

		FOR BHT USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0012328

Facility Name: Apostolic Christian Home of Eureka

Address: 610 West Cruger Eureka 61530
Number City Zip Code

County: Woodford

Telephone Number: (309) 467-2311 Fax # (309) 467-2584

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

In the event there are further questions about this report, please contact:
Name: Thomas A. Hoffman Telephone Number: (309) 467-2311
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 01/01/2011 to 12/31/2011
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)
(Type or Print Name) Thomas A. Hoffman
(Title) Administrator

Paid
Preparer

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,855</u>	3
4		Intermediate/DD			4
5	<u>10</u>	Sheltered Care (SC)	<u>10</u>	<u>3,650</u>	5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.						
1	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,770</u>	<u>19,165</u>	<u>1,340</u>	<u>26,275</u>	8
9	SNF/PED					9
10	ICF	<u>1,474</u>	<u>7,833</u>		<u>9,307</u>	10
11	ICF/DD	-	-			11
12	SC	-	<u>2,877</u>		<u>2,877</u>	12
13	DD 16 OR LESS	-	-			13
14	TOTALS	7,244	29,875	1,340	38,459	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.940777886

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, Duplex, Condominium

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 1966 NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 32 and days of care provided 1,340

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	361,329	16,546	17,361	395,236	-	395,236	-	395,236			1
2	Food Purchase		274,148		274,148	-	274,148	(23,938)	250,210			2
3	Housekeeping	131,749	32,431	5,933	170,113	-	170,113	(6,253)	163,860			3
4	Laundry	141,417	14,080	2,239	157,736	-	157,736	-	157,736			4
5	Heat and Other Utilities			238,066	238,066	-	238,066	(41,041)	197,025			5
6	Maintenance	141,259	9,096	57,827	208,182	-	208,182	(30,043)	178,139			6
7	Other (specify):*	-	-	-	-	-	-	-	-			7
8	TOTAL General Services	775,754	346,301	321,426	1,443,481	-	1,443,481	(101,275)	1,342,206			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	3,036,542	34,904	48,014	3,119,460	33,774	3,153,234		3,153,234			10
10a	Therapy	57,820	2,464	188,102	248,386		248,386	(13,775)	234,611			10a
11	Activities	204,462	4,133	7,207	215,802		215,802		215,802			11
12	Social Services	67,668	380	946	68,994		68,994		68,994			12
13	CNA Training				-	11,809	11,809	(2,343)	9,466			13
14	Program Transportation				-		-		-			14
15	Other (specify):*				-		-		-			15
16	TOTAL Health Care and Programs	3,366,492	41,881	249,069	3,657,442	45,583	3,703,025	(16,118)	3,686,907			16
	C. General Administration											
17	Administrative	193,120	-	-	193,120	-	193,120	(23,610)	169,510			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			22,743	22,743	(123)	22,620	-	22,620			19
20	Dues, Fees, Subscriptions & Promotions			27,432	27,432	(400)	27,032	(7,596)	19,436			20
21	Clerical & General Office Expenses	128,319	8,843	48,634	185,796	(755)	185,041	(15,967)	169,074			21
22	Employee Benefits & Payroll Taxes			997,460	997,460	-	997,460	(16,795)	980,665			22
23	Inservice Training & Education			-	-	-	-	-	-			23
24	Travel and Seminar			13,916	13,916	1,278	15,194	-	15,194			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			105,634	105,634	-	105,634	(18,502)	87,132			26
27	Other (specify):*		-	-	-	-	-	-	-			27
28	TOTAL General Administration	321,439	8,843	1,215,819	1,546,101	-	1,546,101	(82,470)	1,463,631			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,463,685	397,025	1,786,314	6,647,024	45,583	6,692,607	(199,863)	6,492,744			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.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Apostolic Christian Home of Eureka #0012328 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			388,829	388,829	-	388,829	(71,887)	316,942			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			-	-	-	-	-	-			32
33	Real Estate Taxes			9,141	9,141	-	9,141	(9,141)	-			33
34	Rent-Facility & Grounds			-	-	-	-	-	-			34
35	Rent-Equipment & Vehicles			-	-	-	-	-	-			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			397,970	397,970	-	397,970	(81,028)	316,942			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	130,153	6,547	136,700	(45,583)	91,117	-	91,117			39
40	Barber and Beauty Shops	-	-	23,962	23,962	-	23,962	-	23,962			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	168,808	168,808	-	168,808	-	168,808			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	130,153	199,317	329,470	(45,583)	283,887	-	283,887			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,463,685	527,178	2,383,601	7,374,464	-	7,374,464	(280,891)	7,093,573			45

