

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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>100</u>	Skilled (SNF)	<u>100</u>	<u>36,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD		-	4
5	<u>9</u>	Sheltered Care (SC)	<u>9</u>	<u>3285</u>	5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	1166		2516		27492	472	468	32,114	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	-								11
12	SC					2383			2,383	12
13	DD 16 OR LESS									13
14	TOTALS	1,166		2,516		29,875	472	468	34,497	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 86.71%D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Apartment, Duplex, CondominiumF. Does the facility maintain a daily midnight census? YesG. 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 certified beds.
number of certified beds 100Medicare 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: 12/31/2025 Fiscal Year: 12/31/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	Dietary	705,144	27,914	27,161	760,219		760,219		760,219		1
2	Food Purchase		419,905		419,905		419,905	(39,940)	379,965		2
3	Housekeeping	183,905	54,302	2,133	240,340		240,340	(11,798)	228,542		3
4	Laundry	154,784	13,884	3,618	172,286		172,286		172,286		4
5	Heat and Other Utilities			342,154	342,154		342,154	(85,340)	256,814		5
6	Maintenance	276,752	22,715	164,730	464,197		464,197	(68,870)	395,327		6
7	Other (specify):*										7
8	TOTAL General Services	1,320,585	538,720	539,796	2,399,101		2,399,101	(205,948)	2,193,153		8
9	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	4,918,908	72,969	100,731	5,092,608	26,714	5,119,322		5,119,322		10
10a	Therapy	142,697	1,540	176,937	321,174		321,174	(1,324)	319,850		10a
11	Activities	341,265	7,634	12,750	361,649		361,649	(1,597)	360,052		11
12	Social Services	64,134	460	2,843	67,437		67,437		67,437		12
13	CNA Training					29,317	29,317		29,317		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,467,004	82,603	298,061	5,847,668	56,031	5,903,699	(2,921)	5,900,778		16
17	C. General Administration										
17	Administrative	293,247			293,247		293,247	(16,110)	277,137		17
18	Directors Fees										18
19	Professional Services			10,521	10,521	5,603	16,124		16,124		19
20	Dues, Fees, Subscriptions & Promotions			72,999	72,999	(77)	72,922	(15,235)	57,687		20
21	Clerical & General Office Expenses	389,178	15,030	210,018	614,226	(7,501)	606,725	(14,317)	592,408		21
22	Employee Benefits & Payroll Taxes			1,601,319	1,601,319		1,601,319	(6,869)	1,594,450		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,174	16,174	1,975	18,149		18,149		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			209,919	209,919		209,919	(41,128)	168,791		26
27	Other (specify):*										27
28	TOTAL General Administration	682,425	15,030	2,120,950	2,818,405		2,818,405	(93,659)	2,724,746		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,470,014	636,353	2,958,807	11,065,174	56,031	11,121,205	(302,528)	10,818,677		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.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
30	Depreciation			662,883	662,883		662,883	(149,404)	513,479			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			41,928	41,928		41,928	(41,928)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			704,811	704,811		704,811	(191,332)	513,479			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,384	1,034	149,418	(56,031)	93,387		93,387			39
40	Barber and Beauty Shops			24,469	24,469		24,469		24,469			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			293,383	293,383		293,383		293,383			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		148,384	318,886	467,270	(56,031)	411,239		411,239			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,470,014	784,737	3,982,504	12,237,255		12,237,255	(493,860)	11,743,395			45

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

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Reference	BHF USE ONLY	
1	NON-ALLOWABLE EXPENSES			
1	Day Care	\$	\$	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(35,097)	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	5,267	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		13	27
28	Yellow Page Advertising	(15,235)	20.3	28
29	Other-Attach Schedule	(448,795)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (493,860)	\$	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	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (493,860)	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.

