FOR BHF USE

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) Matt Feucht
(Title) Administrator

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less		-	6
7	86	TOTALS	86	31,476	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	5,270	14,248	890	20,408	8
9	SNF/PED					9
10	ICF	-	-			10
11	ICF/DD	-	-			11
12	SC	663	6,800		7,463	12
13	DD 16 OR LESS	-	-			13
14	TOTALS	5,933	21,048	890	27,871	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.885468293

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Apartment, Assisted Living

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 14 and days of care provided 890

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	319,320	18,529	6,650	344,499	(16,330)	328,169		328,169			1
2	Food Purchase		235,551		235,551	(11,166)	224,385	(35,791)	188,594			2
3	Housekeeping	95,590	22,849		118,439		118,439		118,439			3
4	Laundry	56,502	8,601		65,103		65,103		65,103			4
5	Heat and Other Utilities			139,190	139,190		139,190		139,190			5
6	Maintenance	182,835	37,944	40,675	261,454		261,454	(24,926)	236,528			6
7	Other (specify):*											7
8	TOTAL General Services	654,247	323,474	186,515	1,164,236	(27,496)	1,136,740	(60,717)	1,076,023			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,414,209	104,049	32,698	2,550,956	(1)	2,550,955	(9,495)	2,541,460			10
10a	Therapy		2,501	91,453	93,954		93,954		93,954			10a
11	Activities	180,378		5,941	186,319		186,319	(3,153)	183,166			11
12	Social Services	68,864			68,864		68,864		68,864			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,663,451	106,550	130,092	2,900,093	(1)	2,900,092	(12,648)	2,887,444			16
	C. General Administration											
17	Administrative	100,911			100,911		100,911		100,911			17
18	Directors Fees											18
19	Professional Services			34,607	34,607		34,607		34,607			19
20	Dues, Fees, Subscriptions & Promotions			47,829	47,829		47,829	(9,853)	37,976			20
21	Clerical & General Office Expenses	180,553	25,940	97,017	303,510		303,510	(24,572)	278,938			21
22	Employee Benefits & Payroll Taxes			784,340	784,340	27,496	811,836		811,836			22
23	Inservice Training & Education			7,915	7,915		7,915		7,915			23
24	Travel and Seminar			8,227	8,227		8,227		8,227			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,033	82,033		82,033		82,033			26
27	Other (specify):*											27
28	TOTAL General Administration	281,464	25,940	1,061,968	1,369,372	27,496	1,396,868	(34,425)	1,362,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,599,162	455,964	1,378,575	5,433,701	(1)	5,433,700	(107,790)	5,325,910			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: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			308,519	308,519		308,519	(75,506)	233,013			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			448	448		448	(448)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			308,967	308,967		308,967	(75,954)	233,013			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,040	5,678	35,718	1	35,719		35,719			39
40	Barber and Beauty Shops			32,612	32,612		32,612		32,612			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,175	150,175		150,175		150,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		30,040	188,465	218,505	1	218,506		218,506			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,599,162	486,004	1,876,007	5,961,173		5,961,173	(183,744)	5,777,429			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: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(35,791)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,135	30.3		9
10	Interest and Other Investment Income	(448)	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				27
28	Yellow Page Advertising	(650)	20.3		28
29	Other-Attach Schedule	(147,990)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (183,744)		$	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))	$ (183,744)		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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2					-							2
3					-							3
4					-							4
5					-							5
	Working Capital											
6	Promissory Note		x	Operations	-	2003	41,891		2008	0.0400	448	6
7					-						-	7
8					-							8
9	TOTAL Facility Related						$ 41,891	$			$ 448	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 41,891	$			$ 448	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: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
2007		8
2008		9
2009		10
2010		11
2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2011 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2011 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2011.

Please complete the Real Estate Tax Statement below and include it in the 2012 cost report along with a copy of your 2011 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matt Feucht

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		7023 N.E. Skyline Drive	$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 & 14 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: 01/01/2012 Ending: 12/31/2012

