

		FOR BHF USE					

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2006
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT FOR
 LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2006)

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.

<p>I. IDPH Facility ID Number: <u>0012328</u></p> <p>Facility Name: <u>Apostolic Christian Home of Eureka</u></p> <p>Address: <u>610 West Cruger</u> <u>Eureka</u> <u>61530</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 467-2311</u> Fax # <u>(309) 467-2584</u></p> <p>HFS ID Number: <u>37-6036029001</u></p> <p>Date of Initial License for Current Owners: <u>Feb-66</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501c(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Thomas A. Hoffman</u> Telephone Number: <u>(309) 467-2311</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Thomas A. Hoffman</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Administrator</u></td> </tr> </table> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Thomas A. Hoffman</u>			(Title) <u>Administrator</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u> Fax # ()	
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Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>38</u>	Intermediate (ICF)	<u>38</u>	<u>13,870</u>	3
4		Intermediate/DD			4
5	<u>10</u>	Sheltered Care (SC)	<u>10</u>	<u>3,650</u>	5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,363</u>	<u>17,508</u>	<u>957</u>	<u>24,828</u>	8
9	SNF/PED					9
10	ICF	<u>2,089</u>	<u>11,402</u>		<u>13,491</u>	10
11	ICF/DD					11
12	SC		<u>3,211</u>		<u>3,211</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,452</u>	<u>32,121</u>	<u>957</u>	<u>41,530</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.61%

D. How many bed-hold days during this year were paid by the Department?

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Apartment, Duplex, CondominiumF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started Feb-66

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

YES Date Feb-66 NO

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

YES NO If YES, enter number of beds certified 36 and days of care provided 957Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	315,680	17,185	12,696	345,561	-	345,561	-	345,561			1
2	Food Purchase		241,553		241,553	-	241,553	(13,435)	228,118			2
3	Housekeeping	133,445	20,822	2,288	156,555	-	156,555	(3,847)	152,708			3
4	Laundry	128,401	11,010	2,032	141,443	-	141,443	-	141,443			4
5	Heat and Other Utilities			232,901	232,901	-	232,901	(39,730)	193,171			5
6	Maintenance	157,281	15,474	42,026	214,781	-	214,781	(30,573)	184,208			6
7	Other (specify):*				-		-		-			7
8	TOTAL General Services	734,807	306,044	291,943	1,332,794	-	1,332,794	(87,585)	1,245,209			8
	B. Health Care and Programs											
9	Medical Director	-	-	2,100	2,100	-	2,100	-	2,100			9
10	Nursing and Medical Records	2,809,620	31,666	208,440	3,049,726	49,115	3,098,841	-	3,098,841			10
10a	Therapy	59,107	2,994	142,194	204,295	-	204,295	923	205,218			10a
11	Activities	139,245	9,430	6,807	155,482	-	155,482	(905)	154,577			11
12	Social Services	54,844	383	2,632	57,859	-	57,859	-	57,859			12
13	CNA Training	-	-	-	-	9,901	9,901	-	9,901			13
14	Program Transportation	-	-	-	-	-	-	-	-			14
15	Other (specify):*				-		-		-			15
16	TOTAL Health Care and Programs	3,062,816	44,473	362,173	3,469,462	59,016	3,528,478	18	3,528,496			16
	C. General Administration											
17	Administrative	160,160	-	-	160,160	-	160,160	(19,810)	140,350			17
18	Directors Fees				-	-	-	-	-			18
19	Professional Services			9,039	9,039	-	9,039	-	9,039			19
20	Dues, Fees, Subscriptions & Promotions			21,233	21,233	-	21,233	-	21,233			20
21	Clerical & General Office Expenses	112,044	7,581	54,869	174,494	(2,958)	171,536	(15,859)	155,677			21
22	Employee Benefits & Payroll Taxes			985,964	985,964	-	985,964	(2,444)	983,520			22
23	Inservice Training & Education				-	-	-	-	-			23
24	Travel and Seminar			8,641	8,641	(3,325)	5,316	-	5,316			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			136,485	136,485	-	136,485	(23,000)	113,485			26
27	Other (specify):*				-		-		-			27
28	TOTAL General Administration	272,204	7,581	1,216,231	1,496,016	(6,283)	1,489,733	(61,113)	1,428,620			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,069,827	358,098	1,870,347	6,298,272	52,733	6,351,005	(148,680)	6,202,325			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			346,325	346,325		346,325	(74,108)	272,217		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			12,041	12,041		12,041	(12,041)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles					2,958	2,958		2,958		35
36	Other (specify):*										36
37	TOTAL Ownership			358,366	358,366	2,958	361,324	(86,149)	275,175		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		132,142	3,493	135,635	(55,691)	79,944		79,944		39
40	Barber and Beauty Shops			31,055	31,055		31,055		31,055		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678		59,678		59,678		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		132,142	94,226	226,368	(55,691)	170,677		170,677		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,069,827	490,240	2,322,939	6,883,006		6,883,006	(234,829)	6,648,177		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 Eureka