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x	\$		38
39					39
40	Gift and Coffee Shops	x			40
41	Barber and Beauty Shops	x			41
42	Laboratory and Radiology	x			42
43	Prescription Drugs	x			43
44		x			44
45	Other-Attach Schedule	x			45
46	Other-Attach Schedule	x			46
47	TOTAL (C): (sum of lines 38-46)		\$		47

VII. RELATED PARTIES

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

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

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

☐ YES
☒ NO

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

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

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

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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:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____Fax Number () _____

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2					-							2	
3					-							3	
4					-							4	
5					-							5	
	Working Capital												
6					-							6	
7					-						-	7	
8					-							8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

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

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

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

Facility Name & ID Number **Apostolic Christian Home of Eureka**# **0012328** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 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 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2024 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION\$ 16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Apostolic Christian Home of Eureka</u>	COUNTY	<u>Woodford</u>
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FACILITY IDPH LICENSE NUMBER 0012328

CONTACT PERSON REGARDING THIS REPORT Kimberly S. Joos

TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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: 44,259

B. General Construction Type:
 Exterior Brick
 Frame Protected Ord. & Fire Resistance
 Number of Stories Two

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

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

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

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

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

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES NO ☒
 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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

YES
 NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2025

Ending:

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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		40			605,234	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	1,223,586	6
7	4		1994	1994	226,582	3,954	39	5,810	1,856	180,200	7
8				1989	3,512		20			3,512	8
	Improvement Type**										
9	Building & land improvements - '67 - '90			1967	222,229		40			222,229	9
10	Building & land improvements - '92			1992	16,565		20			16,565	10
11	Building & land improvements - '93			1993	4,470		20			4,470	11
12	Office Addition			1994	57,234	1,431	39	1,468	37	46,489	12
13	Building & land improvements - '94			1994	24,711		20			24,711	13
14	Building & land improvements - '95			1995	53,207		20			53,207	14
15	Building & land improvements - '96			1996	47,626		20			47,626	15
16	Building & land improvements - '97			1997	3,535		10			3,535	16
17	Hall Remodeling			1997	16,641		20			16,641	17
18	Building & land improvements - '98			1998	7,862		10			7,862	18
19	Building & land improvements - '99			1999	26,225		10			26,225	19
20	Generator & Building			2000	303,007	7,579	40	7,575	(4)	196,367	20
21	Building & land improvements - '00			2000	14,076		10			14,076	21
22	Air conditioner			2001	9,725		20			9,725	22
23	Building & land improvements - '01			2001	5,314		10			5,314	23
24	New dumpster door			2002	928		20			928	24
25	Flooring for 2002 addition and remodel			2002	85,333		20			85,333	25
26	2002 addition and remodel			2002	2,247,842	56,196	40	56,196		1,292,508	26
27	Landscaping for 2002 addition			2002	198,700		20			198,700	27
28	Building & land improvements - '02			2002	35,098		10			35,098	28
29	Electrical work addition			2003	8,185	205	40	205		4,682	29
30	Addition painting			2003	5,289	132	40	132		3,004	30
31	Remodel breakroom			2003	3,085		20			3,085	31
32	Steel Doors			2003	1,095		20			1,095	32
33	Oxygen room exhaust fan			2003	2,062	52	40	52		1,161	33
34	Building & land improvements - '03			2003	7,367		10			7,367	34
35	Door alert system			2004	1,342		10			1,342	35
36	Smoke detectors, roller latches, fire window			2004	8,913		13			8,913	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
Improvement Type**								
37 Life safety, wall repair, carpeting	2004	\$ 9,202	\$	15	\$	\$	\$ 9,202	37
38 Handrails	2004	1,472		10			1,472	38
39 Roofing	2004	6,500		20			6,500	39
40 Remodel tubroom, room 121 & 123, hallways	2004	47,702		20			47,702	40
41 Carpeting room 255-257, office renovations	2004	13,647		20			13,647	41
42 Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348		17			8,348	42
43 Water softner for kitchen	2005	3,708		10			3,708	43
44 Cabinet for dining	2005	719		10			719	44
45 ADON office remodel	2005	1,841	46	20	16	(30)	1,841	45
46 Living room remodel	2005	1,615		20	8	8	1,615	46
47 Door for laundry room	2005	536	13	20	3	(10)	536	47
48 Water lines for water softner	2005	780	20	20	16	(4)	780	48
49 Central air conditioning unit	2005	4,902	123	20	123		4,902	49
50 Remodel tub rooms	2005	47,940	1,199	20	1,392	193	47,940	50
51 Kitchen hood and light fixtures	2005	9,076	227	20	298	71	9,076	51
52 Replace floor in walk-in cooler	2005	2,160	54	20	81	27	2,160	52
53 Doors for east hall room	2005	1,280	32	20	59	27	1,280	53
54 Wall carpet and corner guards	2005	2,278	26	15		(26)	2,278	54
55 Hot water delivery system	2006	2,142		10			2,142	55
56 Carpeting	2006	969		10			969	56
57 Storage area	2006	1,228		10			1,228	57
58 Plumbing & electrical for diswasher	2006	1,089		10			1,089	58
59 Soffit work	2006	4,268		10			4,268	59
60 Floor & wall tiling	2006	13,669	683	20	683		13,091	60
61 West entrance automatic door	2006	1,736		10			1,736	61
62 Sheltered care and tub room renovations	2006	16,029	801	20	801		15,287	62
63 Automatic door	2007	4,979		10			4,979	63
64 Drywall in stairwell	2007	1,973	99	20	99		1,865	64
65 Sprinkler system	2007	802	40	20	40		754	65
66 Fireproofing of stairwell	2007	1,951	98	20	98		1,829	66
67 Carpeting & cabinets rm 200	2007	2,172		10			2,172	67
68 Fire panel	2007	2,311		10			2,311	68
69 Flooring rooms 134, 135, 136	2007	5,628		10			5,628	69
70 TOTAL (lines 4 thru 69)		\$ 6,488,176	\$ 111,063		\$ 114,184	\$ 3,121	\$ 5,062,248	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2025

Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

1	2	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		\$ 6,488,176	\$ 111,063		\$ 114,184	\$ 3,121	\$ 5,062,248	1
2	Flooring in quad	2007	52,194	2,610	20	2,610		47,416	2
3	Front entrance hallway renovations	2007	2,374		10			2,374	3
4	Exterior quad soffit replacement	2007	10,400	520	20	520		9,447	4
5	Smoke detectors	2007	569		10			569	5
6	Flooring	2007	2,910		10			2,910	6
7	Sprinkler system	2007	10,644	533	20	532	(1)	9,576	7
8	Fire grid ceiling	2008	1,725	86	20	86		1,541	8
9	Cabinetry in laundry	2008	561		10			561	9
10	Sprinkler system	2008	19,429	971	20	971		17,399	10
11	Air conditioning system	2008	2,300	115	20	115		1,984	11
12	Wood flooring install	2008	9,647		10			9,647	12
13	Doors for stairwell	2008	2,472		10			2,472	13
14	Phone system install	2008	26,715		10			26,715	14
15	Draperies	2008	1,568		10			1,568	15
16	Tub for upstairs w.s. room	2009			10				16
17	Sprinklers, fire damper updates w/caulking	2009	13,436	113	12		(113)	13,436	17
18	Flooring rms 109,110,111,112	2009	5,800		10			5,800	18
19	Auto doors, elevator & phone, walls, floors east rms.	2009	267,524	13,146	20	13,376	230	221,858	19
20	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009	15,716		10			15,716	20
21	Cabinets kitchen, water line n. hall & wing	2009	4,711	146	16	227	81	4,711	21
22	Tub for upstairs east south room	2010			10				22
23	Overhead & auto doors lawns shop & upeast entrance	2010	5,345		10			5,345	23
24	Blinds, flooring, walls for 214-220, utility, nurse station	2010	482,556	22,723	20	24,128	1,405	374,083	24
25	Flooring & wall tiles for upeastsouth hall spa rm	2010	7,140		10			7,140	25
26	Flooring, walls, ceiling upeast library	2010	5,632		10			5,632	26
27	Flooring, walls, ceiling for 101-108	2010	42,719		10			42,719	27
28	A/C for main kitchen	2010	4,250	213	20	213		3,249	28
29	Gutter coverings south & north sides	2010	3,475	116	15	169	53	3,475	29
30	Water heaters	2010	4,343		10			4,343	30
31	Flooring for downstairs E & W + nurse station	2011	42,244	2,112	20	2,112		31,501	31
32	Repair boiler & zone valves 214 - 220	2011	4,461		10			4,461	32
33	Vinyl flooring for 245 & 249	2011	4,494		10			4,494	33
34	TOTAL (lines 1 thru 33)		\$ 7,545,530	\$ 154,467		\$ 159,243	\$ 4,776	\$ 5,944,390	34