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

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	(23,938)	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	(1,078)	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(255,875)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$(280,891)		\$	30

BHF USE ONLY							
48		49		50		51	

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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$(280,891)		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			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☒ NO

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

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

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

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

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

()

()

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

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

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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:	2006	8	FOR BHF USE ONLY	
	2007	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	11	15	LESS REFUND FROM LINE 6 \$ 15
	2010	12	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: 2010 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 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

A. Square Feet:

42,865

B. General Construction Type:

Exterior

Brick

Frame

Protected Ord. & Fire Resistance

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	63,500	1963	\$ 58,945	1
2					2
3	TOTALS	63500		\$ 58945	3

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	62		1966	1966	\$ 488,404	\$	40	\$	\$	\$ 488,404	4
5	38		1975	1975	605,234	15,091	40	15,131	40	538,248	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	677,180	6
7	4		1994	1994	226,582	6,237	39	5,810	(427)	98,860	7
8				1989	3,512		20			3,512	8
	Improvement Type**										
9				1967	17,605		40			17,605	9
10				1968	1,508		20			1,508	10
11				1969	11,406		20			11,406	11
12				1970	8,431		20			8,431	12
13				1971	2,975		20			2,975	13
14				1972	550		5			550	14
15				1977	38,346		20			38,346	15
16				1979	1,260		5			1,260	16
17				1981	4,140		10			4,140	17
18				1982	15,776		20			15,776	18
19				1983	4,826		10			4,826	19
20				1984	8,271		10			8,271	20
21				1985	15,630		20			15,630	21
22				1986	8,500		10			8,500	22
23				1987	950		19			950	23
24				1988	69,201		20			69,201	24
25	Kitchen Addition			1989	12,677		20			12,677	25
26	Bldg Improvement			1989	10,281		10			10,281	26
27	Water Heater			1990	2,272		20			2,272	27
28	Central Air			1990	3,978		10			3,978	28
29	Improve Door			1990	2,235		10			2,235	29
30	Remodeling			1990	503		20			503	30
31	Sprinkler Heads			1990	1,504		20			1,504	31
32	Blacktopping			1990	3,000		20			3,000	32
33	Cubicle Curtain Track			1991	850	21	20		(21)	850	33
34	Carpeting/Woodwork			1991	795	20	20		(20)	795	34
35	Key Pads/Door System			1991	2,670	67	20	23	(44)	2,670	35
36	Thermo Mixing Valves			1991	3,310	83	20	38	(45)	3,310	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Air Conditioning Unit	1991	\$ 3,012	\$	10	\$	\$	\$ 3,012	37
38 Wall Air Conditioning Unit	1991	910		10			910	38
39 Patio	1991	2,150	54	20	35	(19)	2,150	39
40 Asphalt Parking	1992	8,938	447	20	447		8,757	40
41 Trees & Shrubs	1992	403	20	20	20		392	41
42 Radiator Covers	1992	5,500	275	20	275		5,493	42
43 Plumbing Upgrade	1992	2,348	117	20	117		2,336	43
44 Shed	1992	2,000	100	20	100		1,956	44
45 Alarm System	1992	4,520	226	20	226		4,408	45
46 Lock Sets	1992	1,207	60	20	60		1,145	46
47 Water Heater	1992	10,252		10			10,252	47
48 Air Conditioner	1992	886		10			886	48
49 Air Conditioner	1992	926		10			926	49
50 Air Conditioner	1992	858		10			858	50
51 Drapes and Rods	1992	1,057		10			1,057	51
52 Fireplace Glass	1992	587		10			587	52
53 Air Conditioner	1993	1,303		10			1,303	53
54 Fountain Lights	1993	1,179		10			1,179	54
55 Exterior Lighting	1993	850	42	20	43	1	808	55
56 Hallway Remodeling	1993	2,383	119	20	119		2,225	56
57 Kitchen Flooring	1993	2,441	122	20	122		2,263	57
58 Office Addition	1994	57,234	1,431	39	1,468	37	25,937	58
59 Roof	1994	17,577	879	20	879		15,162	59
60 Interior Hallway	1994	7,134		10			7,134	60
61								61
62 Phone System	1994	13,120		10			13,120	62
63 Air Conditioner	1995	1,158		10			1,158	63
64 Drapes	1995	529		10			529	64
65 Remodel	1995	5,366		5			5,366	65
66 Improvements	1995	3,293		10			3,293	66
67 Roof & Insulation	1995	21,002	1,050	20	1,050		17,329	67
68 Building Improvements	1995	7,787		10			7,787	68
69 Life Safety Code	1995	21,125	1,056	20	1,056		16,942	69
70 TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 65,570		\$ 66,048	\$ 478	\$ 2,226,314	70

