

		FOR BHF USE				

LL1

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: 0006353

Facility Name: Apostolic Christian Skylines

Address: 7023 N E Skyline Dr Peoria 61614
Number City Zip Code

County: Peoria

Telephone Number: (309) 691-8091 Fax # (309) 683-2505

HFS ID Number: _____

Date of Initial License for Current Owners: 1966

Type of Ownership:

☒ 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: Matthew J. Feucht

Telephone Number: (309) 691-8091

Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/2025 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) Matthew J. Feucht

(Title) Executive Director

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 Skylines# 0006353Report 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>62</u>	Skilled (SNF)	<u>62</u>	<u>22,630</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>62</u>	TOTALS	<u>62</u>	<u>22,630</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>959</u>		<u>1095</u>		<u>18807</u>	<u>787</u>	<u>173</u>	<u>21,821</u>	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	-								11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	<u>959</u>		<u>1,095</u>		<u>18,807</u>	<u>787</u>	<u>173</u>	<u>21,821</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 96.43%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, Assisted LivingF. 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 62Medicare Intermediary National Government Services

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 Skylines # 0006353 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
	A. General Services										
1	Dietary	646,556	35,349	6,679	688,584	(78,401)	610,183	(98,955)	511,228		1
2	Food Purchase		406,484		406,484	(46,282)	360,202	(120,259)	239,943		2
3	Housekeeping	288,300	39,212		327,512		327,512	(56,088)	271,424		3
4	Laundry	127,898	10,606		138,504		138,504	(32,476)	106,028		4
5	Heat and Other Utilities			263,139	263,139		263,139		263,139		5
6	Maintenance	234,772	41,844	289,715	566,331		566,331	(153,964)	412,367		6
7	Other (specify):*										7
8	TOTAL General Services	1,297,526	533,495	559,533	2,390,554	(124,683)	2,265,871	(461,742)	1,804,129		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,876,447	125,537	86,682	4,088,666	(1)	4,088,665	(392,937)	3,695,728		10
10a	Therapy	182,429	135	173,644	356,208		356,208	(40,639)	315,569		10a
11	Activities	302,393		17,620	320,013		320,013	(26,686)	293,327		11
12	Social Services	193,368		1,615	194,983		194,983	(35,010)	159,973		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,554,637	125,672	303,561	4,983,870	(1)	4,983,869	(495,272)	4,488,597		16
	C. General Administration										
17	Administrative	169,839			169,839		169,839	(76,669)	93,170		17
18	Directors Fees										18
19	Professional Services			116,354	116,354	(938)	115,416		115,416		19
20	Dues, Fees, Subscriptions & Promotions			54,101	54,101		54,101	(13,624)	40,477		20
21	Clerical & General Office Expenses	559,716	22,788	254,276	836,780	938	837,718	(230,745)	606,973		21
22	Employee Benefits & Payroll Taxes			1,442,294	1,442,294	124,683	1,566,977		1,566,977		22
23	Inservice Training & Education			8,544	8,544		8,544		8,544		23
24	Travel and Seminar			6,967	6,967		6,967		6,967		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			173,446	173,446		173,446		173,446		26
27	Other (specify):*										27
28	TOTAL General Administration	729,555	22,788	2,055,982	2,808,325	124,683	2,933,008	(321,038)	2,611,970		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,581,718	681,955	2,919,076	10,182,749	(1)	10,182,748	(1,278,052)	8,904,696		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 Skylines #0006353 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			772,959	772,959		772,959	(264,791)	508,168			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18	18		18	(18)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			772,977	772,977		772,977	(264,809)	508,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,375	7,422	66,797	1	66,798		66,798			39
40	Barber and Beauty Shops			38,867	38,867		38,867		38,867			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,748	212,748		212,748		212,748			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,375	259,037	318,412	1	318,413		318,413			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,581,718	741,330	3,951,090	11,274,138		11,274,138	(1,542,861)	9,731,277			45

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

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

01/01/2025

Ending:

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	Refer-	BHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(120,259)	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	(4,500)	30.3		9
10 Interest and Other Investment Income	(18)	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	(13,624)	20.3		28
29 Other-Attach Schedule	(1,404,460)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,542,861)		\$	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))	\$ (1,542,861)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	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 Skylines # 0006353 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 Skylines# 0006353