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

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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		\$ 7,545,530	\$ 154,467		\$ 159,243	\$ 4,776	\$ 5,944,390	1
2	Bus garage and mezzanine	2011	112,089	3,623	30	3,736	113	52,928	2
3	Water heater for kitchen	2011	5,769		10			5,769	3
4	Fire alarm kit/lndr, DW wall, chr rail, window trim, security cam lvg m	2012	13,097		5			13,097	4
5	Flooring:120,125,122,126,239,124,Breakroom,Entrance,Kitchen	2012	46,149		10			46,149	5
6	Front entrance wall, window, door, ceiling, wiring, A/C, signage	2012	872,571	43,569	20	43,629	60	581,760	6
7	Laundry A/C, walls	2012	8,510		10			8,510	7
8	Mixing Valve for kitchen, laundry, resident rooms	2013	5,019		10			5,019	8
9	HL room - painting, wall board, lights	2013	5,859		10			5,859	9
10	Main Kitchen dishroom flooring	2013	2,937		10			2,937	10
11	Vinyl wood flooring for upstairs family & activity room	2013	13,757		10			13,757	11
12	Convert fire alarms to chimes	2013	9,565		10			9,565	12
13	Vinyl wood flooring for Room #123 & #247	2013	5,247		10			5,247	13
14	Air conditioning unit for Social Service office	2013	2,550		10			2,550	14
15	Tile & carpet flooring for UW hallways & SS Office	2013	32,389	1,538	20	1,619	81	19,836	15
16	UW nurses station walls, closet, cabinetry, countertop	2013	10,221		10			10,221	16
17	Boiler Replacement	2013	154,265		10			154,265	17
18	Flooring & bathroom tile work UE rooms 201-209	2013	41,832		10			41,832	18
19	Concrete to replace asphalt at entrance	2013	10,680	534	20	534		6,721	19
20	Concrete portion of parking lot	2013	5,940	297	20	297		3,589	20
21	Vinyl & carpet flooring for Rms 131, 127, 129, 121, 241, 224	2014	12,706		10			12,706	21
22	Controller for boiler	2014	2,796		5			2,796	22
23	Adjust-a-sink & electrical for beauty shop	2014	4,758		5			4,758	23
24	Air conditioning condensing unit for beauty shop	2014	3,450		10			3,450	24
25	Awning for courtyard west door	2014	2,861		5			2,861	25
26	Courtyard brick patio and landscaping	2014	47,424	1,793	20	2,371	578	26,874	26
27	Concrete main parking lot	2014	18,200	910	20	910		10,162	27
28	Expansion of rooms 201-212-HVAC, Carpentry, Electrical, Plumbing,	2014	691,032	34,660	20	34,552	(108)	406,104	28
29	Flooring in commons, kitchen, baths, storage, hallways	2014	39,895	1,995	20	1,995		22,114	29
30	Dining & Kitchen cabinetry & counter top, carpentry, electrical	2014	66,432	3,322	20	3,322		36,824	30
31	Palatium Care nurse call system	2015	105,024	5,642	10	1,701	(3,941)	105,024	31
32	Vinyl wood flooring rm:237,241,256,242,246,254,255,259,128,130,258,dining	2015	34,803	1,741	10	1,729	(12)	34,803	32
33	Autodoors rm: dining, break, break	2015	12,595	630	10	517	(113)	12,595	33
34	TOTAL (lines 1 thru 33)		\$ 9,945,952	\$ 254,721		\$ 256,155	\$ 1,434	\$ 7,615,072	34