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

XI. OWNERSHIP COSTS (continued) B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,308,343	\$ 65,570		\$ 66,048	\$ 478	\$ 2,226,314	1
2	Air Conditioner	1996	485		10			485	2
3	Phone System-Social Service	1996	1,201		10			1,201	3
4	Air Conditioner	1996	2,886		10			2,886	4
5	Water Softner	1996	3,442		10			3,442	5
6	Social Service Office Remodel	1996	2,750	207	20	138	(69)	2,545	6
7	Life Safety Code	1996	8,113	336	20	406	70	6,105	7
8	Life Safety Door	1996	5,061	253	20	253		3,997	8
9	Front Room Wallpaper	1996	1,008		10			1,008	9
10	Ventilation & A/C System	1996	5,990		10			5,990	10
11	Front Room Carpet	1996	2,432	122	20	122		1,901	11
12	Guttering System	1996	3,355	168	20	168		2,611	12
13	Air Conditioning	1996	9,314	466	20	466		7,244	13
14	Air Conditioning	1996	1,008	50	20	50		769	14
15	Cabinetry in Tub Room	1996	2,945		10			2,945	15
16	Air Conditioning & Ventilation System	1996	8,942	447	20	447		6,836	16
17	Speaker System	1996	3,798		10			3,798	17
18	Life Safety Ventilation System	1996	798	40	20	40		608	18
19	Six Air Conditioners	1997	2,882		10			2,882	19
20	Water Heater	1997	5,871		10			5,871	20
21	Wall Fountain	1997	653		10			653	21
22	Draperys	1997	2,839		10			2,839	22
23	Smoke Detectors	1997	3,103		10			3,103	23
24	Carpeting	1997	3,525	176	20	176		2,493	24
25	Hall Remodeling	1997	16,641	832	20	832		11,787	25
26	Five Air Conditioners	1998	2,447		10			2,447	26
27	Water Heater	1998	2,940		10			2,940	27
28	Air Conditioner	1998	5,415		10			5,415	28
29	Room Door Guards	1999	2,139		10			2,139	29
30	Door Alarm Keypads	1999	2,293		10			2,293	30
31	Seven Air Conditioners	1999	3,182		10			3,182	31
32	Kitchen Shelving Units	1999	2,838		10			2,838	32
33	Three Air Conditioners	1999	1,425		10			1,425	33
34	TOTAL (lines 1 thru 33)		\$ 3,430,064	\$ 68,667		\$ 69,146	\$ 479	\$ 2,332,992	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