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 Skylines # 0006353 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	John Deere Financial		x	Equipment		2023	33,837	16,883	2027	None Stated		10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 33,837	\$ 16,883			\$	14	
15	TOTALS (line 9+line14)						\$ 33,837	\$ 16,883			\$	15	

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

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

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

Facility Name & ID Number **Apostolic Christian Skylines**# **0006353** Report Period Beginning: **01/01/2025** 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 Skylines</u>	COUNTY	<u>Peoria</u>
---------------	-------------------------------------	--------	---------------

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matthew J. Feucht

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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: 57,400

B. General Construction Type: Exterior Brick Frame Steel & Masonry

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).

Apartments & Assisted Living: 18,850 sq. ft., 3 Independent Living Units & 33 Assisted Living Units.

Duplexes: 1,150 sq. ft. per unit, 16 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.

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 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	200,000	1964	\$ 743	1
2					2
3	TOTALS	200,000		\$ 743	3

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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	29		1966	1965	\$ 348,310	\$	40	\$		\$ 348,310	4
5	21		1971	1970	396,963		40			396,963	5
6	16		1985	1985	750,000	18,750	40	18,750		678,750	6
7	3		1989	1988	205,070	5,127	40	5,127		169,188	7
8	17		1995	1995	870,388	21,760	40	21,760		635,389	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		543,565	9
10	Building & land improvements - '74 - '98			1974	522,952		40			522,952	10
11	Building & land improvements - '00			2000	102,105		15			102,105	11
12	Building & land improvements - '01			2001	65,042		10			65,042	12
13	Building & land improvements - '02			2002	42,093	163	20		(163)	42,093	13
14	Air Conditioning unit			2003	1,700		20			1,700	14
15	Sewer system upgrade			2003		256	20		(256)		15
16	Countertops in kitchen			2003	6,594		15			6,594	16
17	Carpeting			2004	5,878		5			5,878	17
18	Wiremesh			2004	1,825		15			1,825	18
19	Sewer system upgrade			2004		360	20		(360)		19
20	Electrical panel upgrade			2004	2,068		15			2,068	20
21	Water heater			2004	7,646		10			7,646	21
22	Rewiring			2004	1,327		20	62	62	1,327	22
23	Roofing			2005	4,858		10			4,858	23
24	Tub room remodel			2005	3,855	154	25	154		3,144	24
25	Carpeting			2005	2,128		5			2,128	25
26	Alarm system			2005	2,357		15			2,357	26
27	External water carryoff system			2005	512	21	25	20	(1)	400	27
28	Nurses Station Connector			2006	364,158	9,679	40	9,104	(575)	177,540	28
29	Door latches			2006	7,110	178	40	178		3,532	29
30	Automatic Doors			2006	2,886		15			2,886	30
31	Walk-in Cooler upgrades			2006	3,135		10			3,135	31
32	Fire safety improvements			2007	19,182	480	40	480		8,657	32
33	Garage			2007	5,944	149	40	149		2,691	33
34	Locks			2007			10				34
35	Office expansion - social services			2007	2,346	59	40	59		1,114	35
36	Elevator jack replacement			2007	35,560	1,778	20	1,778		33,543	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