0012328

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,420)	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	(80)	30.3		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(221,329)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (234,829)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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))	\$ (234,829)		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			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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 Eureka # 0012328 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

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

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

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328 Report Period Beginning: 01/01/2006

Ending: 2/31/200 12/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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. \$ N/A 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0012328

CONTACT PERSON REGARDING THIS REPORT Thomas A. Hoffman

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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: 42,865 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire Resistance Number of Stories One

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Home</u>	<u>63,500</u>	<u>1963</u>	<u>\$ 58,945</u>	1
2					2
3	TOTALS	63,500		\$ 58,945	3

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

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		Dec-66	Dec-66	\$ 488,404	\$	40	\$	\$	\$ 488,404	4
5	38		Dec-75	Dec-75	605,234	15,091	40	15,131	40	462,593	5
6	11		Aug-94	Aug-94	1,522,126	38,053	39	39,029	976	482,035	6
7	8		Dec-94	Dec-94	226,582	6,237	39	5,810	(427)	69,810	7
8				Feb-89	3,512	176	20	176		3,080	8
		Improvement Type**									
9				Dec-67	17,605	440	40	440		17,576	9
10				Dec-68	1,508		20			1,508	10
11				Dec-69	11,406		20			11,406	11
12				Dec-70	8,431		20			8,431	12
13				Dec-71	2,975		20			2,975	13
14				Dec-72	550		5			550	14
15				Dec-77	38,346		20			38,346	15
16				Dec-79	1,260		5			1,260	16
17				Dec-81	4,140		10			4,140	17
18				Dec-82	15,776	770	20		(770)	15,776	18
19				Dec-83	4,826		10			4,826	19
20				Dec-84	8,271		10			8,271	20
21				Dec-85	15,630		20			15,630	21
22				Dec-86	8,500		10			8,500	22
23				Dec-87	950		19			950	23
24				Dec-88	69,201	2,768	20	3,460	692	65,740	24
25		Kitchen Addition		Dec-89	12,677	634	20	634		11,095	25
26		Bldg Improvement		Dec-89	10,281		10			10,281	26
27		Water Heater		Dec-90	2,272		20	114	114	1,919	27
28		Central Air		Dec-90	3,978		10			3,978	28
29		Improve Door		Dec-90	2,235		10			2,235	29
30		Remodeling		Dec-90	503	25	20	25		413	30
31		Sprinkler Heads		Dec-90	1,504	75	20	75		1,250	31
32		Blacktopping		Dec-90	3,000	150	20	150		2,525	32
33		Cubicle Curtain Track		Jan-91	850	43	20	43		685	33
34		Carpeting/Woodwork		Jan-91	795	40	20	40		636	34
35		Key Pads/Door System		Mar-91	2,670	134	20	134		2,111	35
36		Thermo Mixing Valves		Apr-91	3,310	166	20	166		2,608	36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Air Conditioning Unit	Jun-91	\$ 3,012	\$	10	\$	\$	\$ 3,012	37
38	Wall Air Conditioning Unit	Aug-91	910		10			910	38
39	Patio	Jun-91	2,150	108	20	108		1,683	39
40	Asphalt Parking	May-92	8,938	447	20	447		6,522	40
41	Trees & Shrubs	May-92	403	20	20	20		292	41
42	Radiator Covers	Jan-92	5,500	275	20	275		4,118	42
43	Plumbing Upgrade	Jan-92	2,348	117	20	117		1,751	43
44	Shed	Jun-92	2,000	100	20	100		1,456	44
45	Alarm System	Jun-92	4,520	226	20	226		3,278	45
46	Lock Sets	Nov-92	1,207	60	20	60		845	46
47	Water Heater	Mar-92	10,252		10			10,252	47
48	Air Conditioner	Jun-92	886		10			886	48
49	Air Conditioner	Jul-92	926		10			926	49
50	Air Conditioner	Sep-92	858		10			858	50
51	Drapes and Rods	Nov-92	1,057		10			1,057	51
52	Fireplace Glass	Nov-92	587		10			587	52
53	Air Conditioner	May-93	1,303		10			1,303	53
54	Fountain Lights	Sep-93	1,179		10			1,179	54
55	Exterior Lighting	Mar-93	850	42	20	43	1	593	55
56	Hallway Remodeling	Apr-93	2,383	119	20	119		1,630	56
57	Kitchen Flooring	Jun-93	2,441	122	20	122		1,653	57
58	Office Addition	May-94	57,234	1,431	39	1,468	37	18,597	58
59	Roof	Oct-94	17,577	879	20	879		10,767	59
60	Interior Hallway	Jun-94	7,134		10			7,134	60
61									61
62	Phone System	Jun-94	13,120		10			13,120	62
63	Air Conditioner	May-95	1,158		10			1,158	63
64	Drapes	Dec-95	529		10			529	64
65	Remodel	Feb-95	5,366		5			5,366	65
66	Improvements	Apr-95	3,293		10			3,293	66
67	Roof & Insulation	Jun-95	21,002	1,050	20	1,050		12,079	67
68	Building Improvements	Oct-95	7,787		10			7,787	68
69	Life Safety Code	Dec-95	21,125	1,056	20	1,056		11,662	69
70	TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 70,854		\$ 71,517	\$ 663	\$ 1,887,826	70

