

		FOR BHF USE				

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0021493

Facility Name: Apostolic Christian Home

Address: 1102 W Randolph B530 Roanoke 61561
Number City Zip Code

County: Woodford

Telephone Number: (309) 923-2071 Fax # (309) 923-7919

HFS ID Number: _____

Date of Initial License for Current Owners: 27519

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT

☒ Charitable Corp.

☐ Trust

IRS Exemption Code 501c(3)

☐ PROPRIETARY

☐ Individual

☐ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other _____

☐ GOVERNMENTAL

☐ State

☐ County

☐ Other _____

In the event there are further questions about this report, please contact:

Name: Nathan J. Hoffman

Telephone Number: (309) 923-2071

Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Nathan J. Hoffman

(Title) Administrator

Paid
Preparer

(Signed) _____ (Date) _____

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493Report 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>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</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>60</u>	TOTALS	<u>60</u>	<u>21,900</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	<u>477</u>	<u>586</u>	<u>1156</u>		<u>12606</u>	<u>264</u>	<u>173</u>	<u>15,262</u>	8
9	SNF/PED									9
10	ICF					<u>1303</u>			<u>1,303</u>	10
11	ICF/DD	-								11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	<u>477</u>	<u>586</u>	<u>1,156</u>		<u>13,909</u>	<u>264</u>	<u>173</u>	<u>16,565</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 75.64%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)Outpatient Part B TherapyF. 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 1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 1975 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 31Medicare 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.

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	498,963	37,706	5,940	542,609		542,609		542,609		1
2	Food Purchase		258,195		258,195		258,195	(6,053)	252,142		2
3	Housekeeping	210,917	37,269	428	248,614		248,614		248,614		3
4	Laundry		2,930		2,930		2,930		2,930		4
5	Heat and Other Utilities			152,609	152,609		152,609		152,609		5
6	Maintenance	86,616	23,454	94,566	204,636		204,636		204,636		6
7	Other (specify):*										7
8	TOTAL General Services	796,496	359,554	253,543	1,409,593		1,409,593	(6,053)	1,403,540		8
9	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,133,999	77,282	127,483	2,338,764	538	2,339,302		2,339,302		10
10a	Therapy		1,595	124,594	126,189		126,189		126,189		10a
11	Activities	184,677	14,505	3,546	202,728		202,728		202,728		11
12	Social Services	46,786	50	867	47,703		47,703		47,703		12
13	CNA Training			4,184	4,184	(539)	3,645		3,645		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,365,462	93,432	260,674	2,719,568	(1)	2,719,567		2,719,567		16
17	C. General Administration										
17	Administrative	140,580			140,580		140,580		140,580		17
18	Directors Fees										18
19	Professional Services			87,952	87,952	996	88,948		88,948		19
20	Dues, Fees, Subscriptions & Promotions			15,787	15,787	3,083	18,870	(3,472)	15,398		20
21	Clerical & General Office Expenses	164,675	40,140	44,083	248,898	(4,079)	244,819		244,819		21
22	Employee Benefits & Payroll Taxes			844,299	844,299		844,299		844,299		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,169	62,169		62,169		62,169		26
27	Other (specify):*										27
28	TOTAL General Administration	305,255	40,140	1,054,290	1,399,685		1,399,685	(3,472)	1,396,213		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,467,213	493,126	1,568,507	5,528,846	(1)	5,528,845	(9,525)	5,519,320		29

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

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

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Home of Roanoke #0021493 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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			160,466	160,466		160,466	(21,100)	139,366			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			160,466	160,466		160,466	(21,100)	139,366			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,285		18,285	1	18,286		18,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,598	161,598		161,598		161,598			42
43	Other (specify):*		13,689	344,554	358,243		358,243	(358,243)				43
44	TOTAL Special Cost Centers		31,974	506,152	538,126	1	538,127	(358,243)	179,884			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,467,213	525,100	2,235,125	6,227,438		6,227,438	(388,868)	5,838,570			45

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

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493Report Period Beginning: 01/01/2025Ending: 12/31/2025

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	Day Care	\$	\$	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(6,053)	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	(21,100)	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		20.3	28
29	Other-Attach Schedule	(361,715)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (388,868)	\$	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))	\$ (388,868)	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	Rounding	x	1	10.3	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)		\$ 1		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.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 Roanoke# 0021493

Report Period Beginning:

01/01/2025Ending: 12/31/2025

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 Roanoke # 0021493 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 Roanoke# 0021493 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:

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Apostolic Christian Home of Roanoke</u>	COUNTY	<u>Woodford</u>
---------------	--	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT Nathan J. Hoffman

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 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: 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 Duplex 20 Units

Apostolic Christian Home of Roanoke Independent Living 14 Units

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.