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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	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 Fire hydrant - sprinkler heads	2007	\$ 5,719	\$ 286	20	\$ 286		\$ 5,229	37
38 Wood door	2007			15				38
39 Air conditioner compressor	2007	8,418		10			8,418	39
40 Sprinklers	2007		62	20		(62)		40
41 Maglock outswing door	2007	1,173		10			1,173	41
42 81 gal water heater - kitchen	2007	5,797		10			5,797	42
43 Heat exchangers	2007	8,455	423	20	423		7,884	43
44 Disposer 3 hp	2007	3,472		10			3,472	44
45 Door monitoring unit	2007			10				45
46 Sprinkler-kitchen; flooring-306; fire safety improv	2008	58,524	1,520	48	1,219	(301)	21,057	46
47 Walkway and snow melt	2008	5,357		15			5,357	47
48 Septic field St. Luke Ct	2008		268	50		(268)		48
49 Iron guard hand railings	2008	6,781		15			6,781	49
50 Commercial disposal	2008			10				50
51 Rm flooring, wall	2008	6,604	165	40	165		2,805	51
52 Internet wiring	2009	4,849	242	20	242		4,013	52
53 Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		9,506	53
54 Water heater	2009	13,950		20	698	698	11,246	54
55 Air conditioning units	2009	2,673		25	107	107	1,813	55
56 Salem cabinetry refacing	2009	7,230	362	20	362		5,973	56
57 Dining room walls	2009	5,391	216	40	135	(81)	2,252	57
58 Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	274	20	316	42	5,357	58
59 Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		2,626	59
60 Lwr southbathrm architectural work	2009	6,935	277	25	277		4,551	60
61 Senior TV hook-up	2009		13	20		(13)		61
62 Salem architectural	2009	3,392	136	25	136		2,244	62
63 Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		16,770	63
64 Flooring, basebd Salem dining rm	2009	9,028	361	25	361		5,866	64
65 Flooring Salem lounge	2009	14,443	578	25	578		9,344	65
66 Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		12,162	66
67 Social room tv cabinetry	2009		50	20		(50)		67
68 Drywall, carpet Canaan room	2009	2,769	111	25	111		1,776	68
69 Maglock outswing door, sensor push bars	2009	2,999	27	20	150	123	2,549	69
70 TOTAL (lines 4 thru 69)		\$ 4,828,212	\$ 86,656		\$ 85,558	\$ (1,098)	\$ 3,943,401	70

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

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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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,828,212	\$ 86,656		\$ 85,558	\$ (1,098)	\$ 3,943,401	1
2	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	8,829	2
3	Roofing, flooring rm 226	2009			15				3
4	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941		10			10,941	4
5	Elevator repair	2010	12,698	635	10		(635)	12,698	5
6	Salem flooring, baseboards	2010	13,507	593	25	540	(53)	8,372	6
7	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		2,669	7
8	Nurses Station	2010	2,533	101	10		(101)	2,533	8
9	Flooring Canaan room	2010			5				9
10	Dining room flooring	2010		48	15		(48)		10
11	New burner boiler 1	2010	12,225	489	25	489		7,434	11
12	Commercial water heater	2010	4,900		15	276	276	4,900	12
13	Surveillance hardware & smoke detector	2010	5,421	46	10		(46)	5,421	13
14	Rebuild \ replace heat exchangers	2010	4,129	252	15	256	4	4,129	14
15	Zion & Galilee tubs, fire safety wall	2011		2,824	10		(2,824)		15
16	South bath plumbing piping & fixtures	2011	6,824	273	25	273		3,990	16
17	Judea bath walls, floor, doors, plumbing, drapes	2011	62,271	1,559	25	2,491	932	35,707	17
18	Activity room walls, ceiling, flooring, electrical, plumbing.	2011		732	40		(732)		18
19	Laundry room plumbing, electrical, walls, ceiling.	2011	6,030	151	40	151		2,140	19
20	Drinking fountain and air conditioning unit	2012	2,495		10			2,495	20
21	Showers and valves	2012	4,823	193	25	193		2,674	21
22	Elevator starter and door	2012	5,504	221	25	220	(1)	3,001	22
23	Therapy rm sprinklers, plumbing, walls, ceiling	2012	22,029	936	25	881	(55)	12,015	23
24	Dining room air conditioner	2012	10,212		15	681	681	9,239	24
25	Beauty shop flooring, walls	2012	3,654	146	25	146		1,962	25
26	Dining rm addition:walls, electrical, plumbing, ceilings	2012	507,333	12,683	40	12,683		169,118	26
27	Door protectors	2012	4,403		10			4,403	27
28	Walk in freezer dining rm addition	2012	35,435	2,133	15	2,362	229	31,496	28
29	Disposal in dining rm addition	2012			10				29
30	Dining rm:walls, doors, flooring, electrical, plumbing, ceilings	2013	88,266	2,265	40	2,207	(58)	27,862	30
31	30 ton chiller complete with installation	2013	33,263	2,218	15	2,218		28,287	31
32	Dining Room project complete	2013	21,859	546	40	546		7,097	32
33	100 gallon water heater	2013	12,788		10			12,788	33
34	TOTAL (lines 1 thru 33)		\$ 5,747,689	\$ 116,757		\$ 112,885	\$ (3,872)	\$ 4,365,601	34