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

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

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,308,343	\$ 70,854		\$ 71,517	\$ 663	\$ 1,887,826	1
2	Air Conditioner	Feb-96	485	24	10	1	(23)	485	2
3	Phone System-Social Service	Feb-96	1,201	60	10	16	(44)	1,201	3
4	Air Conditioner	May-96	2,886	144	10	116	(28)	2,886	4
5	Water Softner	Jun-96	3,442	172	10	158	(14)	3,442	5
6	Social Service Office Remodel	Jan-96	2,750	207	20	138	(69)	1,855	6
7	Life Safety Code	Feb-96	8,113	336	20	406	70	4,075	7
8	Life Safety Door	Mar-96	5,061	253	20	253		2,732	8
9	Front Room Wallpaper	May-96	1,008	50	10	32	(18)	1,008	9
10	Ventilation & A/C System	May-96	5,990	299	10	246	(53)	5,990	10
11	Front Room Carpet	May-96	2,432	122	20	122		1,291	11
12	Guttering System	Jun-96	3,355	168	20	168		1,771	12
13	Air Conditioning	Jun-96	9,314	466	20	466		4,914	13
14	Air Conditioning	Aug-96	1,008	50	20	50		519	14
15	Cabinetry in Tub Room	Sep-96	2,945	147	10	204	57	2,945	15
16	Air Conditioning & Ventilation System	Sep-96	8,942	447	20	447		4,601	16
17	Speaker System	Oct-96	3,798	190	10	298	108	3,798	17
18	Life Safety Ventilation System	Oct-96	798	40	20	40		408	18
19	Six Air Conditioners	Feb-97	2,882	288	10	288		2,834	19
20	Water Heater	May-97	5,871	587	10	587		5,627	20
21	Wall Fountain	Oct-97	653	65	10	65		596	21
22	Draperys	Oct-97	2,839	284	10	284		2,603	22
23	Smoke Detectors	Jan-97	3,103	310	10	310		3,074	23
24	Carpeting	Oct-97	3,525	176	20	176		1,613	24
25	Hall Remodeling	Oct-97	16,641	832	20	832		7,627	25
26	Five Air Conditioners	Mar-98	2,447	245	10	245		2,152	26
27	Water Heater	Oct-98	2,940	294	10	294		2,416	27
28	Air Conditioner	Nov-98	5,415	542	10	542		4,382	28
29	Room Door Guards	Mar-99	2,139	214	10	214		1,668	29
30	Door Alarm Keypads	Jul-99	2,293	229	10	229		1,710	30
31	Seven Air Conditioners	Jan-99	3,182	318	10	318		2,517	31
32	Kitchen Shelving Units	May-99	2,838	283	10	284	1	2,159	32
33	Three Air Conditioners	Aug-99	1,425	143	10	143		1,054	33
34	TOTAL (lines 1 thru 33)		\$ 3,430,064	\$ 78,839		\$ 79,489	\$ 650	\$ 1,973,779	34

