1974	6,594		40			6,594	10
11	Fire prevention system			1977	23,804		25			23,804	11
12	Dining room addition			1978	38,922		40			38,922	12
13	Fire prevention system			1979	35,330		25			35,330	13
14	Windows replacement			1981	23,820		25			23,820	14
15	Kitchen remodel			1982	21,631		40			21,631	15
16	Energy conservation			1983	8,413		15			8,413	16
17	Shelter care remodel			1984	7,742		40			7,742	17
18	Cabinets			1986	1,618		15			1,618	18
19	Air conditioning units			1987	6,427		10			6,427	19
20	Physical therapy remodel			1989	11,503	288	40	288		10,998	20
21	Office Addition			1991	50,297	1,257	40	1,257		46,267	21
22	New roof			1993	14,210		10			14,210	22
23	Room remodel			1994	5,154		25			5,154	23
24	Front entrance, front office, ceiling back hall			1996	62,294		20			62,294	24
25	Guttering System			1996	89,096	3,564	25	3,564		85,535	25
26	Fencing, soffit/facia, new door			1997	28,036	1,121	25	1,121		26,114	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978		15			4,978	28
29	Flooring, lighting, wall covering			2000	97,127		5			97,127	29
30	Flooring, lighting, wall covering			2001	28,745		5			28,745	30
31	Lobby windows			2001	3,577	143	25	143		3,004	31
32	Blacktopping			2001	13,967		8			13,967	32
33	Balcony repair			2001	6,605		20			6,605	33
34	Insulation installation			2001	9,970		15			9,970	34
35	Lawn sprinkler system			2001			15				35
36	Air Conditioning Unit			2001	2,178		10			2,178	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Locks	2002	$ 691	$ 35	20	$ 35	$	$ 604	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	13,745	38
39	Flooring, wall covering	2002	9,786		5			9,786	39
40	Balcony repair	2002	7,403	370	20	370		6,978	40
41	Carpeting in dining room	2002	5,446		5			5,446	41
42	Water heater	2002	4,197		10			4,197	42
43	Lawn sprinkler system	2002			15				43
44	Sewer system upgrade	2002		256	20		(256)		44
45	Air Conditioning unit	2003	1,700	85	20	85		1,491	45
46	Sewer system upgrade	2003		256	20		(256)		46
47	Countertops in kitchen	2003	6,594		15			6,594	47
48	Carpeting	2004	5,878		5			5,878	48
49	Wiremesh	2004	1,825		15			1,825	49
50	Sewer system upgrade	2004		360	20		(360)		50
51	Electrical panel upgrade	2004	2,068		15	44	44	2,068	51
52	Water heater	2004	7,646		10			7,646	52
53	Rewiring	2004	1,327	66	20	66		1,001	53
54	Roofing	2005	4,858		10			4,858	54
55	Tub room remodel	2005	3,855	154	25	154		2,374	55
56	Carpeting	2005	2,128		5			2,128	56
57	Alarm system	2005	2,357	131	15	133	2	2,357	57
58	External water carryoff system	2005	512	21	25	20	(1)	300	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	132,020	59
60	Door latches	2006	7,110	178	40	178		2,642	60
61	Automatic Doors	2006	2,886	192	15	192		2,785	61
62	Walk-in Cooler upgrades	2006	3,135		10			3,135	62
63	Fire safety improvements	2007	19,182	480	40	480		6,257	63
64	Garage	2007	5,944	149	40	149		1,946	64
65	Locks	2007			10				65
66	Office expansion - social services	2007	2,346	59	40	59		819	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		24,653	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		3,799	68
69	Wood door	2007		63	15		(63)		69
70	TOTAL (lines 4 thru 69)		$ 4,583,249	$ 87,174		$ 85,710	$ (1,464)	$ 3,381,630	70

