

		FOR BHF 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: <u>0021493</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>APOSTOLIC CHRISTAIN HOME OF ROANOKE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01012011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1102 W. RANDOLPH ST.</u> <u>ROANOKE</u> <u>61561</u>																									
Number City Zip Code																									
County: <u>WOODFORD</u>																									
Telephone Number: <u>309-923-2071</u> Fax # <u>309-923-7919</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>RICHARD D. ISAIA</u></td></tr><tr><td>(Title) <u>ADMINISTRATOR</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>RICHARD D. ISAIA</u>	(Title) <u>ADMINISTRATOR</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>RICHARD D. ISAIA</u>																								
	(Title) <u>ADMINISTRATOR</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>05/05/1975</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY,NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>RICHARD D. ISAIA</u>																									
Telephone Number: <u>309-923-2071</u> Email Address: _____																									

Facility Name & ID Number APOSTOLIC CHRISTAIN HOME OF ROANOKE

0021493 Report Period Beginning: 01012011 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 02-01-2011

	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>61</u>	Skilled (SNF)	<u>60</u>	<u>21,931</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>61</u>	TOTALS	<u>60</u>	<u>21,931</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,993</u>	<u>8,573</u>	<u>2,185</u>	<u>20,751</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,993</u>	<u>8,573</u>	<u>2,185</u>	<u>20,751</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.62%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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 05/05/1975

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 31 and days of care provided 2,185

Medicare Intermediary WISCONSIN PHYSICIAN SERVICE (WPS)

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

APOSTOLIC CHRISTAIN HOME OF ROA

#

0021493

Report Period Beginning:

01012011

Ending:

12/31/2011

Page 3

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	279,020	24,279	15,159	318,458		318,458		318,458			1
2	Food Purchase		165,114		165,114		165,114	(5,632)	159,482			2
3	Housekeeping	168,032	8,620	6,063	182,715		182,715		182,715			3
4	Laundry	80,792	2,738	4,046	87,576		87,576		87,576			4
5	Heat and Other Utilities			81,367	81,367		81,367		81,367			5
6	Maintenance	62,969	38,239	48,784	149,992		149,992		149,992			6
7	Other (specify):*		9,418	146,376	155,794		155,794	(155,794)				7
8	TOTAL General Services	590,813	248,408	301,795	1,141,016		1,141,016	(161,426)	979,590			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,595,268	232,276	109,362	1,936,906		1,936,906		1,936,906			10
10a	Therapy	119,134	2,332	21,841	143,307		143,307		143,307			10a
11	Activities	96,717	15,865	1,804	114,386		114,386		114,386			11
12	Social Services	43,118	524	(394)	43,248		43,248		43,248			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,854,237	250,997	132,613	2,237,847		2,237,847		2,237,847			16
	C. General Administration											
17	Administrative	77,382			77,382		77,382		77,382			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			36,540	36,540		36,540		36,540			20
21	Clerical & General Office Expenses	172,635	20,361	42,464	235,460		235,460	(5,986)	229,474			21
22	Employee Benefits & Payroll Taxes			554,080	554,080		554,080		554,080			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,346	36,346		36,346		36,346			26
27	Other (specify):*											27
28	TOTAL General Administration	250,017	20,361	669,430	939,808		939,808	(5,986)	933,822			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,695,067	519,766	1,103,838	4,318,671		4,318,671	(167,412)	4,151,259			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			343,479	343,479		343,479	(172,389)	171,090			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,443	10,443		10,443	(10,440)	3			32
33	Real Estate Taxes			569	569		569	(569)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			354,491	354,491		354,491	(183,398)	171,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			7,739	7,739		7,739		7,739			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				30,106		30,106		30,106			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			7,739	37,845		37,845		37,845			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,695,067	519,766	1,466,068	4,711,007		4,711,007	(350,810)	4,360,197			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	(5,632)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,986)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(10,440)	32		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				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,058)		\$	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	328,752		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 328,752		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 350,810		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		76,203	10B	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 76,203		47

Report Period Beginning: ID# 0021493

Ending: 01012011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	NON-ALLOWABLE REAL ESTATE TAXES	\$ (569)	33	1
2	COUNTRY VIEW EXPENSES	(122,393)	7	2
3	COUNTRY VIEW DEPRECIATION	(45,316)	30	3
4	DUPLEX EXPENSES	(33,401)	7	4
5	DUPLEX DEPRECIATION	(127,073)	30	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(328,752)		49

Summary A

12/31/2011

[illegible]