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

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Page 12D

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,945,952	\$ 254,721		\$ 256,155	\$ 1,434	\$ 7,615,072	1
2	Elevator shunt trip	2015	7,460	373	10	621	248	7,460	2
3	UW dry sprinkler system	2015	68,200	3,410	20	3,410		34,670	3
4	Gas line main kitchen	2015	3,157	158	10	286	128	3,157	4
5	Energy project: VFD's, Zone dampers, Zone valves - air handlers	2015	50,760	2,538	10	5,076	2,538	50,760	5
6	Electrical outlets in rooms, nurse station, therapy	2015	3,313	225	10	331	106	3,310	6
7	Vinyl wood flooring rm:251,260,244,248,238	2016	12,853	1,285	10	1,285		12,104	7
8	Sound system & wiring - activity & dining	2016	7,827	782	10	783	1	7,765	8
9	A/C nursing admin	2016	8,754	875	10	875		8,316	9
10	Smoke detectors & circuit panels	2016	8,048	805	10	805		7,245	10
11	Concrete drive, leveling, repairs	2016	33,386	1,842	20	1,669	(173)	16,000	11
12	DE lighting & door - rm 109-112 & supply	2016	4,199	420	10	420		3,920	12
13	Water heater for kitchens	2017	8,063	806	10	806		6,448	13
14	Vinyl floor Rm #250, Therapy Rm, West entry	2017	13,465	261	5		(261)	13,465	14
15	16 H/C units Rms: 120-131; 245-250; dining; tub	2017	50,313	3,354	15	3,354		27,117	15
16	Water heater - old boiler room	2018	8,953	895	10	895		6,265	16
17	Security system main doors; wiring, wall/ceiling domes.	2018	6,170		5			6,170	17
18	Water heater - new mechanical room	2018	3,900		5			3,900	18
19	Upstairs west resident room lighting Room 236-259	2018	10,800	1,080	10	1,080		8,374	19
20	Wood floor: Up dining, sm dining, office, sm sitting rm.	2018	19,771	1,823	10	1,977	154	15,166	20
21	Vinyl floor: Upstairs and downstairs hallways	2018	18,350	1,835	10	1,835		14,077	21
22	Dining & kitchen:carpentry,plumbing,elec,paint,cabinetry	2018	64,590	4,306	15	4,306		33,032	22
23	5 PTAC units: Upstairs sitting rm; rms 236,238,240,242	2018	29,650	1,977	15	1,977		14,007	23
24	Security cameras for HL doors and Dumpster door	2019	3,260		5			3,260	24
25	Doors: main kitchen, up west nurse station, courtyard.	2019	9,633	909	10	963	54	6,504	25
26	Flooring: rms 252,236,therapy,south breakroom&hallway,1st floor dining&activity	2019	47,413	4,742	10	4,741	(1)	29,641	26
27	Painting west entrance, dw hall, room 130	2019	10,395	1,040	10	1,040		6,240	27
28	PTAC units room 128 & 244, tranquility room	2019	6,118	408	15	408		2,551	28
29	Can lights in rooms: 127-129, 131-137	2019	5,416	542	10	542		3,570	29
30	Break room electrical, walls, painting, ducting, cabinets, counters, sink	2019	24,319	2,432	10	2,432		14,592	30
31	Therapy & activity: plumbing, heat & cool, ducting, walls, drainage, electrical	2019	721,328	36,066	20	36,066		216,396	31
32	Landscaping therapy addition	2019	6,328	633	10	633		4,010	32
33	Down West tv wall mounts:Rms 120,122,124,126	2020	4,587	459	5	77	(382)	4,587	33
34	TOTAL (lines 1 thru 33)		\$ 11,226,731	\$ 331,002		\$ 334,848	\$ 3,846	\$ 8,209,151	34