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	$ 8,708	40	$ 8,708	$	$ 334,380	4
5	21		1971	1970	396,963	9,924	40	9,924		341,388	5
6	16		1985	1985	750,000	18,750	40	18,750		435,000	6
7	3		1989	1988	205,070	5,127	40	5,127		102,537	7
8	17		1995	1995	870,388	21,760	40	21,760		352,509	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		285,671	9
10	Shelter care remodel			1974	6,594	165	40	165		6,030	10
11	Fire prevention system			1977	23,804	873	25	952	79	22,223	11
12	Dining room addition			1978	38,922	973	40	973		34,415	12
13	Fire prevention system			1979	35,330	153	25	1,413	1,260	35,176	13
14	Windows replacement			1981	23,820	544	25	953	409	23,277	14
15	Kitchen remodel			1982	21,631	541	40	541		18,324	15
16	Energy conservation			1983	8,413		15			8,413	16
17	Shelter care remodel			1984	7,742	194	40	194		6,390	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		8,694	20
21	Office Addition			1991	50,297	1,257	40	1,257		36,211	21
22	New roof			1993	14,210		10			14,210	22
23	Room remodel			1994	5,154	206	25	206		3,991	23
24	Front entrance, front office, ceiling back hall			1996	62,294	3,115	20	3,115		49,837	24
25	Guttering System			1996	89,096	3,564	25	3,564		57,023	25
26	Fencing, soffit/facia, new door			1997	28,036	1,121	25	1,121		17,146	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978	332	15	332		3,259	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		1,860	31
32	Blacktopping			2001	13,967		8	436	436	13,967	32
33	Balcony repair			2001	6,605	544	20	330	(214)	5,032	33
34	Insulation installation			2001	9,970	665	15	665		6,254	34
35	Lawn sprinkler system			2001		643	15		(643)		35
36	Air Conditioning Unit			2001	2,178	218	10	218		1,916	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: 01/01/2012 Ending: 12/31/2012

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	$	$ 324	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	7,913	38
39	Flooring, wall covering	2002	9,786		5			9,786	39
40	Balcony repair	2002	7,403	370	20	370		4,018	40
41	Carpeting in dining room	2002	5,446		5			5,446	41
42	Water heater	2002	4,197	420	10	420		3,587	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		256	20		(256)		44
45	Air Conditioning unit	2003	1,700	85	20	85		811	45
46	Sewer system upgrade	2003		256	20		(256)		46
47	Countertops in kitchen	2003	6,594	403	15	440	37	3,673	47
48	Carpeting	2004	5,878		5			5,878	48
49	Wiremesh	2004	1,825	122	15	122		976	49
50	Sewer system upgrade	2004		360	20		(360)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		1,058	51
52	Water heater	2004	7,646	510	10	765	255	5,737	52
53	Rewiring	2004	1,327	66	20	66		473	53
54	Roofing	2005	4,858	486	10	486		3,685	54
55	Tub room remodel	2005	3,855	154	25	154		1,142	55
56	Carpeting	2005	2,128		5			2,128	56
57	Alarm system	2005	2,357	157	15	157		1,125	57
58	External water carryoff system	2005	512	21	25	20	(1)	140	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	59,188	59
60	Door latches	2006	7,110	178	40	178		1,218	60
61	Automatic Doors	2006	2,886	192	15	192		1,249	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		2,149	62
63	Fire safety improvements	2007	19,182	480	40	480		2,417	63
64	Garage	2007	5,944	149	40	149		754	64
65	Locks	2007	691	69	10	69		414	65
66	Office expansion - social services	2007	2,346	59	40	59		347	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		10,429	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		1,511	68
69	Wood door	2007	942	63	15	63		329	69
70	TOTAL (lines 4 thru 69)		$ 4,584,882	$ 118,053		$ 117,632	$ (421)	$ 2,585,016	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: 01/01/2012 Ending: 12/31/2012

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		$ 4,584,882	$ 118,053		$ 117,632	$ (421)	$ 2,585,016	1
2	Air conditioner compressor	2007	8,418	842	10	842		4,401	2
3	Sprinklers	2007	1,230	62	20	62		323	3
4	Maglock outswing door	2007	1,173	117	10	117		696	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		3,313	5
6	Heat exchangers	2007	8,455	423	20	423		2,385	6
7	Disposer 3 hp	2007	3,472	347	10	347		1,872	7
8	Door monitoring unit	2007	1,103	110	10	110		561	8
9	Sprinkler-kitchen; flooring-306; fire safety improvs	2008	60,117	1,839	48	1,252	(587)	5,351	9
10	Walkway and snow melt	2008	5,357	357	15	357		1,526	10
11	Septic field St. Luke Ct	2008	10,726	268	50	215	(53)	969	11
12	Iron guard hand railings	2008	6,781	452	15	452		1,851	12
13	Commercial disposal	2008	1,487	149	10	149		678	13
14	Rm flooring, wall	2008	6,604	165	40	165		660	14
15	Internet wiring	2009	4,849	242	20	242		867	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		1,901	16
17	Water heater	2009	13,950	930	20	698	(232)	2,172	17
18	Air conditioning units	2009	2,673	267	25	107	(160)	422	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		1,267	19
20	Dining room walls	2009	5,391	216	40	135	(81)	497	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	294	20	316	22	1,249	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		598	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		950	23
24	Senior TV hook-up	2009	250	13	20	13		40	24
25	Salem architectural	2009	3,392	136	25	136		476	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		3,354	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		1,173	27
28	Flooring Salem lounge	2009	14,443	578	25	578		1,830	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		2,282	29
30	Social room tv cabinetry	2009	990	50	20	50		150	30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		333	31
32	Maglock outswing door, sensor push bars	2009	2,999	182	20	150	(32)	599	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	1,822	33
34	TOTAL (lines 1 thru 33)		$ 4,868,786	$ 131,198		$ 129,311	$ (1,887)	$ 2,631,584	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: 01/01/2012 Ending: 12/31/2012