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

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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	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		\$ 5,747,689	\$ 116,757		\$ 112,885	\$ (3,872)	\$ 4,365,601	1
2	Security cameras and access control	2013	14,350		10			14,350	2
3	Humidification system - Salem	2015	8,156	135	10	108	(27)	8,156	3
4	Fire alarm system	2015	22,038	1,469	15	1,469		15,922	4
5	Security camera nursing home B	2015	3,275	191	10	191		3,275	5
6	Roofing Salem	2015	4,381	175	25	175		1,821	6
7	100 & 81 gallon water heaters nursing center	2016	17,610	1,761	10	1,761		17,316	7
8	Nursing center pneumatic control system air dryer	2016	3,307	331	10	331		3,110	8
9	Zion hall: wallpaper,paint,drywall,light fixtures,sprinkler,rails,wall protectors,carpet	2016	92,779	3,711	25	3,711		36,500	9
10	Galilee hall: ceiling tile,wallpaper,paint,light fixtures,sprinkler,rails,wa	2016	92,682	3,707	25	3,707		36,461	10
11	Galilee nurse sttn:studs&drywall,ceiling,paint,flooring,wainscot,sprink	2016	101,360	4,054	25	4,054		39,874	11
12	Salem wing: bathroom tub, plumbing connection, wall tie-in.	2016	18,183	1,212	15	1,212		11,669	12
13	Walk in cooler: condenser,evaporator,electronic controls,piping	2016	6,790	452	15	453	1	4,349	13
14	Salem wing: flooring utility rm & rm 149.	2017	3,241	216	15	216		1,820	14
15	Galilee wing ventilation system	2017	17,359	1,157	15	1,157		10,093	15
16	Kitchen drainage / sewer system	2017	9,874	658	15	658		5,486	16
17	Salem wing: landscaping-bushes; ground cover; retaining wall	2017	5,241	349	15	349		2,875	17
18	Electrical circuits; 4 branches-entire facility	2017	49,390	1,976	25	1,976		17,232	18
19	Zion rm 239: floor; window; patch/paint; plumbing; wiring; lights; doo	2017	42,773	1,711	25	1,711		15,305	19
20	EPDM roof entire facility	2017	9,795	392	25	392		3,163	20
21	Zion rms 235, 237: floor; window; patch/paint; plumbing; wiring; light	2017	215,711	8,628	25	8,628		70,986	21
22	Magnetic door devices: Judea, Galilee, Dining	2017	9,585	639	15	639		5,119	22
23	Electrical lights: rms 141, {(142 - 147,149)A&B}, 148A	2017	8,581	572	15	572		4,726	23
24	Electrical lights: Judea rms 130-138,140	2018	4,572	305	15	305		2,378	24
25	Kitchen disposal	2018	2,588		5			2,588	25
26	Trunk water lines: Judea rms 130-138,140	2018	37,304	1,492	25	1,492		11,695	26
27	Kitchen ceiling & lighting	2018	14,332	754	20	717	(37)	5,590	27
28	Parking & driveway asphalt	2018	26,000	1,733	15	1,733		13,076	28
29	Judea rms 130-138,140:Asbestos abate, electrical, plumbing, doors, cov	2018	247,459	9,898	25	9,898		74,005	29
30	Water heater for kitchen, dining, Judea, Salem, Zion wings.	2018	16,791	1,119	15	1,119		8,152	30
31	Copper water pipe replace: rms PT, Kitchen.	2018	8,891	356	25	356		2,551	31
32	Kitchen & dining roof and door.	2018	2,965	132	25	119	(13)	833	32
33	Walk in freezer,coolers: condenser,evaporator,door,electrical,ceiling.	2019	8,588	658	15	573	(85)	3,636	33
34	TOTAL (lines 1 thru 33)		\$ 6,873,640	\$ 166,700		\$ 162,667	\$ (4,033)	\$ 4,819,713	34