Summary B

Facility Name & ID Number	APOSTOLIC CHRISTAIN HOME OF ROANOKE	#	0021493	Report Period Beginning:	01012011	Ending:	12/31/2011
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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 % NONE	Name	City	Name	City	Type of Business

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

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	NONE								\$		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 CHRISTAIN HOME OF ROANOKE # 0021493 Report Period Beginning: 01012011 Ending: 2/31/2011

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

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	APOSTOLIC CHRISTIAN	X		COVERAGE FOR STATE	NONE	Various	\$ 359,000	\$ 200,000	unknown		\$	1	
2	CHURCH			SHORTFALL								2	
3												3	
4												4	
5												5	
	Working Capital												
6	MORTON COMMUNITY		X	WORKING CAPITAL	Various	Various			unknown	5.0000	3	6	
7	BANK			STATE SHORTFALL								7	
8												8	
9	TOTAL Facility Related						\$ 359,000	\$ 200,000			\$ 3	9	
	B. Non-Facility Related*												
10	COMMERCE BANK		X	COUNTRY VIEW LOAN	\$7,800.00	3/28/00	875,000	201,892	04/10/14	4.1660	10,440	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related				\$7,800.00		\$ 875,000	\$ 201,892			\$ 10,440	14	
15	TOTALS (line 9+line14)						\$ 1,234,000	\$ 401,892			\$ 10,443	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
ALL REAL ESTATE TAXES ARE NON-ALLOWABLE AND ARE ADJUSTED OUT ON SCHEDULE V.		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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTAIN HOME OF ROANOKE COUNTY WOODFORD

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT RICHARD D. ISAIA ADMINISTRATOR

TELEPHONE 309-923-2071 FAX #: 309-923-7919

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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.				\$		\$	
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?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,601

B. General Construction Type: Exterior BRICK

Frame BLOCK & WOOD

Number of Stories ONE

C. Does the Operating Entity?

☒ (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).