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 x
 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 Bldg & Grounds	100,000	1975	\$ 35,875	1
	2				2
	3 TOTALS	100,000		\$ 35,875	3

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

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 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	61		1975	1958	\$ 202,000	\$	30	\$		\$ 202,000	4
5			1976	1976	22,708		30			22,708	5
6			1991	1991	671,286		30			671,286	6
7			1992	1992	129,607		30			129,607	7
8											8
	Improvement Type**										
9	Building & land improvements - '76			1976	105,004		20			105,004	9
10	Building & land improvements - '77			1977	6,591		20			6,591	10
11	Building & land improvements - '78			1978	10,960		20			10,960	11
12	Building & land improvements - '79			1979	9,124		20			9,124	12
13	Building & land improvements - '80			1980	8,166		20			8,166	13
14	Building & land improvements - '81			1981	6,506		20			6,506	14
15	Building & land improvements - '82			1982	18,087		20			18,087	15
16	Building & land improvements - '83			1983	36,023		20			36,023	16
17	Building & land improvements - '84			1984	12,947		20			12,947	17
18	Building & land improvements - '85			1985	13,333		20			13,333	18
19	Building & land improvements - '86			1986	8,595		20			8,595	19
20	Building & land improvements - '87			1987	87,248		20			87,248	20
21	Building & land improvements - '88			1988	43,526		20			43,526	21
22	Building & land improvements - '89			1989	64,604		20			64,604	22
23	Building & land improvements - '90			1990	11,217		20			11,217	23
24	Building & land improvements - '91			1991	3,700		20			3,700	24
25	Building & land improvements - '92			1992	5,410		20			5,410	25
26	Building & land improvements - '93			1993	36,135		20			36,135	26
27	Building & land improvements - '94			1994	14,661		20			14,661	27
28	Building & land improvements - '95			1995	30,372		20			30,372	28
29	Building & land improvements - '96			1996	5,114		20			5,114	29
30	Building & land improvements - '97			1997	28,536		20			28,536	30
31	Building & land improvements - '98			1998	63,025		7			63,025	31
32	Building & land improvements - '99			1999	165,965		7			165,965	32
33	Building & land improvements - '00			2000	73,659		7			73,659	33
34	Building & land improvements - '01			2001	112,321		7			112,321	34
35	Building & land improvements - '02			2002	274,745		7			274,745	35
36	Building & land improvements - '03			2003	58,837		7			58,837	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493