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		$ 4,868,786	$ 131,198		$ 129,311	$ (1,887)	$ 2,631,584	1
2	Roofing, flooring rm 226	2009	8,432	878	15	562	(316)	1,793	2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	1,095	10	1,094	(1)	2,410	3
4	Elevator repair	2010	12,698	635	10	1,270	635	3,549	4
5	Salem flooring, baseboards	2010	14,826	593	25	593		1,485	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		394	6
7	Nurses Station	2010	2,533	101	10	253	152	548	7
8	Flooring Canaan room	2010	870	174	5	174		436	8
9	Dining room flooring	2010	1,190	48	15	79	31	218	9
10	New burner boiler 1	2010	12,225	489	25	489		1,077	10
11	Commercial water heater	2010	4,900	327	15	327		700	11
12	Surveillance hardware & smoke detector	2010	5,421	497	10	542	45	1,221	12
13	Rebuild \ replace heat exchangers	2010	4,129	275	15	275		573	13
14	Zion & Galilee tubs, fire safety wall	2011	43,210	2,824	10	4,321	1,497	5,765	14
15	South bath plumbing piping & fixtures	2011	6,824	273	25	273		441	15
16	Judea bath walls, floor, doors, plumbing, drapes	2011	62,365	1,559	25	2,495	936	3,329	16
17	Activity room walls, ceiling, flooring, electrical, plumbing.	2011	29,264	732	40	732		1,183	17
18	Laundry room plumbing, electrical, walls, ceiling.	2011	6,030	151	40	151		177	18
19	Drinking fountain and air conditioning unit	2012	2,495	137	10	244	107	244	19
20	Showers and valves	2012	4,823	161	25	165	4	165	20
21	Elevator starter and door	2012	5,504	164	25	141	(23)	141	21
22	Therapy rm sprinklers, plumbing, walls, ceiling	2012	23,395	597	25	597		597	22
23	Dining room air conditioner	2012	10,212	397	15	386	(11)	386	23
24	Beauty shop flooring, walls	2012	3,654	61	25	64	3	64	24
25	Dining rm addition:walls, electrical, plumbing, ceilings	2012	507,333	4,228	40	4,239	11	4,239	25
26	Door protectors	2012	4,403	294	10	281	(13)	281	26
27	Walk in freezer dining rm addition	2012	35,435	826	15	790	(36)	790	27
28	Disposal in dining rm addition	2012	4,421	147	10	148	1	148	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,700,691	$ 149,036		$ 150,171	$ 1,135	$ 2,663,938	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: 01/01/2012 Ending: 12/31/2012

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	$ 1,034,910	$ 71,355	$ 71,355	$	Various	$ 611,062	71
72	Current Year Purchases	148,218	6,382	6,382		Various	6,382	72
73	Fully Depreciated Assets	181,213					181,213	73
74								74
75	TOTALS	$ 1,364,341	$ 77,737	$ 77,737	$		$ 798,657	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	99 Ford Bus	2005	$ 58,988	$	$	$	4	$ 58,988	76
77	Maintenance	02 John Deere	2005	6,475				3	6,475	77
78										78
79	Patient Transport	06 Ford Van	2006	36,187				5	36,187	79
80	TOTALS			$ 101,650	$	$	$		$ 101,650	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,167,425	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,773	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 227,908	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,135	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,564,245	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	$ 1,937,398	$ 58,971	$ 1,053,029	86
87	Equipment	Various	236,398	19,903	126,827	87
88	Vehicle	Various	22,254	2,872	45,233	88
89	Land	Various	112,446			89
90						90
91	TOTALS		$ 2,308,496	$ 81,746	$ 1,225,089	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	$ 40,436	92
93			93
94			94
95		$ 40,436	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

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

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: 01/01/2012 Ending: 12/31/2012