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		\$ 3,430,064	\$ 68,667		\$ 69,146	\$ 479	\$ 2,332,992	1
2	Room Door Guards	1999	2,610		10			2,610	2
3	Seven Air Conditioners	2000	3,626		10			3,626	3
4	Air Conditioner	2000	1,508		10			1,508	4
5	Generator & Building	2000	303,007	7,579	40	7,575	(4)	90,317	5
6	Wall Carpet	2000	3,630		10			3,630	6
7	Carpeting	2000	21,956		10			21,956	7
8	Courtyard Improvements	2000	5,312		10	2	2	5,312	8
9	Courtyard improvements	1999	11,738		10			11,738	9
10	Air conditioner	2001	632	32	10	25	(7)	632	10
11	Lighting	2001	2,233		5			2,233	11
12	Attached wash stations	2001	849	42	10	52	10	849	12
13	Hot water heater	2001	939		5			939	13
14	Counter top	2001	550		10	50	50	550	14
15	Air conditioner	2001	9,725	486	20	486		5,062	15
16	Installation of sinks	2001	1,050	53	10	74	21	1,050	16
17	New dumpster door	2002	928	46	20	46		449	17
18	Flooring for 2002 addition and remodel	2002	85,333	4,267	20	4,267		38,403	18
19	2002 addition and remodel	2002	2,247,842	56,196	40	56,196		505,764	19
20	Room designation	2002	627	63	10	63		622	20
21	Water heater	2002	4,147		10	415	415	4,083	21
22	Drapes and blinds for dining, activity, therapy	2002	15,437	1,544	10	1,544		13,896	22
23	Courtyard sprinkler system	2002	8,800	880	10	880		8,434	23
24	Gravel driveway	2002	634		5			634	24
25	Landscaping for 2002 addition	2002	198,700	9,935	20	9,935		89,415	25
26	Sprinkler system for 2002 addition	2002	9,600	960	10	960		8,640	26
27	Surveillance camera	2003	1,750		5			1,750	27
28	Water heater	2003	4,965	496	10	497	1	4,392	28
29	Signage	2003	895	90	10	90		795	29
30	Valances	2003	662	66	10	66		578	30
31	Electrical work addition	2003	8,185	205	40	205		1,812	31
32	Addition painting	2003	5,289	132	40	132		1,156	32
33	Remodel breakroom	2003	3,085	154	20	154		1,348	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,308	\$ 151,893		\$ 152,860	\$ 967	\$ 3,167,175	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,396,308	\$ 151,893		\$ 152,860	\$ 967	\$ 3,167,175	1
2	Thermostats in addition	2003	560	56	10	56		476	2
3	Steel Doors	2003	1,095	55	20	55		463	3
4	Oxygen room exhaust fan	2003	2,062	52	40	52		433	4
5	Storm sewer work	2003	3,500	350	10	350		2,947	5
6	Door alert system	2004	1,342	134	10	134		1,061	6
7	Hot water heater	2004	2,977	298	10	298		2,111	7
8	Smoke detectors, roller latches, fire window	2004	8,913	797	13	686	(111)	5,431	8
9	Life safety, wall repair, carpeting	2004	9,202	633	15	613	(20)	4,805	9
10	Handrails	2004	1,472	147	10	147		1,140	10
11	Roofing	2004	6,500	325	20	325		2,466	11
12	Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		17,897	12
13	Carpeting room 255-257, office renovations	2004	13,647	683	20	682	(1)	4,832	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	485	17	491	6	3,437	14
15	Water softner for kitchen	2005	3,708	371	10	371		2,475	15
16	Cabinet for dining	2005	719	72	10	72		468	16
17	ADON office remodel	2005	1,841	92	20	92		629	17
18	Living room remodel	2005	1,615	81	20	81		554	18
19	Door for laundry room	2005	536	27	20	27		182	19
20	Water lines for water softner	2005	780	39	20	39		257	20
21	Central air conditioning unit	2005	4,902	245	20	245		1,594	21
22	Remodel tub rooms	2005	47,940	2,397	20	2,397		15,387	22
23	Kitchen hood and light fixtures	2005	9,076	454	20	454		2,876	23
24	Replace floor in walk-in cooler	2005	2,160	108	20	108		675	24
25	Doors for east hall room	2005	1,280	64	20	64		389	25
26	Wall carpet and corner guards	2005	2,278	176	15	152	(24)	925	26
27	Water Heater	2006	3,566	357	10	357		1,785	27
28	Hot water delivery system	2006	2,142	214	10	214		1,250	28
29	Carpeting	2006	969	97	10	97		558	29
30	Storage area	2006	1,228	123	10	123		708	30
31	Plumbing & electrical for diswasher	2006	1,089	109	10	109		581	31
32	Soffit work	2006	4,268	427	10	427		2,206	32
33	Floor & wall tiling	2006	13,669	683	20	683		3,529	33
34	TOTAL (lines 1 thru 33)		\$ 6,607,394	\$ 164,429		\$ 165,246	\$ 817	\$ 3,251,702	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,607,394	\$ 164,429		\$ 165,246	\$ 817	\$ 3,251,702	1
2	West entrance automatic door	2006	1,736	174	10	174		899	2
3	Sheltered care and tub room renovations	2006	16,029	801	20	801		4,073	3
4	Sealcoat front parking area	2006	420	42	5	63	21	420	4
5	Garbage Disposal	2007	942	188	5	188		815	5
6	Cabinets	2007	679	68	10	68		283	6
7	Draperies	2007	946	95	10	95		388	7
8	Automatic door	2007	4,979		10	498	498	2,448	8
9	Drywall in stairwell	2007	1,973	99	20	99		479	9
10	Sprinkler system	2007	802	40	20	40		194	10
11	Fireproofing of stairwell	2007	1,951	98	20	98		457	11
12	Carpeting & cabinets rm 200	2007	2,172	217	10	217		995	12
13	Fire panel	2007	2,311	231	10	231		1,001	13
14	Flooring rooms 134, 135, 136	2007	5,628	563	10	563		2,394	14
15	Flooring in quad	2007	52,194	2,610	20	2,610		10,876	15
16	Front entrance hallway renovations	2007	2,374	237	10	237		988	16
17	Exterior quad soffit replacement	2007	10,400	520	20	520		2,167	17
18	Smoke detectors	2007	569	57	10	57		228	18
19	Flooring	2007	2,910	291	10	291		1,164	19
20	Sprinkler system	2007	10,644	533	20	532	(1)	2,128	20
21	Fire grid ceiling	2008	1,725	86	20	86		337	21
22	Cabinetry in laundry	2008	561	56	10	56		219	22
23	Sprinkler system	2008	19,429	971	20	971		3,805	23
24	Air conditioning system	2008	2,300	115	20	115		374	24
25	Wood flooring install	2008	9,647	965	10	965		2,895	25
26	Doors for stairwell	2008	2,472	247	10	247		741	26
27	Wyse terminals	2008	2,546	535	5	509	(26)	1,994	27
28	Phone system install	2008	26,715	2,672	10	2,672		10,256	28
29	Draperies	2008	1,568	157	10	157		589	29
30	Tub for upstairs w.s. room	2009	15,241	1,524	10	1,524		3,557	30
31	Sprinklers, fire damper updates w/caulking	2009	13,436	1,232	12	1,120	(112)	3,179	31
32	Flooring rms 109,110,111,112	2009	5,800	580	10	580		1,597	32
33	Auto doors, elevator & phone, walls, floors east rms.	2009	267,524	13,608	20	13,376	(232)	34,594	33
34	TOTAL (lines 1 thru 33)		\$ 7,096,017	\$ 194,041		\$ 195,006	\$ 965	\$ 3,348,236	34