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	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 Building & land improvements - '04	2004	\$ 111,862	\$	7	\$	\$	\$ 111,862	37
38 Building & land improvements - '05	2005	82,009		7			82,009	38
39 Building & land improvements - '06	2006	22,391		7			22,391	39
40 Building & land improvements - '06	2006	4,866		7			4,866	40
41 Building & land improvements - '07	2007	133,282		7			133,282	41
42 Building & land improvements - '08	2008	81,487		7			81,487	42
43 Sprinkler system upgrade	2009	3,288		5			3,288	43
44 Water heaters, fresh air hook-up, door upgrade w/ramps	2009	12,302		5			12,302	44
45 Roofing project	2009	72,252	2,408	30	2,408		39,135	45
46 Kitchen cabinets, countertop, plumbing	2009	2,798		5			2,798	46
47 Building & land improvements - '10	2010	52,889		5			52,889	47
48 Building & land improvements - '11	2011	95,648		10			95,648	48
49 Building & land improvements - '12	2012	161,070		5			161,070	49
50 South floors, walls, ceiling, electrical, plumbing	2013	9,750		10			9,750	50
51 Water line replacement west side	2013	13,456		10			13,456	51
52 Dining Room a/c unit and pad	2013	4,274		5			4,274	52
53 Door locks	2013	4,809		5			4,809	53
54 Concrete N.E. loading area	2014	36,506	1,825	20	1,825		20,380	54
55 Elevator door restrictor, heat detector, call box	2014	5,121		5			5,121	55
56 Sprinkler piping and spray heads	2014	14,177		5			14,177	56
57 Security system wiring & affixed hardware	2014	15,456		5			15,456	57
58 Rms 21 & 15, conference rm flooring	2014	6,634		5			6,634	58
59 N.E. elevator control board	2015	3,761		5			3,761	59
60 Compressor sprinkler system & tamper switches	2015	2,822		5			2,822	60
61 Generator auto governor & power meter	2015	8,163		5			8,163	61
62 Electrical outlet replacement	2015	22,548		10	740	740	22,548	62
63 Door alarm system	2015	4,691		5			4,691	63
64 Sprinkler system	2015	10,777		5			10,777	64
65 Tub room water heater	2015	7,750		5			7,750	65
66 N.E., N.W., S.W. Furnaces & HVAC systems	2015	33,452		5			33,452	66
67 Lobby fireplace	2015	17,336		10	1,730	1,730	17,336	67
68 Generator auto governor	2016	2,703		5			2,703	68
69 Wall speakers	2016	3,764		5			3,764	69
70 TOTAL (lines 4 thru 69)		\$ 3,404,106	\$ 4,233		\$ 6,703	\$ 2,470	\$ 3,354,863	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,404,106	\$ 4,233		\$ 6,703	\$ 2,470	\$ 3,354,863	1
2	Fire alarm system	2016	15,081	1,508	10	1,508		14,204	2
3	Water softner	2016	4,033		5			4,033	3
4	Office air conditioner	2016	4,227		5			4,227	4
5	Sprinkler system	2016	18,238		5			18,238	5
6	4 large windows & 3 sills: lobby, activity, tub rms	2016	15,750	788	20	788		7,489	6
7	Rms E7-E9;W2;W10;W14;W19 & east hall flooring project	2016	29,647		5			29,647	7
8	East 8 & West wing plumbing: fixture, water pipes, mixing valve	2017	4,017	201	20	201		1,642	8
9	Electrical junction boxes, outlet, lobby & entire facility	2017	7,215	722	10	722		6,320	9
10	Attic insulation batting: entire facility	2017	11,470	1,147	10	1,147		10,226	10
11	Dining room furnace and condensing unit	2017	8,350	835	10	835		6,680	11
12	Replace water lines/valves in kitchen & attic	2018	10,001	500	20	500		3,911	12
13	Courtyard pergola & concrete base	2018	19,080	1,272	15	1,272		9,117	13
14	Garbage disposal & water heater in kitchen	2018	10,328		5			10,328	14
15	Asphalt driveway and parking lot	2019	6,075	1,215	5		(1,215)	6,075	15
16	South basement outside west concrete stairs	2019	34,750	1,738	20	1,738		10,576	16
17	Activity room furnace and air conditioning unit	2019	12,800	1,280	10	1,280		8,644	17
18	Sprinkler system upgrades: new piping and supply line	2019	4,393		5			4,393	18
19	Room west 19 & 21: flooring, plumbing, electrical, painting,	2019	10,870	544	20	544		3,535	19
20	East wing furnace and cooling unit	2020	10,720	1,072	10	1,072		6,344	20
21	Spinkler system: replace sections of piping in attic	2020	6,668	667	10	667		3,783	21
22	Room west 19 & 21: flooring, plumbing, electrical, painting,	2020	15,426	1,543	10	1,543		8,486	22
23	South basement: two outside doors	2020	7,912	396	20	396		2,343	23
24	Front canopy lighting and architect fees for redesign	2020	29,706	1,485	20	1,485		7,425	24
25	Rooms 1 & 12 flooring East wing	2021	2,955	296	10	296		1,407	25
26	Front canopy: steel col,stone,metal roof,gutters w/downspouts,drivewa	2021	245,021	12,251	20	12,251		49,004	26
27	Water heater north basement main laundry	2021	9,155	1,831	5	1,831		8,704	27
28	South West wing furnace & A/C	2021	10,950	1,095	10	1,095		5,022	28
29	Lobby renovations architectural drawing	2022	11,986	599	20	599		1,948	29
30	Front canopy stone columns & roofing	2022	33,512	1,676	20	1,676		5,308	30
31	9 planter boxes & soil by front canopy	2022	8,157	1,631	5	1,631		5,849	31
32	Front canopy area landscaping & sidewalk	2022	10,565	1,057	10	1,057		3,348	32
33	MPR parking lot - asphalt remove & replace	2022	35,302	1,765	20	1,765		5,295	33
34	TOTAL (lines 1 thru 33)		\$ 4,068,466	\$ 43,347		\$ 44,602	\$ 1,255	\$ 3,628,414	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	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 12B, Carried Forward		\$ 4,068,466	\$ 43,347		\$ 44,602	\$ 1,255	\$ 3,628,414	1