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	295	$ 15,863	$	295	$ 15,863	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		379	24,234		379	24,234	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		380	20,227		380	20,227	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits		23	1,690		23	1,690	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				28,024		28,024	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					2,016		2,016	13
14	TOTAL			$	1,077	$ 62,014	$ 30,040	1,077	$ 92,054	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (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	$ 265,127	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	795,593		3
4	Supply Inventory (priced at FIFO)	20,030		4
5	Short-Term Investments	206,348		5
6	Prepaid Insurance	122,356		6
7	Other Prepaid Expenses	43,589		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,453,043	$	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	9,354,583		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,769,118		16
17	Accumulated Depreciation (book methods)	(4,858,261)		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	40,436		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 6,419,065	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 7,872,108	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,597	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	23,500		29
30	Accrued Salaries Payable	56,007		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)	$ 306,104	$	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	1,772,923		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 1,772,923	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 2,079,027	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 5,793,081	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 7,872,108	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 5,277,702	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(9,520)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 5,268,182	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	524,899	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)	$ 524,899	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)	$ 5,793,081	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 5,173,907	1
2	Discounts and Allowances for all Levels	(428,087)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 4,745,820	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	166,041	6
7	Oxygen	23,368	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 189,409	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	461	12
13	Barber and Beauty Care	32,692	13
14	Non-Patient Meals	35,965	14
15	Telephone, Television and Radio	10,496	15
16	Rental of Facility Space		16
17	Sale of Drugs	23,335	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,246	19
20	Radiology and X-Ray	5,409	20
21	Other Medical Services	537,003	21
22	Laundry	560	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 648,167	23
	D. Non-Operating Revenue		
24	Contributions	775,420	24
25	Interest and Other Investment Income***	1,086	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 776,506	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	75,120	27
28	Non-Care Facility	20,183	28
28a	Miscellaneous Income	30,867	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 126,170	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 6,486,072	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,164,236	31
32	Health Care	2,900,093	32
33	General Administration	1,369,372	33
	B. Capital Expense		
34	Ownership	308,967	34
	C. Ancillary Expense		
35	Special Cost Centers	68,330	35
36	Provider Participation Fee	150,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,961,173	40
41	Income before Income Taxes (line 30 minus line 40)**	524,899	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 524,899	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 602,363	44
45	Private Pay - Net Inpatient Revenue	3,943,031	45
46	Medicare - Net Inpatient Revenue	200,425	46
47	Other-(specify)	1	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,745,820	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: 01/01/2012 Ending: 12/31/2012

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,080	$ 73,614	$ 35.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,467	18,643	498,701	26.75	3
4	Licensed Practical Nurses	16,068	16,998	383,508	22.56	4
5	CNAs & Orderlies	77,168	80,921	1,070,020	13.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,977	2,065	32,962	15.96	9
10	Activity Assistants	12,755	13,627	147,416	10.82	10
11	Social Service Workers	3,782	4,046	68,864	17.02	11
12	Dietician					12
13	Food Service Supervisor	3,968	4,146	82,460	19.89	13
14	Head Cook	3,666	4,026	50,722	12.60	14
15	Cook Helpers/Assistants	12,581	13,540	157,276	11.62	15
16	Dishwashers	2,516	2,897	28,862	9.96	16
17	Maintenance Workers	7,863	8,416	163,976	19.48	17
18	Housekeepers	7,982	8,644	95,590	11.06	18
19	Laundry	5,638	6,072	56,502	9.31	19
20	Administrator	2,000	2,080	100,911	48.51	20
21	Assistant Administrator	2,072	2,080	67,911	32.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,082	6,136	112,642	18.36	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	2,390	2,514	39,924	15.88	31
32	Other Health Care(specify)	24,144	24,520	338,947	13.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,183	223,451	$ 3,570,808 *	$ 15.98	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	166	$ 6,650	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	41	2,656	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	41	3,300	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	18	875	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	$ 13,481		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 608	10.3	50
51	Licensed Practical Nurses	667	22,678	10.3	51
52	Certified Nurse Assistants/Aides	81	1,668	10.3	52
53	TOTAL (lines 50 - 52)	764	$ 24,954		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)			$ 100,911

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)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 34,607

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,367
Unemployment Compensation Insurance	2,738
FICA Taxes	271,730
Employee Health Insurance	332,395
Employee Meals	27,496
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan & Administration	69,365
Employee Physical	13,450
Employee Incentives	8,863
Uniform Allowance	432
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 811,836

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	32,031
Health Care Worker Background Check	347
(Indicate # of checks performed 23)	
Patient Background Checks 28	280
Life Services Network Dues	5,529
Publications	922
Licenses	4,438
Other Membership Dues	2,292
Rounding	
Less: Public Relations Expense	( )
Non-allowable advertising	(9,203)
Yellow page advertising	(650)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,976

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,532
Seminar Expense	5,695
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,227

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. Life Services Network Dues 5,529

(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? 6

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 36,621 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. $ 150,175
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. $ 27,496 Has any meal income been offset against related costs? Yes Indicate the amount. $ 35,791

(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. $

(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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.