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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 7,096,017	\$ 194,041		\$ 195,006	\$ 965	\$ 3,348,236	1	
2	Water heater	2009 6,216	622	10	622		1,452	2	
3	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009 15,716	1,572	10	1,572		3,540	3	
4	Cabinets kitchen, water line n. hall & wing	2009 4,711	326	16	294	(32)	662	4	
5	Flooring rm 253	2009 1,845	185	10	185		386	5	
6	Exit lighting	2009 2,304	230	10	230		460	6	
7	Tub for upstairs east south room	2010 17,948	1,795	10	1,795		2,700	7	
8	Overhead & auto doors lawnshop & upeast entrance	2010 5,345	535	10	535		804	8	
9	Blinds, flooring, walls for 214-220, utility, nurse station	2010 482,556	25,532	20	24,128	(1,404)	36,291	9	
10	Flooring & wall tiles for upeastsouth hall spa rm	2010 7,140	714	10	714		1,074	10	
11	Flooring, walls, ceiling upeast library	2010 5,632	563	10	563		751	11	
12	Flooring, walls, ceiling for 101-108	2010 42,719	4,272	10	4,272		5,700	12	
13	A/C for main kitchen	2010 4,250	213	20	213		267	13	
14	Vinyl flooring for 240	2010 2,327	233	10	233		292	14	
15	Gutter coverings south & north sides	2010 3,475	231	15	232	1	290	15	
16	Water heaters	2010 8,157	816	10	816		885	16	
17	Flooring for downstairs E & W + nurse station	2011 42,244	1,056	20	1,933	877	1,933	17	
18	Repair boiler & zone valves 214 - 220	2011 4,461	223	10	408	185	408	18	
19	Vinyl flooring for 245 & 249	2011 4,494	225	10	150	(75)	150	19	
20	Bus garage and mezzanine	2011 112,089	1,982	30	624	(1,358)	624	20	
21	Water heater for kitchen	2011 5,769	288	10		(288)		21	
22	Walnut street directional signage	2011 1,025	103	5	154	51	154	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)	\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	34	