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,583,249	$ 87,174		$ 85,710	$ (1,464)	$ 3,381,630	1
2	Air conditioner compressor	2007	8,418		10			8,418	2
3	Sprinklers	2007		62	20		(62)		3
4	Maglock outswing door	2007	1,173		10			1,173	4
5	81 gal water heater - kitchen	2007	5,797		10			5,797	5
6	Heat exchangers	2007	8,455	423	20	423		5,769	6
7	Disposer 3 hp	2007	3,472		10			3,472	7
8	Door monitoring unit	2007			10				8
9	Sprinkler-kitchen; flooring-306; fire safety improvs	2008	58,524	1,520	48	1,219	(301)	14,962	9
10	Walkway and snow melt	2008	5,357	357	15	357		4,382	10
11	Septic field St. Luke Ct	2008		268	50		(268)		11
12	Iron guard hand railings	2008	6,781	452	15	452		5,467	12
13	Commercial disposal	2008			10				13
14	Rm flooring, wall	2008	6,604	165	40	165		1,980	14
15	Internet wiring	2009	4,849	242	20	242		2,803	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		6,581	16
17	Water heater	2009	13,950	930	20	698	(232)	7,756	17
18	Air conditioning units	2009	2,673		25	107	107	1,278	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		4,163	19
20	Dining room walls	2009	5,391	216	40	135	(81)	1,577	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	294	20	316	22	3,777	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		1,846	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		3,166	23
24	Senior TV hook-up	2009		13	20		(13)		24
25	Salem architectural	2009	3,392	136	25	136		1,564	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		11,610	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		4,061	27
28	Flooring Salem lounge	2009	14,443	578	25	578		6,454	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		8,362	29
30	Social room tv cabinetry	2009		50	20		(50)		30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		1,221	31
32	Maglock outswing door, sensor push bars	2009	2,999	182	20	150	(32)	1,799	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	6,134	33
34	TOTAL (lines 1 thru 33)		$ 4,849,774	$ 97,588		$ 94,871	$ (2,717)	$ 3,507,202	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,849,774	$ 97,588		$ 94,871	$ (2,717)	$ 3,507,202	1
2	Roofing, flooring rm 226	2009		404	15		(404)		2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	807	10	873	66	10,941	3
4	Elevator repair	2010	12,698	635	10	259	(376)	12,698	4
5	Salem flooring, baseboards	2010	13,507	593	25	540	(53)	5,672	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		1,794	6
7	Nurses Station	2010	2,533	101	10	214	113	2,533	7
8	Flooring Canaan room	2010			5				8
9	Dining room flooring	2010		48	15		(48)		9
10	New burner boiler 1	2010	12,225	489	25	489		4,989	10
11	Commercial water heater	2010	4,900	327	15	327		3,316	11
12	Surveillance hardware & smoke detector	2010	5,421	497	10	406	(91)	5,421	12
13	Rebuild \ replace heat exchangers	2010	4,129	275	15	275		2,773	13
14	Zion & Galilee tubs, fire safety wall	2011		2,824	10		(2,824)		14
15	South bath plumbing piping & fixtures	2011	6,824	273	25	273		2,625	15
16	Judea bath walls, floor, doors, plumbing, drapes	2011	62,271	1,559	25	2,491	932	23,252	16
17	Activity room walls, ceiling, flooring, electrical, plumbing.	2011		732	40		(732)		17
18	Laundry room plumbing, electrical, walls, ceiling.	2011	6,030	151	40	151		1,385	18
19	Drinking fountain and air conditioning unit	2012	2,495	188	10	250	62	2,244	19
20	Showers and valves	2012	4,823	193	25	193		1,709	20
21	Elevator starter and door	2012	5,504	221	25	220	(1)	1,901	21
22	Therapy rm sprinklers, plumbing, walls, ceiling	2012	22,029	936	25	881	(55)	7,610	22
23	Dining room air conditioner	2012	10,212	681	15	681		5,834	23
24	Beauty shop flooring, walls	2012	3,654	146	25	146		1,232	24
25	Dining rm addition:walls, electrical, plumbing, ceilings	2012	507,333	12,683	40	12,683		105,703	25
26	Door protectors	2012	4,403	440	10	440		3,801	26