2	Lobby/Office: Cabinetry,Flooring,Electrical,Doors,Masonry,Sprinkler,Plumb&Heat ,Painting	2023	115,090	5,755	20	5,755		12,933	2
3	Activity Rm remodel: flooring,wall protection,electrical	2024	86,334	4,317	20	4,317		4,317	3
4	Dining Rm remodel: flooring,cabinetry,wall protection	2024	128,243	6,412	20	6,412		6,412	4
5	MultiPurposeRm remodel: flooring,wall protection,cabinetry	2024	119,983	5,999	20	5,999		5,999	5
6	Back parking lot - remove & replace concrete	2024	64,735	3,237	20	3,237		3,237	6
7	New roofing of facility	2025	35,703	1,190	30		(1,190)		7
8	Call light system for facility	2025	99,079	9,908	10	7,981	(1,927)	7,981	8
9	Kitchen gas convection oven	2025	7,454	1,065	7	613	(452)	613	9
10	Closet refacing for East Hall Rm:1,3,10,11; West Hall Rm:2,4,6,8,10,12,16	2025	60,280	6,028	10	1,404	(4,624)	1,404	10
11	West Side Remodel:Flooring,Wall Protectors,Doors,Plumbing: Rms 4,5,6,8,10,12,14,16,18	2025	295,381	14,769	20	607	(14,162)	607	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)		\$ 5,080,748	\$ 102,027		\$ 80,927	\$ (21,100)	\$ 3,671,917	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	\$ 255,907	\$ 49,742	\$ 49,742	\$	5	\$ 254,206	71
72	Current Year Purchases	86,968	8,697	8,697		5	8,697	72
73	Fully Depreciated Assets	1,687,359					1,687,359	73
74								74
75	TOTALS	\$ 2,030,234	\$ 58,439	\$ 58,439	\$		\$ 1,950,262	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 Van / '14 Caravan	2018	\$ 35,500	\$	\$	\$	5	\$ 35,500	76
77	Patient Transport	98 Bus	2015	6,149				5	6,149	77
78	Patient Transport	2009 Beau Van	2009	1,964				5	1,964	78
79	Patient Transport	2011 Dodge Caravan	2011	48,628				10	48,628	79
80	TOTALS			\$ 92,241	\$	\$	\$		\$ 92,241	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,239,098	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,466	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,366	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,100)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,714,420	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 Various	\$ 3,285,464	\$ 97,368	\$ 2,501,260	86
87	Country View Apartments Various	1,185,101	27,837	625,158	87
88	Duplex Furniture & Fixtures Various	663,694	33,461	405,890	88
89	Country View Furniture & Fixt Various	380,908	5,132	380,634	89
90	Duplex Land & Improvements Various	470,518		410,544	90
91	TOTALS	\$ 5,985,684	\$ 163,798	\$ 4,323,486	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:
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 Roanoke # 0021493 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 _____
		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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,390		3,390
8	CNA Competency Tests		255		255
9	TOTALS	\$	\$ 3,645	\$	\$ 3,645
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,645		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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 Roanoke# 0021493 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	\$	103	\$ 8,025	\$	103	\$ 8,025	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		180	13,993		180	13,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		196	15,221		196	15,221	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 prescripts				10,499		10,499	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					7,787		7,787	13
14	TOTAL			\$	479	\$ 37,239	\$ 18,286	479	\$ 55,525	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493Report 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	\$ 6,909,692	\$	1
2	Cash-Patient Deposits	714		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	110,670		3
4	Supply Inventory (priced at FIFO)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,802		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,070,878	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,626		13
14	Buildings, at Historical Cost	8,999,116		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,226,752		16
17	Accumulated Depreciation (book methods)	(9,984,788)		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)	\$ 3,305,706	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,376,584	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 185,543	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	714		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,015		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,836		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Life Lease Deferred Income	107,020		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 409,128	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	2,355,395		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,355,395	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,764,523	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,612,061	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,376,584	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,352,913	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	182,618	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,535,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(398,885)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,475,415	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,076,530	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)	\$ 7,612,061	24 *