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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	34

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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	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
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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)		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	34

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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,876,440	\$ 235,757		\$ 234,679	\$ (1,078)	\$ 3,407,059	34

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

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	\$433,426	\$65,752	\$65,752	\$	10	\$294,632	71
72	Current Year Purchases	56,761	5,406	5,406		10	5,406	72
73	Fully Depreciated Assets	1,051,586					1,051,586	73
74								74
75	TOTALS	\$1,541,773	\$71,158	\$71,158	\$		\$1,351,624	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	1999	\$49,239	\$	\$	\$	10	\$49,239	76
77	Maintenance	98 Dodge Pickup	1999	13,280				10	13,280	77
78	Patient Transport	07 Chevy Van	2008	35,100	3,510	3,510		10	14,040	78
79	Patient Transport	05 Chevy bus	2005	46,122	4,612	4,612		10	32,284	79
80	TOTALS			\$143,741	\$8,122	\$8,122	\$		\$108,843	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$9,620,899	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$315,037	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$313,959	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(1,078)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,867,526	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments Various	\$406,331	\$5,489	\$369,426	86
87	Condos Various	1,434,595	39,027	773,811	87
88	Duplexes Various	985,437	26,293	834,908	88
89	Rental Units Various	702,998	1,658	8,520	89
90	Garages Various	35,248	1,325	30,231	90
91	TOTALS	\$3,564,609	\$73,792	\$2,016,896	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$265,606	92
93			93
94			94
95		\$265,606	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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

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

C. Vehicle Rental (See instructions.)

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ 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

☒

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER CNA

80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☒

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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		8,446	2,043	10,489
8	CNA Competency Tests		1,020	300	1,320
9	TOTALS	\$	\$ 9,466	\$ 2,343	\$ 11,809
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,466			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$4,438

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	17
2. From other facilities (f)	5
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	1
TOTAL TRAINED	24