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

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

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,430,064	\$ 78,839		\$ 79,489	\$ 650	\$ 1,973,779	1
2	Room Door Guards	Dec-99	2,610	261	10	261		1,840	2
3	Seven Air Conditioners	Jan-00	3,626	363	10	363		2,511	3
4	Air Conditioner	Sep-00	1,508	151	10	151		950	4
5	Generator & Building	Jan-00	303,143	7,579	40	7,579		52,430	5
6	Wall Carpet	Jan-00	3,630	363	10	363		2,541	6
7	Carpeting	Mar-00	21,956	2,196	10	2,196		14,830	7
8	Courtyard Improvements	May-00	5,312	306	10	531	225	3,186	8
9	Courtyard improvements	May-99	11,738	1,444	10	1,174	(270)	8,070	9
10	Air conditioner	May-01	632	63	10	63		355	10
11	Lighting	Jul-01	2,233	223	5	238	15	2,233	11
12	Attached wash stations	Aug-01	849	85	10	85		457	12
13	Hot water heater	Oct-01	939	94	5	147	53	939	13
14	Counter top	Dec-01	550	55	10	55		280	14
15	Air conditioner	Aug-01	9,725	486	20	486		2,632	15
16	Installation of sinks	Sep-01	1,050	105	10	105		556	16
17	New dumpster door	Mar-02	928	46	20	46		219	17
18	Flooring for 2002 addition and remodel	Dec-02	85,333	4,267	20	4,267		17,068	18
19	2002 addition and remodel	Dec-02	2,247,842	56,196	40	56,196		224,784	19
20	Room designation	Feb-02	627	63	10	63		307	20
21	Water heater	Feb-02	4,147	415	10	415		2,008	21
22	Drapes and blinds for dining, activity, therapy	Dec-02	15,437	1,544	10	1,544		6,176	22
23	Courtyard sprinkler system	Jun-02	8,800	880	10	880		4,034	23
24	Gravel driveway	Jun-02	634	127	5	127		582	24
25	Landscaping for 2002 addition	Dec-02	198,700	9,935	20	9,935		39,740	25
26	Sprinkler system for 2002 addition	Dec-02	9,600	960	10	960		3,840	26
27	Surveillance camera	Feb-03	1,750	350	5	350		1,343	27
28	Water heater	Feb-03	4,965	496	10	497	1	1,907	28
29	Signage	Feb-03	895	90	10	90		345	29
30	Valances	Mar-03	662	66	10	66		248	30
31	Electrical work addition	Feb-03	8,185	205	40	205		787	31
32	Addition painting	Mar-03	5,289	132	40	132		496	32
33	Remodel breakroom	Mar-03	3,085	154	20	154		578	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,444	\$ 168,539		\$ 169,213	\$ 674	\$ 2,372,051	34