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

STATE OF ILLINOIS

Page 12E

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2025

Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,226,731	\$ 331,002		\$ 334,848	\$ 3,846	\$ 8,209,151	1
2	Heat/Cool units rooms 224 - 231	2020	35,704	3,570	10	3,570		19,650	2
3	Flooring down west main entryway	2020	6,053	605	10	605		3,532	3
4	Fire alarm entire facility less new therapy, dining, activity	2020	11,089	1,109	10	1,109		6,475	4
5	Room/directional signage entire facility less rms 201-220	2020	7,503	751	5	619	(132)	7,503	5
6	Sound speakers in ceiling of front office	2020	3,557	356	10	356		1,959	6
7	Window,plumbing,carpentry,cabinetry down west Bistro	2020	15,212	1,521	10	1,521		7,988	7
8	100 gallon water heater old mechanical room	2020	9,358	936	5	1,557	621	9,358	8
9	Window coverings therapy room	2020	2,781	278	5	91	(187)	2,781	9
10	Windows business office	2021	5,311	266	20	266		1,220	10
11	Mini split unit DE nurse station	2021	6,580	658	10	658		2,964	11
12	Exhaust fan kitchen dishwashing	2021	4,490	449	10	449		1,909	12
13	Exterior pantry door	2021	3,161	158	20	158		672	13
14	Doors beauty shop & family room	2021	8,526	426	20	426		1,811	14
15	Boiler control board mechanical room	2021	4,913	491	10	491		2,046	15
16	West entrance: structural steel,doors,patch-paint-trim	2021	25,589	2,559	10	2,559		12,578	16
17	Rms:244-247,249-250:bathrms-cabinets,countertops,doors,paint,electrical,framing,walls,plumbing	2021	65,862	6,586	10	6,586		30,765	17
18	Heiterland bathroom: cabinets,countertop,painting	2021	3,187	159	20	159		676	18
19	Mitel phone system install entire facility	2022	50,559	5,056	10	5,056		16,442	19
20	Cabinets,countertops,door Heiterland kitchen	2022	16,091	1,609	10	1,609		6,039	20
21	A/C up nurse station; up/down satellite kitchens;up west hallway	2022	39,001	3,900	10	3,900		13,666	21
22	West entrance bathroom sink, cabinets, countertop, flooring, walls	2022	8,849	885	10	885		3,101	22
23	Fire alarm entire facility less new therapy, dining, activity	2022	6,580	658	10	658		2,306	23
24	Up west hallway lighting,handrails,painting,wall coverings	2022	17,280	1,728	10	1,728		5,908	24
25	Two PTAC up west hallways	2022	10,530	1,053	10	1,053		3,600	25
26	Up west/down west doors for all rooms, linen, bath	2022	28,412	2,841	10	2,841		8,998	26
27	Up west bathroom flooring, cabinets, vanities rooms 236-243	2022	113,775	11,378	10	11,378		34,134	27
28	Up west Fish Tank Rm: painting; electrical; carpentry; flooring	2023	8,076	808	10	808		2,224	28
29	Heiterland Rm doors	2023	30,814	3,082	10	3,081	(1)	8,484	29
30	Addressable fire alarm system upper floor	2023	33,453	3,345	10	3,345		6,690	30
31	New concrete patio center court	2023	25,093	1,255	20	1,255		3,352	31
32	East End of UpWest Rm Doors: Rms 251-260	2024	32,838	3,284	10	3,284		4,660	32
33	Shingle entire HealthCenter except front bistro addition	2024	283,143	14,157	20	14,157		18,889	33
34	TOTAL (lines 1 thru 33)		\$ 12,150,101	\$ 406,919		\$ 411,066	\$ 4,147	\$ 8,461,531	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	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 12E, Carried Forward		\$ 12,150,101	\$ 406,919		\$ 411,066	\$ 4,147	\$ 8,461,531	1
2	UpWest rm 251-259 & Heiterland rm 132-137 cabinets,vanities,flooring,plumbing,carpentry	2024	188,321	17,889	10	18,832	943	23,579	2
3	Hot water mixing valve for Health Center	2024	18,591	1,859	10	1,859		2,170	3
4	Mini-split unit A/C for UpEast tub room	2024	5,907	591	10	591		690	4
5	Heiterland courtyard pavilion w/concrete,landscaping,water fountain	2024	46,513	4,652	10	4,651	(1)	7,378	5
6	New lightpole for main parking lot	2024	3,961	396	10	396		496	6
7	Rooftop A/C unit for 2002 addition	2025	95,127	2,572	20	3,193	621	3,193	7
8	A/C unit for main kitchen	2025	10,961	548	10	643	95	643	8
9	Water heater in machanical room	2025	10,853	543	10	455	(88)	455	9
10	Automatic doors & keypad control DR; upstairs courtyard	2025	17,392	1,104	10	729	(375)	729	10
11	Sunken patio wall repair	2025	4,500	225	10	150	(75)	150	11
12									12
13									13
14									14
15									15
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,552,227	\$ 437,298		\$ 442,565	\$ 5,267	\$ 8,501,014	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