27	Walk in freezer dining rm addition	2012	35,435	2,478	15	2,362	(116)	19,686	27
28	Disposal in dining rm addition	2012			10				28
29	Dining rm:walls, doors, flooring, electrical, plumbing, ceilings	2013	88,266	2,265	40	2,207	(58)	16,827	29
30	30 ton chiller complete with installation	2013	33,263	2,218	15	2,218		17,197	30
31	Dining Room project complete	2013	21,859	601	40	546	(55)	4,367	31
32	100 gallon water heater	2013	12,788	1,279	10	1,279		9,472	32
33	Security cameras and access control	2013	14,350	1,435	10	1,435		10,627	33
34	TOTAL (lines 1 thru 33)		$ 5,762,039	$ 133,242		$ 126,885	$ (6,357)	$ 3,792,811	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 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 12C, Carried Forward		$ 5,762,039	$ 133,242		$ 126,885	$ (6,357)	$ 3,792,811	1
2	Humidification system - Salem	2015	8,156	816	10	816		4,784	2
3	Fire alarm system	2015	22,038	1,469	15	1,469		8,577	3
4	Security camera nursing home B	2015	3,275	328	10	328		1,772	4
5	Roofing Salem	2015	4,381	175	25	175		946	5
6	100 & 81 gallon water heaters nursing center	2016	17,610	1,761	10	1,761		8,511	6
7	Nursing center pneumatic control system air dryer	2016	3,307	331	10	331		1,455	7
8	Zion hall: wallpaper,paint,drywall,light fixtures,sprinkler,rails,wall protectors,carpet	2016	92,779	3,711	25	3,711		17,945	8
9	Galilee hall: ceiling tile,wallpaper,paint,light fixtures,sprinkler,rails,wall protectors,carpet	2016	92,682	3,707	25	3,707		17,926	9
10	Galilee nurse sttn:studs&drywall,ceiling,paint,flooring,wainscot,sprinkler,plumbing,duct,electrica	2016	101,360	4,054	25	4,054		19,604	10
11	Salem wing: bathroom tub, plumbing connection, wall tie-in.	2016	18,183	1,212	15	1,212		5,609	11
12	Walk in cooler: condenser,evaporator,electronic controls,piping	2016	6,790	452	15	453	1	2,084	12
13	Salem wing: flooring utility rm & rm 149.	2017	3,241	216	15	216		740	13
14	Galilee wing ventilation system	2017	17,359	1,157	15	1,157		4,308	14
15	Kitchen drainage / sewer system	2017	9,874	658	15	658		2,196	15
16	Salem wing: landscaping-bushes; ground cover; retaining wall	2017	5,241	349	15	349		1,130	16
17	Electrical circuits; 4 branches-entire facility	2017	49,390	1,976	25	1,976		7,352	17
18	Zion rm 239: floor; window; patch/paint; plumbing; wiring; lights; doors; A/C unit	2017	42,773	1,711	25	1,711		6,750	18
19	EPDM roof entire facility	2017	9,795	392	25	392		1,203	19
20	Zion rms 235, 237: floor; window; patch/paint; plumbing; wiring; lights; doors; A/C unit	2017	215,711	8,628	25	8,628		27,846	20
21	Magnetic door devices: Judea, Galilee, Dining	2017	9,585	639	15	639		1,924	21
22	Electrical lights: rms 141, {(142 - 147,149)A&B}, 148A	2017	8,581	572	15	572		1,866	22
23	Electrical lights: Judea rms 130-138,140	2018	4,572	305	15	305		853	23
24	Kitchen disposal	2018	2,588	518	5	518		1,213	24
25	Trunk water lines: Judea rms 130-138,140	2018	37,304	1,492	25	1,492		4,235	25
26	Kitchen ceiling & lighting	2018	14,332	754	20	717	(37)	2,005	26
27	Parking & driveway asphalt	2018	26,000	1,733	15	1,733		4,411	27
28	Judea rms 130-138,140:Asbestos abate, electrical, plumbing, doors, counters, trim, molding, cabin	2018	247,459	9,898	25	9,898		24,515	28
29	Water heater for kitchen, dining, Judea, Salem, Zion wings.	2018	16,791	1,119	15	1,119		2,557	29
30	Copper water pipe replace: rms PT, Kitchen.	2018	8,891	356	25	356		771	30
31	Kitchen & dining roof and door.	2018	2,965	132	25	119	(13)	238	31
32	Walk in freezer,coolers: condenser,evaporator,door,electrical,ceiling.	2019	8,588	658	15	573	(85)	771	32
33	Kitchen commercial disposal	2019	3,132	78	10	313	235	402	33
34	TOTAL (lines 1 thru 33)		$ 6,876,772	$ 184,599		$ 178,343	$ (6,256)	$ 3,979,310	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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 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 12D, Carried Forward		$ 6,876,772	$ 184,599		$ 178,343	$ (6,256)	$ 3,979,310	1