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

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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	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		\$ 6,873,640	\$ 166,700		\$ 162,667	\$ (4,033)	\$ 4,819,713	1
2	Kitchen commercial disposal	2019	3,132	313	10	313		1,967	2
3	Zion/Galilee/Judea nurse stations,rooms,hallways nurse call:walllamps,electrical,wiring,installatio	2019	100,940	10,094	10	10,094		60,702	3
4	Judea/Salem boiler bearing assy, seals, gauges, valve	2019	7,162	477	15	477		3,218	4
5	Kitchen ventilation:rangehood,suppression syst,makeup air,roof fans	2019	45,188	1,808	25	1,808		11,769	5
6	Plumbing:kitchen,exam rm, mech rm:Zurn hydrant, water lines, softener	2019	2,872	115	25	115		743	6
7	Zion/Judea:fire materials,insulation,drywall,installation,heat detector	2019	9,060	396	25	362	(34)	2,316	7
8	Zion/Judea ERU-HVAC:structuralSupport,units/condensers/controls 18rms,wiring,painting,relays	2019	231,364	9,255	25	9,255		57,989	8
9	Upper/Lower parking lots front bldg: blacktop resurfacing	2019	8,000	533	15	533		3,322	9
10	Salem dining/resident rooms: exterior tile & grading for water drainage	2019	16,150	1,077	15	1,077		6,645	10
11	South/Central Elevators: doors,switching,valves,controls,hangers,guide	2019	49,698	3,313	15	3,313		20,014	11
12	JudeaHall: Wiring,lights,walls,flooring,door,nursing sttn,paint,installati	2019	75,826	3,033	25	3,033		18,198	12
13	SE Kitchen disposal	2020	4,273	610	7	610		3,555	13
14	JudeaHall: Boiler pump rebuild	2020	3,893	389	10	389		2,283	14
15	Sprinkler system:5sidewalls + 2 pendants-kitchen:pressure switch:new main piping.	2020	5,173	517	10	517		2,911	15
16	Galilee:chiller brushes;sensors;transducer;gauges;valves;flowmeter;pip	2020	4,515	301	15	301		1,593	16
17	Main kitchen door,fire alarm,plumbing	2020	3,548	237	15	237		1,201	17
18	Main kitchen roof replacement	2020	54,711	2,736	20	2,736		14,092	18
19	Laundry hall:door hardware;flooring;wall protection;sheeting;horizontal board.	2020	11,833	473	25	473		2,746	19
20	Air purification system in:Galilee;diningrm;kitchen;activity;therapy;Sa	2020	11,058	442	25	442		2,332	20
21	Galilee shower enlargement,walls&floorCorian,plumbing,carpentry	2021	21,675	867	25	867		4,192	21
22	Activity room carpeting	2021	23,309	4,662	5	4,662		20,870	22
23	Therapy HVAC	2021	66,401	2,656	25	2,656		12,363	23
24	Mustard Seed Cafe ceiling	2021	22,747	910	25	910		3,959	24
25	South elevator cab remodel	2021	42,380	1,695	25	1,695		6,785	25
26	Walk in kitchen cooler refirb	2021	6,400	427	15	427		1,987	26
27	Security cameras access control panel replacement	2021	4,240	424	10	424		1,820	27
28	81 gal water heater - kitchen	2021	7,758	517	15	517		2,449	28
29	Generator replacement w/electrical upgrades	2021	185,827	7,433	25	7,433		33,072	29
30	Wifi access points throughout care facility	2021	16,523	3,305	5	3,305		13,410	30
31	Salem courtyard:concrete,topsoil,rock,fence,gate,gazebo,bench,irrigation,columnwrap	2021	57,147	2,286	25	2,286		10,171	31
32	Salem memory care 5 room addition	2021	1,225,200	49,008	25	49,008		218,052	32
33	WS-224-2 HE-4000 whole house water softener	2021	12,878	1,288	10	1,288		6,031	33
34	TOTAL (lines 1 thru 33)		\$ 9,214,521	\$ 278,297		\$ 274,230	\$ (4,067)	\$ 5,372,470	34