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Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	\$ 419,558	\$ 66,697	\$ 66,697	\$	5	\$ 319,780	71
72	Current Year Purchases	47,629	4,069	4,069		5	4,069	72
73	Fully Depreciated Assets	1,602,909					1,602,909	73
74								74
75	TOTALS	\$ 2,070,096	\$ 70,766	\$ 70,766	\$		\$ 1,926,758	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	05 Chevy bus/17 E350 bus	2005/2018	\$ 111,744	\$	\$	\$	10	\$ 111,744	76
77	Patient Transport	14 Dodge Caravan	2015	36,443	1,822	1,822		10	36,440	77
78	Patient Transport	Chrysler Voyager 25;Pacifica 20	2025	104,025	6,701	6,701		10	41,801	78
79	Maintenance	13 Nissan Pickup	2016	14,509				5	14,509	79
80	TOTALS			\$ 266,721	\$ 8,523	\$ 8,523	\$		\$ 204,494	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,947,989 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 516,587 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 521,854 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,267 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,632,266 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	\$ 596,592	\$ 10,191	\$ 508,966	86
87	Condos Various	1,874,689	58,482	1,468,973	87
88	Duplexes Various	2,257,239	75,032	1,541,894	88
89	Rental Units Various	1,892,348	1,978	35,818	89
90	Garages Various	46,917	613	38,819	90
91	TOTALS	\$ 6,667,785	\$ 146,296	\$ 3,594,470	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 182,900	92
93			93
94			94
95		\$ 182,900	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. /2026 \$

13. /2027 \$

14. /2028 \$

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM ☒	IN-HOUSE PROGRAM ☒
		IN OTHER FACILITY ☐	IN OTHER FACILITY ☐
		COMMUNITY COLLEGE ☐	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		5,593		5,593
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		21,174		21,174
8	CNA Competency Tests		2,550		2,550
9	TOTALS	\$	\$ 29,317	\$	\$ 29,317
10	SUM OF line 9, col. 1 and 2 (e)	\$	29,317		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	30
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	31

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

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328 Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	\$	691	\$ 53,959	\$	691	\$ 53,959	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		78	16,113		78	16,113	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,121	87,504		1,121	87,504	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				51,774		51,774	9
	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					40,579		40,579	13
14	TOTAL			\$	1,890	\$ 157,576	\$ 92,353	1,890	\$ 249,929	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.

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Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2025Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,789,532	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	469,400		3
4	Supply Inventory (priced at <u>FIFO</u>)	69,700		4
5	Short-Term Investments	95,787		5
6	Prepaid Insurance	9,142		6
7	Other Prepaid Expenses	42,448		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Assets</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,476,009	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,152,981		13
14	Buildings, at Historical Cost	16,709,645		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,763,959		16
17	Accumulated Depreciation (book methods)	(13,927,943)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>	182,900		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,881,542	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,357,551	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 279,223	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	507,259		30
31	Accrued Taxes Payable (excluding real estate taxes)	(107)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,333		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	21,318		36
37	<u>Life Lease Deferred Income</u>	367,697		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,176,723	\$	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	<u>Life Lease Equity</u>	3,128,961		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,128,961	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,305,684	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,051,867	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,357,551	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,252,418	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,252,418	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	799,449	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)	\$ 799,449	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)	\$ 13,051,867	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2025Ending: 12/31/2025

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		Amount	
I. Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,152,900	1
2	Discounts and Allowances for all Levels	(485,740)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,667,160	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	372,658	6
7	Oxygen	24,581	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 397,239	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	23,790	13
14	Non-Patient Meals	35,097	14
15	Telephone, Television and Radio	9,993	15
16	Rental of Facility Space		16
17	Sale of Drugs	67,393	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	120,139	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 256,412	23
D. Non-Operating Revenue			
24	Contributions	822,155	24
25	Interest and Other Investment Income***	452,263	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,274,418	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	37,642	28
28a	Non-Care Facility	403,833	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 441,475	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,036,704	30