2	Zion/Galilee/Judea nurse stations,rooms,hallways nurse call:walllamps,electrical,wiring,installatio	2019	100,940		10	10,094	10,094	10,232	2
3	Judea/Salem boiler bearing assy, seals, gauges, valve	2019	7,162	477	15	477		833	3
4	Kitchen ventilation:rangehood,suppression syst,makeup air,roof fans	2019	45,188	1,808	25	1,808		2,729	4
5	Plumbing:kitchen,exam rm, mech rm:Zurn hydrant, water lines, softner	2019	2,872	115	25	115		168	5
6	Zion/Judea:fire materials,insulation,drywall,installation,heat detector	2019	9,060	396	25	362	(34)	506	6
7	Zion/Judea ERU-HVAC:structuralSupport,units/condensers/controls 18rms,wiring,painting,relays	2019	231,364	9,255	25	9,255		11,714	7
8	Upper/Lower parking lots front bldg: blacktop resurfacing	2019	8,000	533	15	533		657	8
9	Salem dining/resident rooms: exterior tile & grading for water drainage	2019	16,150	1,077	15	1,077		1,260	9
10	South/Central Elevators: doors,switching,valves,controls,hangers,guides	2019	49,698	3,313	15	3,313		3,449	10
11	JudeaHall:Wiring,lights,walls,flooring,door,nursing sttn,paint,installation	2019	75,826	3,033	25	3,033		3,033	11
12	SE Kitchen disposal	2020	4,273	509	7	505	(4)	505	12
13	JudeaHall: Boiler pump rebuild	2020	3,893	324	10	338	14	338	13
14	Sprinkler system:5sidewalls + 2 pendants-kitchen;pressure switch;new main p	2020	5,173	345	10	326	(19)	326	14
15	Galilee:chiller brushes;sensors;transducer;gauges;valves;flowmeter;piping	2020	4,515	100	15	88	(12)	88	15
16	Main kitchen door,fire alarm,plumbing	2020	3,548	79	15	16	(63)	16	16
17	Main kitchen roof replacement	2020	54,711	456	20	412	(44)	412	17
18	Laundry hall:door hardware;flooring;wall protection;sheeting;horizontal board	2020	11,833	394	25	381	(13)	381	18
19	Air purification system in:Galilee;diningrm;kitchen;activity;therapy;Salem	2020	11,058	111	25	122	11	122	19
20									20
21									21
22									22
23									23
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)		$ 7,522,036	$ 206,924		$ 210,598	$ 3,674	$ 4,016,079	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 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	$ 811,911	$ 72,688	$ 72,688	$	Various	$ 539,528	71
72	Current Year Purchases	48,839	4,735	4,735		Various	4,735	72
73	Fully Depreciated Assets	821,903					821,903	73
74								74
75	TOTALS	$ 1,682,653	$ 77,423	$ 77,423	$		$ 1,366,166	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	06 Ford Van	2006	$ 36,187	$	$	$	5	$ 36,187	76
77	Patient Transport	18 Ford Transit	2019	30,281	5,056	6,056	1,000	5	8,644	77
78	Patient Transport	15 Doge Van	2015	39,933	5,705	5,705		7	30,979	78
79	Patient Transport	16 Ford Bus	2016	66,200	9,457	9,457		7	46,611	79
80	TOTALS			$ 172,601	$ 20,218	$ 21,218	$ 1,000		$ 122,421	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)	$ 9,378,033	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 304,565	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 309,239	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,674	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,504,666	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired		2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	Various	$ 3,363,265	$ 153,458	$ 1,883,376	86
87	Equipment	Various	421,767	28,011	308,911	87
88	Vehicle	Various	51,586	5,197	29,068	88
89	Land	Various	112,446			89
90	Duplexes	Various	2,063,541	17,574	56,541	90
91	TOTALS		$ 6,012,605	$ 204,240	$ 2,277,896	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	$ 569,037	92
93			93
94			94
95		$ 569,037	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 [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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