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
			Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	305	\$ 26,375	\$	305	\$ 26,375	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		471	30,127		471	30,127	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		367	31,728		367	31,728	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				51,011		51,011	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					33,559		33,559	13
14	TOTAL			\$	1,143	\$ 88,230	\$ 84,570	1,143	\$ 172,800	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,005,632	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	667,649		3
4	Supply Inventory (priced at FIFO)	49,450		4
5	Short-Term Investments			5
6	Prepaid Insurance	75,555		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,798,286	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	981,693		13
14	Buildings, at Historical Cost	10,316,770		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,080,490		16
17	Accumulated Depreciation (book methods)	(6,881,643)		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	265,606		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,762,916	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,561,202	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 297,643	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,122		30
31	Accrued Taxes Payable (excluding real estate taxes)	50,111		31
32	Accrued Real Estate Taxes(Sch.IX-B)	123		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	134,281		36
37	Life Lease Deferred Income	155,042		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 889,322	\$	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	Life Lease Equity	2,103,549		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,103,549	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,992,871	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,568,331	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,561,202	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,935,867	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,935,867	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	632,464	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)	\$ 632,464	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)	\$ 8,568,331	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,049,447	1
2	Discounts and Allowances for all Levels	(453,876)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,595,571	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	439,224	6
7	Oxygen	23,461	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 462,685	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,489	13
14	Non-Patient Meals	23,938	14
15	Telephone, Television and Radio	9,463	15
16	Rental of Facility Space		16
17	Sale of Drugs	65,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,102	19
20	Radiology and X-Ray		20
21	Other Medical Services	137,147	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 270,110	23
	D. Non-Operating Revenue		
24	Contributions	363,342	24
25	Interest and Other Investment Income****	61,064	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 424,406	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,974	28
28a	Non-Care Facility	252,182	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 254,156	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,006,928	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,443,481	31
32	Health Care	3,657,442	32
33	General Administration	1,546,101	33
	B. Capital Expense		
34	Ownership	397,970	34
	C. Ancillary Expense		
35	Special Cost Centers	160,662	35
36	Provider Participation Fee	168,808	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,374,464	40
41	Income before Income Taxes (line 30 minus line 40)**	632,464	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 632,464	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,160	2,160	\$ 73,274	\$ 33.92	1
2	Assistant Director of Nursing	1,872	1,872	53,670	28.67	2
3	Registered Nurses	28,647	30,946	910,740	29.43	3
4	Licensed Practical Nurses	17,318	19,066	406,653	21.33	4
5	CNAs & Orderlies	108,602	118,711	1,592,205	13.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,212	3,590	57,820	16.11	8
9	Activity Director	2,080	2,080	31,402	15.10	9
10	Activity Assistants	15,435	17,006	173,060	10.18	10
11	Social Service Workers	3,684	3,826	67,668	17.69	11
12	Dietician					12
13	Food Service Supervisor	3,691	3,787	66,399	17.53	13
14	Head Cook	4,021	4,425	56,015	12.66	14
15	Cook Helpers/Assistants	11,351	12,066	136,077	11.28	15
16	Dishwashers	9,418	10,097	102,838	10.19	16
17	Maintenance Workers	6,426	7,007	130,810	18.67	17
18	Housekeepers	10,754	11,814	125,680	10.64	18
19	Laundry	12,048	13,190	141,417	10.72	19
20	Administrator	1,826	1,826	98,338	53.85	20
21	Assistant Administrator					21
22	Other Administrative	8,886	9,628	96,089	9.98	22
23	Office Manager	1,826	1,826	71,172	38.98	23
24	Clerical	1,609	1,769	17,771	10.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,866	276,692	\$ 4,409,098 *	\$ 15.94	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	202	\$ 8,900	1.3	35
36	Medical Director	24	4,800	9.3	36
37	Medical Records Consultant	36	2,355	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	82	8,225	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	3	202	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	244	10a.3	43
44	Activity Consultant	6	288	11.3	44
45	Social Service Consultant	6	288	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	\$ 25,302		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides			10.3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Thomas A. Hoffman		Administrator		\$ 112,036	Workers' Compensation Insurance		\$ 131,397	IDPH License Fee		\$ 205	
Kim Joos		Business Manager		81,084	Unemployment Compensation Insurance			Advertising: Employee Recruitment		12,223	
					FICA Taxes		322,581	Health Care Worker Background Check		1,404	
					Employee Health Insurance		416,562	(Indicate # of checks performed 63)			
					Employee Meals			Patient Background Checks 80		800	
					Illinois Municipal Retirement Fund (IMRF)*			Life Services Network Dues		7,012	
					Hepatitis Immunization		450	Journal Star & Pantagraph Newspaper		1,119	
					Employee Life/Disability		8,442	Nursing Manuals & Oth Subscriptions		635	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 193,120	Employee Physicals		10,684	Other Membership Dues \ Licenses		3,407	
(List each licensed administrator separately.)					Uniform Allowance			Activity Manuals & Oth Subscriptions		227	
B. Administrative - Other					Tax Deferred Annuity		101,765	Less: Public Relations Expense (			
Description				Amount	Non-Care Employee Benefits		(11,217)	Non-allowable advertising		(7,596)	
				\$	Rounding		1	Yellow page advertising (			
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 980,665	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,436	
					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
TOTAL (agree to Schedule V, line 17, col. 3)				\$	Description	Line #	Amount	Description		Amount	
(Attach a copy of any management service agreement)							\$	Out-of-State Travel		\$	
C. Professional Services											
Vendor/Payee		Type		Amount							
Heinald Banwart		Accounting		\$ 11,000							
J.L. Hubbard Insurance		Surety Bond		200							
Robert Rein, CPA		Consulting		5,086							
Benefit Planning Consultants		Consulting		5,660				In-State Travel		894	
Polsinelli Shughart - Matthew Murer		Legal									
FR&R Healthcare		Consulting		252							
Heyl, Royster, Voelker & Allen		Legal		75							
West Bend Mutual		Surety Bond		347				Seminar Expense		14,300	
Reclassifications				123							
Rounding								Entertainment Expense (			
					TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)				\$ 22,743				TOTAL		\$ 15,194	
(If total legal fees exceed \$5,000, attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>Life Services Network Dues</u> <u>7,012</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>6</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>45,583</u> Line <u>10.2</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>168,808</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>23,938</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> 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? <u>100%</u>
d. Have vehicle usage logs been maintained? <u>Yes</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u></p> <p>(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? <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
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