2		Amount	
II. Expenses			
A. Operating Expenses			
31	General Services	2,399,101	31
32	Health Care	5,847,668	32
33	General Administration	2,818,405	33
B. Capital Expense			
34	Ownership	704,811	34
C. Ancillary Expense			
35	Special Cost Centers	173,887	35
36	Provider Participation Fee	293,383	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,237,255	40
41	Income before Income Taxes (line 30 minus line 40)**	799,449	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 799,449	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 275,965	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	-	45
46	MMAI-Medicaid is the Primary Payer	535,397	46
47	MMAI-Medicare is the Primary Payer	-	47
48	Private Pay	9,749,120	48
49	Medicare Part A	140,786	49
50	Other-(specify) Medicare Part C	(16,101)	50
51	Other-(specify) Commercial Ins	30,756	51
52	Other-(specify) Medicare Part B	(48,763)	52
53	Other-(specify)	-	53
54	Other-(specify)	-	54
55	Other-(specify)	-	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,667,160	56

Facility Name & ID Number Apostolic Christian Home of Eureka

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Report Period Beginning: 01/01/2025 Ending: 12/31/2025 Page 20

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 126,385	\$ 60.76	1
2	Assistant Director of Nursing	2,080	2,080	93,543	44.97	2
3	Registered Nurses	26,550	29,134	1,199,366	41.17	3
4	Licensed Practical Nurses	15,862	17,229	744,788	43.23	4
5	CNAs & Orderlies	104,862	114,129	2,754,826	24.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,837	5,408	142,697	26.39	8
9	Activity Director	1,927	2,106	56,166	26.67	9
10	Activity Assistants	14,729	16,123	285,099	17.68	10
11	Social Service Workers	2,080	2,112	64,134	30.37	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	63,350	30.46	13
14	Head Cook	2,712	2,974	65,913	22.16	14
15	Cook Helpers/Assistants	10,972	11,880	241,066	20.29	15
16	Dishwashers	17,621	18,873	334,815	17.74	16
17	Maintenance Workers	8,498	9,296	265,046	28.51	17
18	Housekeepers	8,493	9,327	183,905	19.72	18
19	Laundry	7,726	8,433	154,784	18.35	19
20	Administrator	1,966	1,988	156,412	78.68	20
21	Assistant Administrator	1,966	1,966	120,725	61.41	21
22	Other Administrative	10,810	11,353	301,985	26.60	22
23	Office Manager					23
24	Clerical	3,179	3,506	81,991	23.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	251,030	272,077	\$ 7,436,996 *	\$ 27.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	155	\$ 11,281	1.3	35
36	Medical Director	12	4,800	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	79	7,855	10.3	39
40	Physical Therapy Consultant	44	2,922	10a.3	40
41	Occupational Therapy Consultant	4	191	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0.17	13	10a.3	43
44	Activity Consultant	8	617	11.3	44
45	Social Service Consultant	14	1,073	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	316	\$ 28,752		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2025Ending: 12/31/2025**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	
			\$	Workers' Compensation Insurance	\$ 64,314	IDPH License Fee	\$ 1,991	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	52,766	
				FICA Taxes	553,723	Health Care Worker Background Check	1,868	
				Employee Health Insurance	812,282	(Indicate # of checks performed <u>55</u>)		
				Employee Meals		Patient Background Checks <u>83</u>	830	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	10,000	
				Hepatitis Immunization		Journal Star & Pantagraph Newspaper	627	
				Employee Life/Disability	9,240	Nursing Manuals & Oth Subscriptions	398	
				Employee Physicals	20,273	Other Membership Dues \ Licenses	4,172	
				Uniform Allowance & Other	247	Activity Manuals & Oth Subscriptions	270	
				Tax Deferred Annuity	141,238	Less: Public Relations Expense ()		
				Non-Care Employee Benefits	(6,869)	PAC and Lobbying payments ()		
				Reclassifications & Rounding	2	All non-allowable advertising	(15,235)	
See Schedule								
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 293,247	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,594,450	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 57,687	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	3,533
							Seminar Expense	14,616
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 18,149
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
See Schedule								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 10,521					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Home of Eureka

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name

Amount

LEADING AGE

10,000

Other, please specify

10,000 Total

- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE

10

Other, please specify: Illinois Aging Services Network

- Total

- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE

10,000

Other, please specify _____ Illinois Aging Services Network

1

—

10,000 Total

- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 56,031 Line 10.2
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 293,383
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 35,097
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ Zero
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.