APOSTOLIC CHRISTIAN HOME OF ROANOKE DUPLEXES - 20 UNITS

APOSTOLIC CHRISTIAN HOME OF ROANOKE COUNTRY VIEW APARTMENTS - INDEPENDENT LIVING APARTMENTS - 14 UNITS

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BLDG. & GROUNDS	100,000	1975	\$ 35,875	1
2					2
3	TOTALS	100,000		\$ 35,875	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	61		1975	1958	\$ 202,000	\$	30	\$	\$	202,000
5			1976	1976	22,708		30			22,708
6			1991	1991	671,286	22,376	30	22,376		449,385
7			1992	1992	129,607	4,469	30	4,469		87,145
8										
	Improvement Type**									
9	Land & Bldg Improvements			1976	105,004					
10				1977	6,591					
11				1978	10,960					
12				1979	9,124					
13				1980	8,166					
14				1981	6,506					
15				1982	18,087					
16				1983	36,023					
17				1984	12,947					
18				1985	13,333		VARIOUS			577,013
19				1986	8,595					
20				1987	87,248					
21				1988	43,526					
22				1989	64,604					
23				1990	11,217					
24				1991	3,700					
25				1992	5,410					
26				1993	36,135					
27				1994	14,661					
28				1995	30,372					
29	Soiled Utility Remodeling			1996	680					680
30	Fixed TV Monitoring System			1996	278					278
31	Remodel 14 East			1996	2,781					2,781
32	New Sidewalk			1996	1,375					1,375
33	Room Remodeling (9,21,17)			1997	11,487					11,487
34	Room Remodeling (11,8,10,19,5,6)			1997	17,049					17,049
35										
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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FIRE ALARM SYSTEM COSTS	1998	\$ 12,671	\$	7	\$		\$ 12,671	37
38	ROOM REMODELING (3,12,14)	1998	13,953		7			13,953	38
39	GAS LINE WORK	1998	1,033		7			1,033	39
40	PARKING LOT	1998	19,397		7			19,397	40
41	COURTYARD	1998	15,971		7			15,971	41
42	FIRE ALARM SYSTEM COSTS	1999	87,698		7			87,698	42
43	CALL LIGHT SYSTEM COSTS	1999	40,500		7			40,500	43
44	EAST ROOM REMODELING	1999	23,345		7			23,345	44
45	PT RESTROOM REMODELING	1999	605		7			605	45
46	MULTI-PURPOSE ROOM REMODELING	1999	1,438		7			1,438	46
47	SPRINKLER SYSTEM ADDITIONS	1999	3,166		7			3,166	47
48	STORM SEWER WORK	1999	2,396		7			2,396	48
49	DOOR ALARM SYSTEM	1999	2,075		7			2,075	49
50	WEST STATION ARCHITECT FEES	1999	4,742		7			4,742	50
51	EAST SIDE STATION REMODELING	2000	43,536		7			43,536	51
52	WEST SIDE STATION	2000	4,637		7			4,637	52
53	CALL LIGHT SYSTEM COSTS	2000	11,500		7			11,500	53
54	DOOR ALARM SYSTEM REMODEL	2000	2,093		7			2,093	54
55	RESIDENT ROOM REMODEL	2000	7,066		7			7,066	55
56	LANDSCAPING	2000	3,152		7			3,152	56
57	WATER MAIN EXTENSION	2000	1,675		7			1,675	57
58	SPRINKLER WORK	2001	19,622		7			19,622	58
59	NURSING AND SOCIAL SERVICE OFFICES	2001	1,587		7			1,587	59
60	NEW PARKING AREA	2001	2,363		7			2,363	60
61	ROOM REMODELING (12W)	2001	2,612		7			2,612	61
62	NEW WATER LINES	2001	4,581		7			4,581	62
63	ROOM REMODELED (8W)	2001	3,422		7			3,422	63
64	TUB ROOM ROOF	2001	27,941		7			27,941	64
65	WEST TUB REMODEL	2001	25,454		7			25,454	65
66	EAST HALL REMODEL	2001	23,052		7			23,052	66
67	EAST PARK AREA	2001	1,687		7			1,687	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,006,430	\$ 26,845		\$ 26,845	\$	\$ 1,786,871	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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,006,430	\$ 26,845		\$ 26,845	\$	\$ 1,786,871	1
2	VINYL FLOORING - HSKG	2002	1,001		7			1,001	2
3	NURSING OFFICE	2002	1,068		7			1,068	3
4	EAST HALL REMODEL	2002	12,749		7			12,749	4
5	DELAYED EGRESS LOCK	2002	1,934		7			1,934	5
6	ROOM 5 REMODEL	2002	2,999		7			2,999	6
7	ROOM REMODEL	2002	3,173		7			3,173	7
8	WATER LINE REPAIRS	2002	15,959		7			15,959	8
9	TUB ROOM REMODEL	2002	235,862		7			235,862	9
10	WEST NURSES STATION	2003	21,472		7			21,472	10
11	WATER LINE REPAIRS	2003	4,424		7			4,424	11
12	ROOM REMODEL - 2 ROOMS	2003	3,808		7			3,808	12
13	NORTH CEILING REPAIR	2003	2,980		7			2,980	13
14	MIXING VALVES	2003	679		7			679	14
15	BASEMENT STAIRS	2003	6,956		7			6,956	15
16	CANOPY SPRINKLER	2003	1,425		7			1,425	16
17	ALARM SYSTEMS	2003	3,017		7			3,017	17
18	MECHANICAL ROOM WORK	2003	2,907		7			2,907	18
19	SPRINKLER IMPROVEMENTS	2003	6,428		7			6,428	19
20	LANDSCAPING SIDEWALK	2003	4,741		7			4,741	20
21	DRYWALL REPAIR/FIRE DRYWALL	2004	13,476	964	7	964		13,476	21
22	FIRE DAMPERS	2004	2,100	150	7	150		2,100	22
23	EXIT LIGHTS	2004	4,011	287	7	287		4,011	23
24	DRAIN LINES - EAST WING	2004	1,504	113	7	113		1,504	24
25	ELEVATOR WORK	2004	8,359	598	7	598		8,359	25
26	CONCRETE EXIT	2004	850	63	7	63		850	26
27	NORTH BASEMENT IMPROVEMENTS	2004	15,554	1,111	7	1,111		15,554	27
28	FENCING	2004	10,980	782	7	782		10,980	28
29	PLUMBING UPDATE	2004	3,949	283	7	283		3,949	29
30	KITCHEN FLOOR	2004	3,713	268	7	268		3,713	30
31	GENERATOR SHED - ELECTRIC	2004	2,380	170	7	170		2,380	31
32	BASEMENT ELECTRIC PANELS	2004	1,056	81	7	81		1,056	32
33	WEST HALL & DINING ROOM	2004	6,600	471	7	471		6,600	33
34	TOTAL (lines 1 thru 33)		\$ 2,414,544	\$ 32,186		\$ 32,186	\$	\$ 2,194,985	34

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

Facility Name & ID Number APOSTOLIC CHRISTAIN HOME OF ROANOKE

0021493

Report Period Beginning:

01012011

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 12B, Carried Forward		\$ 2,414,544	\$ 32,186		\$ 32,186	\$	\$ 2,194,985	1
2	KTICHEN STEAMER WIRING	2004	614	42	7	42		614	2
3	MAINTENANCE SHED	2004	34,020	2,430	7	2,430		34,020	3
4	CANOPY SPRINKLER REPAIR	2004	2,696	194	7	194		2,696	4
5	NEW FLOOR 18W	2005	1,750	250	7	250		1,625	5
6	DRYWALL STATE SURVEY	2005	8,016	1,145	7	1,145		7,442	6
7	AC RELOCATE	2005	448	64	7	64		416	7
8	WEST SIDE PLUMBING	2005	4,108	587	7	587		3,815	8
9	DINING REMODEL	2005	67,687	9,670	7	9,670		62,855	9
10	WATER LINE REPAIR	2006	728	104	7	104		572	10
11	DINING INSTALLATION	2006	850	121	7	121		666	11
12	WEST FLOOR JOIST WORK	2006	2,315	330	7	330		1,815	12
13	CANOPY UPGRADE SPRINKLER	2006	4,866	695	7	695		3,823	13
14	WEST STEPS RETAINING WALL	2006	700	100	7	100		550	14
15	SPRINKLER SYSTEM REPAIRS	2006	1,524	218	7	218		1,199	15
16	LAUNDRY PLUMING UPGRADE	2006	1,840	263	7	263		1,446	16
17	ROOM 12 REMODEL	2006	926	132	7	132		726	17
18	SIDEWALK	2007	1,008	144	7	144		648	18
19	WATER LINE REPAIRS	2007	3,300	471	7	471		2,120	19
20	NORTH END FIRE DAMPERS	2007	11,784	1,683	7	1,683		7,574	20
21	KITCHEN REMODEL	2007	92,132	13,084	7	13,084		58,793	21
22	WATER LINES WEST WING	2007	1,234	176	7	176		792	22
23	BASEMENT DOORS	2007	2,605	372	7	372		1,674	23
24	SIDEWALK DOOR H	2008	16,218	1,622	10	1,622		5,677	24
25	FRONT SEWER REPAIR	2008	4,216	422	10	422		1,477	25
26	EXIT LIGHT UPGRADE	2008	1,089	156	7	156		545	26
27	REPIPING KITCHEN HOT WATER	2008	1,658	236	7	236		826	27
28	KITCHEN DOOORS	2008	12,848	1,835	7	1,835		6,422	28
29	ROOM 9 REMODEL	2008	2,289	327	7	327		1,144	29
30	SOUTH BASEMENT UPGRADE	2008	3,404	486	7	486		1,701	30
31	ACTIVITY CANOPY SPRINKLER	2008	1,295	185	7	185		647	31
32	BASEMENT SEWER IMPROVEMENT	2008	4,282	612	7	612		2,141	32
33	PLUMBING UPGRADE	2008	6,072	867	7	867		3,034	33
34	TOTAL (lines 1 thru 33)		\$ 2,713,066	\$ 71,209		\$ 71,209	\$	\$ 2,414,480	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 12C, Carried Forward		\$ 2,713,066	\$ 71,209		\$ 71,209	\$	\$ 2,414,480	1
2 MAINT. GARAGE SEWER HOOK-UP	2008	1,075	153	7	153		535	2
3 PLUMBING UPGRADE	2009	368	52	7	52		130	3
4 ROOF PROJECT	2009	68,922	2,297	30	2,297		5,743	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)		\$ 2,783,431	\$ 73,711		\$ 73,711	\$	\$ 2,420,888	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	\$388,033	\$80,047	\$80,047	\$	5	\$272,086	71
72	Current Year Purchases	208,429	14,508	14,508		5	14,508	72
73	Fully Depreciated Assets	932,890				5	932,890	73
74								74
75	TOTALS	\$1,529,352	\$94,555	\$94,555	\$		\$1,219,484	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	RESIDENT TRIPS	FORD BUS	1999	\$49,239	\$	\$	\$	5	\$49,239	76
77	RESIDENT TRIPS	FORD MONTANA	2005	12,500				5	12,500	77
78	RESIDENT TRIPS	BEAU VAN	2009	1,964	393	393		5	982	78
79	RESIDENT TRIPS	DODGE CARAVAN	2011	48,628	2,431	2,431		10	2,431	79
80	TOTALS			\$112,331	\$2,824	\$2,824	\$		\$65,152	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)	\$4,460,989	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$171,090	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$171,090	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,705,524	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	DUPLEXES	\$2,719,374	\$90,685	\$1,045,715	86
87	COUNTRY VIEW APARTMENTS	1,097,269	23,426	290,829	87
88	DUPLEX FIXTURES	121,960	12,250	80,317	88
89	COUNTRY VIEW FURN & FIX	191,835	21,890	128,823	89
90	DUPLEX LAND IMPROVEMENTS	466,751	24,138	203,822	90
91	TOTALS	\$4,597,189	\$172,389	\$1,749,506	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE
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.