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

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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	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		\$ 9,214,521	\$ 278,297		\$ 274,230	\$ (4,067)	\$ 5,372,470	1
2	KVAR Powerhouse & Monitoring - whole house	2022	7,459	746	10	746		2,271	2
3	Salem Remodel-Architect/Engineer;plumbing,carpentry,roofing,doors,flooring,painting,walls,ceil	2022	932,318	37,293	25	37,293		121,279	3
4	Zion Spa Remodel-flooring and cabinetry	2022	4,014	161	25	161		557	4
5	Salem touchless access-wiring,hardware,mountingbox,cable	2022	18,195	728	25	728		2,792	5
6	Mustard Seed-Backsplash replacement	2022	3,823	382	10	382		1,339	6
7	Security DVR Camera Upgrades-whole house	2022	3,710	371	10	371		1,393	7
8	Main Dining Serving line wall-paneling,wood,trim	2022	3,182	212	15	212		707	8
9	Kitchen touchless entry system access control	2023	8,792	879	10	879		2,201	9
10	Fire alarm panel upgrade	2023	14,651	977	15	977		2,117	10
11	Kitchen water heater	2023	25,263	1,684	15	1,684		4,577	11
12	Sewer Grinder	2023	37,090	2,473	15	2,473		5,271	12
13	Therapy rm paint,electrical,walls,fixtures,sprinkler	2023	14,845	594	25	594		1,487	13
14	Front entry sod, soil, mulch,gravel,shrubs/plants	2023	19,797	1,320	15	1,320		3,515	14
15	Zion spa rm electrical,stone,walls,plumbing,fixtures	2023	21,881	875	25	875		1,963	15
16	Fire door,fire proofing,hardware	2023	4,432	177	25	177		473	16
17	Security cameras,cables,connectores-Galilee, activities	2023	4,173	417	10	417		1,012	17
18	Dining rm:5-ton RTU,electrical, piping	2023	13,466	673	20	673		2,014	18
19	Activity rm:3 fan coil units,piping,electrical	2023	26,150	1,308	20	1,308		3,838	19
20	Salem:2 RTU,piping, electrical	2023	28,500	1,425	20	1,425		3,740	20
21	Galilee air handling unit,electrical	2023	36,600	1,830	20	1,830		4,858	21
22	Front building:masonry,shingles,gutters/soffit/fascia,painting,sidewalkw/radianheat,balcony	2023	449,057	17,962	25	17,962		38,926	22
23	Chiller Replace: Galilee and activity room	2024	41,080	2,739	15	2,739		4,337	23
24	Galilee Remodel:Engineer/Architect;Flooring;Painting;Plumbing;Electrical;HVAC	2024	481,961	24,098	20	24,098		24,626	24
25	Parking Spaces Overlay and Sealcoating for upper parking lot	2024	24,100	2,410	10	2,410		3,737	25
26	Remove & Replace Water Piping in Back Half of Kitchen	2024	9,262	617	15	617		1,221	26
27	NetworkSwitches;Cable;Installation;PatchPanel;Rack;CareFacility	2024	3,001	429	7	429		672	27
28	Wifi access points throughout care facility	2024	8,431	1,204	7	1,204		1,620	28
29	CourtyardSoffit by Galilee&Activity:soffit;trim;foam;nails;labor	2024	10,119	506	20	506		620	29
30	FrontFoyer:Engineering;Painting;ElevatorUpgrade;Plumbing;Electrical;HVAC	2024	754,155	37,708	20	37,708		63,019	30
31	Judea/Zion South Elevator Jack Packing Replace	2024	7,289	1,041	7	1,041		1,435	31
32	Salem chair railing	2024	3,204	214	15	214		425	32
33	GalileeWestSideRms-244,246,248,250,252,254,256,258&NurseStation:Windows,Doors,Walls,Pa	2025	225,921	10,041	15	9,821	(220)	9,821	33
34	TOTAL (lines 1 thru 33)		\$ 12,460,442	\$ 431,791		\$ 427,504	\$ (4,287)	\$ 5,690,333	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		\$ 12,460,442	\$ 431,791		\$ 427,504	\$ (4,287)	\$ 5,690,333	1
2	South Elevator: Engineering, Materials, Install, Lighting, Fire Alarm	2025	114,214	952	20	970	18	970	2
3	Zion Rm #240: HVAC	2025	7,402	165	15	153	(12)	153	3
4	Back Dock Door Access Controls	2025	6,110	436	7	438	2	438	4
5	Laundry Rm: Door Access Controls, Door Replace, Water Line Replace	2025	26,102	949	15	896	(53)	896	5
6	Boiler Controls for Nursing Center	2025	14,404	120	20	150	30	150	6
7	Salem Dining Rm: Ductless HyperHeat 3-Ton	2025	19,443	216	15	167	(49)	167	7
8	Convection Oven, Drip Pan, Casters, Gas Connect, Install Nursing Cntr Kitchen	2025	15,518	1,293	10	1,314	21	1,314	8
9	Water room mixing valves for Nursing Center	2025	5,540	92	15	93	1	93	9
10	Galilee Hall Flooring	2025	27,840	464	15	392	(72)	392	10
11	Zion Hall Flooring	2025	23,895	398	15	336	(62)	336	11
12	Tilt Skillet, Faucet w/Backflow Preventor, Gas Pipe, Seals	2025	35,538	1,777	15	1,766	(11)	1,766	12
13	Tovertafel System in Salem: Projector, Sensors	2025	14,262	1,868	7	1,842	(26)	1,842	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)		\$ 12,770,710	\$ 440,521		\$ 436,021	\$ (4,500)	\$ 5,698,850	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	\$ 804,631	\$ 69,038	\$ 69,038	\$	Various	\$ 472,267	71
72	Current Year Purchases	43,915	3,109	3,109		Various	3,109	72
73	Fully Depreciated Assets	1,237,152					1,237,152	73
74								74
75	TOTALS	\$ 2,085,698	\$ 72,147	\$ 72,147	\$		\$ 1,712,528	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				\$	\$	\$	\$		\$	76
77										77
78	Patient Transport	15 Dodge Van	2015	39,933				7	39,933	78
79	Patient Transport	16 Ford Bus	2016	66,200				7	66,200	79
80	TOTALS			\$ 106,133	\$	\$	\$		\$ 106,133	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)	\$ 14,963,284	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 512,668	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 508,168	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,500)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,517,511	85