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

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: x
   - IN OTHER FACILITY:
   - COMMUNITY COLLEGE:
   - HOURS PER CNA: 80

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,519	$	$ 1,519
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	$	$ 1,519	$	$ 1,519
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,519			

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$	317	$ 19,255	$	317	$ 19,255	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		231	16,190		231	16,190	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		572	35,598		572	35,598	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				54,681		54,681	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					1,664		1,664	13
14	TOTAL			$	1,120	$ 71,043	$ 56,345	1,120	$ 127,388	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.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 2,422,420	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (9,000))	1,029,933		3
4	Supply Inventory (priced at FIFO)	86,719		4
5	Short-Term Investments	77,312		5
6	Prepaid Insurance	259,430		6
7	Other Prepaid Expenses	52,159		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other accounts receivable	54,710		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 3,982,683	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	12,854,442		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,306,688		16
17	Accumulated Depreciation (book methods)	(7,693,633)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	569,037		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 8,149,723	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 12,132,406	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 416,128	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,900		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 452,028	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingency Payable	1,850,293		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 1,850,293	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 2,302,321	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 9,830,085	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 12,132,406	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 7,739,036	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	1,409	4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 7,740,446	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,089,639	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)	$ 2,089,639	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)	$ 9,830,085	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,065,667	1
2	Discounts and Allowances for all Levels	(132,848)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,932,819	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,636	6
7	Oxygen	20,396	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 304,032	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,034,100	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,243	13
14	Non-Patient Meals	127,564	14
15	Telephone, Television and Radio	8,624	15
16	Rental of Facility Space		16
17	Sale of Drugs	41,525	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,134	19
20	Radiology and X-Ray	3,375	20
21	Other Medical Services	1,621,707	21
22	Laundry	7,069	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 2,864,341	23
	D. Non-Operating Revenue		
24	Contributions	2,104,984	24
25	Interest and Other Investment Income***	3,771	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 2,108,755	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	7,380	27
28	Non-Care Facility	4,096	28
28a	Miscellaneous Income	94,245	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 105,721	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 11,315,668	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,551,167	31
32	Health Care	3,476,165	32
33	General Administration	2,019,258	33
	B. Capital Expense		
34	Ownership	508,989	34
	C. Ancillary Expense		
35	Special Cost Centers	1,534,468	35
36	Provider Participation Fee	135,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 9,226,029	40
41	Income before Income Taxes (line 30 minus line 40)**	2,089,639	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 2,089,639	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 275,679	44
45	Private Pay - Net Inpatient Revenue	5,258,925	45
46	Medicare - Net Inpatient Revenue	398,215	46
47	Other-(specify) Rounding		47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,932,819	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 Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 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	1,980	2,075	$ 89,927	$ 43.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,114	21,742	709,650	32.64	3
4	Licensed Practical Nurses	10,541	11,735	325,975	27.78	4
5	CNAs & Orderlies	62,850	68,216	1,244,403	18.24	5
6	CNA Trainees					6
7	Licensed Therapist	189	189	7,145	37.80	7
8	Rehab/Therapy Aides	2,543	2,919	64,961	22.25	8
9	Activity Director	1,861	2,080	43,121	20.73	9
10	Activity Assistants	8,014	8,709	137,113	15.74	10
11	Social Service Workers	3,680	4,062	132,291	32.57	11
12	Dietician					12
13	Food Service Supervisor	3,383	3,788	86,265	22.77	13
14	Head Cook	3,041	3,437	55,179	16.05	14
15	Cook Helpers/Assistants	10,931	12,116	163,976	13.53	15
16	Dishwashers					16
17	Maintenance Workers	4,728	5,662	121,122	21.39	17
18	Housekeepers	12,536	13,457	178,975	13.30	18
19	Laundry	5,028	5,220	69,570	13.33	19
20	Administrator	1,225	1,391	99,840	71.78	20
21	Assistant Administrator	1,806	1,985	102,031	51.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,221	8,261	215,795	26.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,067	1,275	26,557	20.83	31
32	Other Health Care(specify)	67,514	68,820	1,060,209	15.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,252	247,139	$ 4,934,105 *	$ 19.96	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	97	$ 4,838	1.3	35
36	Medical Director	120	15,000	9.3	36
37	Medical Records Consultant	34	2,294	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	44	4,438	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	13	940	11.3	44
45	Social Service Consultant	15	1,027	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	323	$ 28,537		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,201	$ 57,553	10.3	50
51	Licensed Practical Nurses	166	7,626	10.3	51
52	Certified Nurse Assistants/Aides	283	7,068	10.3	52
53	TOTAL (lines 50 - 52)	1,650	$ 72,247		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.)			$ 149,290

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)		$ 65,182

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,467
Unemployment Compensation Insurance	
FICA Taxes	335,228
Employee Health Insurance	460,305
Employee Meals	10,386
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan & Administration	85,665
Employee Physical	58,220
Employee Incentives	56,266
Uniform Allowance	1,565
Reclassifications	
Rounding	(1)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,079,101

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 4,730
Advertising: Employee Recruitment		17,959
Health Care Worker Background Check		2,018
(Indicate # of checks performed	96)	
Patient Background Checks	72	720
LeadingAge		7,105
Publications		1,581
Licenses		2,660
Other Membership Dues & Fees		7,163
Reclassifications		
Less: Public Relations Expense		( )
Non-allowable advertising		(6,118)
Yellow page advertising		(2,025)
TOTAL (agree to Sch. V, line 20, col. 8)		$ 35,793

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,323
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,323

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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. LeadingAge 7,105

(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. $ 41,953 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. $ 135,982
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. $ 10,386 Has any meal income been offset against related costs? Yes Indicate the amount. $ 127,560

(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.