		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.

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

☐

☒

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☒

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	NONE	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ 86,327	\$	1
2	Cash-Patient Deposits	203		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	784,562		3
4	Supply Inventory (priced at)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,402		6
7	Other Prepaid Expenses	(219)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 909,275	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,603		13
14	Buildings, at Historical Cost	7,027,002		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,886,845		16
17	Accumulated Depreciation (book methods)	(5,457,494)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,580,956	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,490,231	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,333	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	203		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,017		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,957		31
32	Accrued Real Estate Taxes(Sch.IX-B)	615		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)	\$ 276,125	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	580,190		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUPLEX EQUITY	2,330,841		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,911,031	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,187,156	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,303,075	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,490,231	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,067,481	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,067,481	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(259,062)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	494,656	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)	\$ 235,594	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)	\$ 1,303,075	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,445,108	1
2	Discounts and Allowances for all Levels	(1,015,592)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,429,516	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	9,195	13
14	Non-Patient Meals	5,632	14
15	Telephone, Television and Radio	5,986	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,616	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,616	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,451,945	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,141,016	31
32	Health Care	2,237,847	32
33	General Administration	939,808	33
	B. Capital Expense		
34	Ownership	354,491	34
	C. Ancillary Expense		
35	Special Cost Centers	7,739	35
36	Provider Participation Fee	30,106	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,711,007	40
41	Income before Income Taxes (line 30 minus line 40)**	(259,062)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (259,062)	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	1,960	2,080	\$ 64,448	\$ 30.98	1
2	Assistant Director of Nursing	1,487	1,653	50,171	30.35	2
3	Registered Nurses	14,309	15,298	404,981	26.47	3
4	Licensed Practical Nurses	5,572	5,940	146,583	24.68	4
5	CNAs & Orderlies	61,232	65,402	929,085	14.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,053	5,621	119,134	21.19	8
9	Activity Director	1,982	2,207	33,910	15.36	9
10	Activity Assistants	5,241	5,598	62,807	11.22	10
11	Social Service Workers	3,157	3,394	43,118	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,811	2,080	45,493	21.87	13
14	Head Cook	7,151	8,029	103,314	12.87	14
15	Cook Helpers/Assistants	11,826	12,516	130,213	10.40	15
16	Dishwashers					16
17	Maintenance Workers	2,028	2,263	62,969	27.83	17
18	Housekeepers	13,336	13,898	137,088	9.86	18
19	Laundry	6,545	6,991	80,792	11.56	19
20	Administrator	1,847	2,080	77,382	37.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,605	10,644	172,635	16.22	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) HSG SUPER	1,952	2,032	30,944	15.23	33
34	TOTAL (lines 1 - 33)	156,094	167,726	\$ 2,695,067 *	\$ 16.07	34

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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberAPOSTOLIC CHRISTAIN HOME OF ROANOKE# 0021493Report Period Beginning: 01012011Ending: 12/31/2011Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RICHARD D. ISAIA	ADMIN.	0	\$ 77,382
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,382

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
MDI ACHIEVE	COMP. SERVICES	\$ 12,998
HOWARD & HOWARD	LEGEL SERVICES	7,811
HEINOLD BANWART	ACCTG. SERVICES	6,464
ROUTE 24 COMPUTERS	COMP. SERVICES	5,283
ROBERT REIN	ACCTG. SERVICES	2,700
MEDIACOM	COMP. SERVICES	879
MICHAEL ARENDS	COMP. SERVICES	405
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 36,540

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 63,010
Unemployment Compensation Insurance	1,390
FICA Taxes	195,385
Employee Health Insurance	294,295
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

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.

AAHSA \$1223, LSN \$2880
- (3)

Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

5
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

41,269

Line

10
- (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.

\$

30,106

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.

\$

NONE

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$

5,632
- (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.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

NONE

d. Have vehicle usage logs been maintained?

NO

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?

NONE

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.

\$

NONE
- (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?

NO

Attach invoices and a summary of services for all architect and appraisal fees.