**

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building Various	\$ 4,783,475	\$ 172,984	\$ 2,667,751	86
87	Equipment Various	535,734	28,169	462,520	87
88	Vehicle Various	94,331	13,168	83,335	88
89	Land Various	112,446			89
90	Duplexes Various	2,441,161	45,970	240,312	90
91	TOTALS	\$ 7,967,147	\$ 260,291	\$ 3,453,918	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 37,567	92
93			93
94			94
95		\$ 37,567	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 Skylines

#

0006353

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	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	☒ NO	IN-HOUSE PROGRAM ☐	IN-HOUSE PROGRAM ☐
		IN OTHER FACILITY ☐	IN OTHER FACILITY ☐
		COMMUNITY COLLEGE ☐	HOURS PER CNA _____
		HOURS PER CNA _____	

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)

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

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

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	197	\$ 12,917	\$	197	\$ 12,917	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		256	20,363		256	20,363	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		439	18,262		439	18,262	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				31,649		31,649	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2					27,726		27,726	13
14	TOTAL			\$	892	\$ 51,542	\$ 59,375	892	\$ 110,917	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,581,035	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	509,743		3
4	Supply Inventory (priced at FIFO)	56,746		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,010		6
7	Other Prepaid Expenses	58,462		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other accounts receivable			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,227,996	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	19,855,257		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,767,344		16
17	Accumulated Depreciation (book methods)	(10,791,471)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	37,567		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,981,886	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,209,882	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 484,860	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	8,442		29
30	Accrued Salaries Payable	190,277		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 683,579	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,442		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingency Payable	2,207,698		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,216,140	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,899,719	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,310,163	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,209,882	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,377,119	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	5,042	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,382,161	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,998)	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)	\$ (71,998)	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)	\$ 11,310,163	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Skylines# 0006353Report 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	\$ 7,606,103	1
2	Discounts and Allowances for all Levels	(174,066)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,432,037	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	228,070	6
7	Oxygen	22,257	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 250,327	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	39,623	13
14	Non-Patient Meals	120,259	14
15	Telephone, Television and Radio	3,982	15
16	Rental of Facility Space		16
17	Sale of Drugs	23,679	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,275	19
20	Radiology and X-Ray	1,040	20
21	Other Medical Services	157,401	21
22	Laundry	12,320	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 361,579	23
D. Non-Operating Revenue			
24	Contributions	1,268,802	24
25	Interest and Other Investment Income***	24,054	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,292,856	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	(425)	27
28	Non-Care Facility	1,789,970	28
28a	Miscellaneous Income	75,796	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,865,341	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,202,140	30