* This must agree with page 17, line 47.

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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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,223,679	1
2	Discounts and Allowances for all Levels	(191,966)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,031,713	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,675	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,675	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	20,932	13
14	Non-Patient Meals	6,053	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,401	17
18	Sale of Supplies to Non-Patients	46,148	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,116	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 117,650	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	96,003	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 96,003	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	8,598	28
28a	Non-Care Facility	418,914	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 427,512	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,828,553	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,409,593	31
32	Health Care	2,719,568	32
33	General Administration	1,399,685	33
B. Capital Expense			
34	Ownership	160,466	34
C. Ancillary Expense			
35	Special Cost Centers	376,528	35
36	Provider Participation Fee	161,598	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,227,438	40
41	Income before Income Taxes (line 30 minus line 40)**	(398,885)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (398,885)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 124,660	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	123,851	45
46	MMAI-Medicaid is the Primary Payer	266,988	46
47	MMAI-Medicare is the Primary Payer	-	47
48	Private Pay	4,412,071	48
49	Medicare Part A	51,323	49
50	Other-(specify) Medicare Part C	52,820	50
51	Other-(specify)	-	51
52	Other-(specify)	-	52
53	Other-(specify)	-	53
54	Other-(specify) Rounding	-	54
55	Other-(specify)	-	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,031,713	56

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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	1,826	2,111	\$ 100,609	\$ 47.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,936	8,874	385,807	43.48	3
4	Licensed Practical Nurses	8,043	9,463	371,129	39.22	4
5	CNAs & Orderlies	41,221	44,870	1,042,619	23.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,667	1,968	36,685	18.64	9
10	Activity Assistants	7,673	8,859	147,992	16.71	10
11	Social Service Workers	1,860	2,073	46,786	22.57	11
12	Dietician					12
13	Food Service Supervisor	1,798	1,984	48,381	24.39	13
14	Head Cook	6,918	7,426	153,632	20.69	14
15	Cook Helpers/Assistants	15,787	17,383	296,950	17.08	15
16	Dishwashers					16
17	Maintenance Workers	1,923	2,175	86,616	39.82	17
18	Housekeepers	11,441	12,745	210,917	16.55	18
19	Laundry					19
20	Administrator	1,832	2,080	140,580	67.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,721	6,723	164,675	24.50	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)	7,712	8,653	233,835	27.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,356	137,385	\$ 3,467,213 *	\$ 25.24	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	79	\$ 5,688	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant	51	3,500	10.3	38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	41	1,946	10a.3	40
41	Occupational Therapy Consultant	4	134	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	27	10a.3	43
44	Activity Consultant	38	2,691	11.3	44
45	Social Service Consultant	12	867	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 14,853		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides	3,134	123,074	10.3	52
53	TOTAL (lines 50 - 52)	3,134	\$ 123,074		53

XIX. SUPPORT SCHEDULES

* Attach copy of IMRF notifications

****See instructions.**

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0021493

Report Period Beginning: 01/01/2025

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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 |
|---|---------------------|
| <u>LEADING AGE</u> | <u>7,000</u> |
| <u>Other, please sp Illinois Aging Services Network</u> | <u>6,092</u> |
| | <u>13,092</u> 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.
- | | |
|---|----------------|
| <u>LEADING AGE</u> | <u>-</u> |
| <u>Other, please sp Illinois Aging Services Network</u> | |
| | <u>-</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>LEADING AGE</u> | <u>7,000</u> |
| <u>Other, please sp Illinois Aging Services Network</u> | <u>6,092</u> |
| | <u>-</u> |
| | <u>-</u> |
| | <u>13,092</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 45,162 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. \$ 161,598
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. \$ 6,053
- (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.