2		Amount	
II. Expenses			
A. Operating Expenses			
31	General Services	2,390,554	31
32	Health Care	4,983,870	32
33	General Administration	2,808,325	33
B. Capital Expense			
34	Ownership	772,977	34
C. Ancillary Expense			
35	Special Cost Centers	105,664	35
36	Provider Participation Fee	212,748	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,274,138	40
41	Income before Income Taxes (line 30 minus line 40)**	(71,998)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (71,998)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 228,363	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	-	45
46	MMAI-Medicaid is the Primary Payer	260,748	46
47	MMAI-Medicare is the Primary Payer	-	47
48	Private Pay	6,507,511	48
49	Medicare Part A	367,454	49
50	Other-(specify) Medicare Part C	83,185	50
51	Other-(specify) Medicare Part B	(15,222)	51
52	Other-(specify)	-	52
53	Other-(specify)	-	53
54	Other-(specify) Rounding	(2)	54
55	Other-(specify)	-	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,432,037	56

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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	1,880	2,080	\$ 96,315	\$ 46.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,005	15,584	703,691	45.15	3
4	Licensed Practical Nurses	16,545	18,131	726,841	40.09	4
5	CNAs & Orderlies	72,424	78,633	1,920,969	24.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,457	4,937	141,790	28.72	8
9	Activity Director	5,152	5,726	139,304	24.33	9
10	Activity Assistants	6,464	6,958	137,008	19.69	10
11	Social Service Workers	4,104	4,618	158,358	34.29	11
12	Dietician					12
13	Food Service Supervisor	3,150	3,499	98,575	28.17	13
14	Head Cook	6,762	7,463	161,377	21.62	14
15	Cook Helpers/Assistants	14,082	15,165	287,649	18.97	15
16	Dishwashers					16
17	Maintenance Workers	4,802	5,418	154,921	28.59	17
18	Housekeepers	10,627	11,864	232,212	19.57	18
19	Laundry	4,435	4,837	95,422	19.73	19
20	Administrator	938	1,141	93,170	81.66	20
21	Assistant Administrator	1,018	1,270	72,100	56.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,190	8,802	300,489	34.14	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: Nursing Admin Assistant	1,169	1,295	35,694	27.56	33
34	TOTAL (lines 1 - 33)	179,204	197,421	\$ 5,555,885 *	\$ 28.14	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	98	\$ 6,679	1.3	35
36	Medical Director	160	24,000	9.3	36
37	Medical Records Consultant	9	638	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	50	5,019	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	7	538	11.3	44
45	Social Service Consultant	20	1,615	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	344	\$ 38,489		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	288	\$ 21,074	10.3	50
51	Licensed Practical Nurses	827	51,588	10.3	51
52	Certified Nurse Assistants/Aides	220	8,363	10.3	52
53	TOTAL (lines 50 - 52)	1,335	\$ 81,025		53

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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	\$ 79,488	IDPH License Fee	\$ 3,121	
				Unemployment Compensation Insurance	17,913	Advertising: Employee Recruitment	26,211	
				FICA Taxes	488,942	Health Care Worker Background Check	738	
				Employee Health Insurance	684,970	(Indicate # of checks performed <u>23</u>)		
				Employee Meals	124,683	Patient Background Checks <u>40</u>	400	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	18,029	
				401k Plan & Administration	110,948	Publications	135	
				Employee Physical	20,234	Licenses	3,309	
				Employee Incentives	39,588	Other Membership Dues & Fees	2,158	
				Uniform Allowance	212	Reclassifications		
				Reclassifications		Less: Public Relations Expense	()	
				Rounding	(1)	PAC and Lobbying payments	()	
						All non-allowable advertising	(13,624)	
See Schedule						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,477	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 169,839	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,566,977			
(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	2,575
							Seminar Expense	4,392
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 6,967
(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)			\$ 116,354					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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>10,000</u> |
| <u>Other, please sp Illinois Aging Services Network</u> | <u>8,029</u> |
| | <u>18,029</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>10,000</u> |
| <u>Other, please sp Illinois Aging Services Network</u> | <u>8,029</u> |
| | <u>-</u> |
| | <u>-</u> |
| | <u>18,029</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 49,407 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. \$ 212,748
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. \$ 124,683 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 120,259
- (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.