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

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

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,396,444	\$ 168,539		\$ 169,213	\$ 674	\$ 2,372,051	1
2	Thermostats in addition	Jun-03	560	56	10	56		196	2
3	Steel Doors	Jul-03	1,095	55	20	55		188	3
4	Oxygen room exhaust fan	Aug-03	2,062	52	40	52		173	4
5	Storm sewer work	Jul-03	3,500	350	10	350		1,197	5
6	Door alert system	Jan-04	1,342	134	10	134		391	6
7	Hot water heater	Nov-04	2,977	298	10	298		621	7
8	Smoke detectors, roller latches, fire window	Jan-04	8,913	797	13	686	(111)	2,001	8
9	Life safety, wall repair, carpeting	Feb-04	9,202	633	15	613	(20)	1,740	9
10	Handrails	Mar-04	1,472	147	10	147		405	10
11	Roofing	May-04	6,500	325	20	325		841	11
12	Remodel tubroom, room 121 & 123, hallways	Jun-04	47,702	2,385	20	2,385		5,972	12
13	Carpeting room 255-257, office renovations	Nov-04	13,647	683	20	682	(1)	1,422	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	Dec-04	8,348	485	17	491	6	982	14
15	Water softner for kitchen	Apr-05	3,708	371	10	371		620	15
16	Cabinet for dining	Jun-05	719	72	10	72		108	16
17	ADON office remodel	Feb-05	1,841	92	20	92		169	17
18	Living room remodel	Feb-05	1,615	80	20	81	1	149	18
19	Door for laundry room	Mar-05	536	27	20	27		47	19
20	Water lines for water softner	May-05	780	39	20	39		62	20
21	Central air conditioning unit	Jun-05	4,902	245	20	245		369	21
22	Remodel tub rooms	Jul-05	47,940	2,397	20	2,397		3,402	22
23	Kitchen hood and light fixtures	Aug-05	9,076	454	20	454		606	23
24	Replace floor in walk-in cooler	Sep-05	2,160	108	20	108		135	24
25	Doors for east hall room	Nov-05	1,280	64	20	64		69	25
26	Wall carpet and corner guards	Nov-05	2,278	176	15	152	(24)	165	26
27	Water Heater	Dec-06	3,566	178	10		(178)		27
28	Hot water delivery system	Feb-06	2,142	107	10	180	73	180	28
29	Carpeting	Mar-06	969	48	10	73	25	73	29
30	Storage area	Mar-06	1,228	61	10	93	32	93	30
31	Plumbing & electrical for dishwasher	Aug-06	1,089	54	10	36	(18)	36	31
32	Soffit work	Oct-06	4,268	213	10	71	(142)	71	32
33	Floor & wall tiling	Oct-06	13,669	342	20	114	(228)	114	33
34	TOTAL (lines 1 thru 33)		\$ 6,607,530	\$ 180,067		\$ 180,156	\$ 89	\$ 2,394,648	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,607,530	\$ 180,067		\$ 180,156	\$ 89	\$ 2,394,648	1
2	West entrance automatic door	Oct-06	1,736	87	10	29	(58)	29	2
3	Sheltered care and tub room renovations	Nov-06	16,029	401	20	68	(333)	68	3
4	Sealcoat front parking area	Sep-06	420	42	5	21	(21)	21	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,625,715	\$ 180,597		\$ 180,274	\$ (323)	\$ 2,394,766	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,625,715	\$ 180,597		\$ 180,274	\$ (323)	\$ 2,394,766	1
2									2
3									3
4									4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,625,715	\$ 180,597		\$ 180,274	\$ (323)	\$ 2,394,766	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,625,715	\$ 180,597		\$ 180,274	\$ (323)	\$ 2,394,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,625,715	\$ 180,597		\$ 180,274	\$ (323)	\$ 2,394,766	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 524,879	\$ 74,342	\$ 74,342	\$	10	\$ 180,044	71
72	Current Year Purchases	67,187	4,857	4,857		10	4,857	72
73	Fully Depreciated Assets	945,692					945,692	73
74								74
75	TOTALS	\$ 1,537,758	\$ 79,199	\$ 79,199	\$		\$ 1,130,593	75

D. Vehicle Depreciation (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	91 Chevy van, 99 Ford bus	1992 & 1999	\$ 73,703	\$ 4,924	\$ 4,924	\$	10	\$ 61,792	76
77	Maintenance	86 Chevy Pickup	1996	8,159	573	816	243	10	7,139	77
78	Maintenance	98 Dodge Truck	1999	13,280	1,328	1,328		10	10,500	78
79	Patient Transport	05 Chevy bus	2005	46,122	4,612	4,612		10	9,224	79
80	TOTALS			\$ 141,264	\$ 11,437	\$ 11,680	\$ 243		\$ 88,655	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)	\$ 8,363,682	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 271,233	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,153	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (80)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,614,014	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments	\$ 362,286	\$ 6,162	\$ 342,313	86
87	Condos	1,407,937	36,534	580,939	87
88	Duplexes	924,760	30,961	688,320	88
89	Rental Units	584,356	529	529	89
90	Garages	29,956	906	25,054	90
91	TOTALS	\$ 3,309,295	\$ 75,092	\$ 1,637,155	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 44,364	92
93			93
94			94
95		\$ 44,364	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: \$ 2,958 Description: Copy machines
 (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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		8,376		8,376
8	CNA Competency Tests		1,525		1,525
9	TOTALS	\$	\$ 9,901	\$	\$ 9,901
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,901		

C. CONTRACTUAL INCOME

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

\$ 3,000

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>25</u>
2. From other facilities (f)	<u>5</u>
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	30

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

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

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

01/01/2006 Ending: 12/31/2006

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

	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	\$	148	\$ 11,787	\$	148	\$ 11,787	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		362	19,472		362	19,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		193	16,175		193	16,175	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				39,599		39,599	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2					40,346		40,346	13
14	TOTAL			\$	703	\$ 47,433	\$ 79,944	703	\$ 127,377	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.

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 1,653,463	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	295,236		3
4	Supply Inventory (priced at <u>FIFO</u>)	48,726		4
5	Short-Term Investments			5
6	Prepaid Insurance	48,791		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)	\$ 2,046,216	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	871,693		13
14	Buildings, at Historical Cost	9,016,111		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,884,794		16
17	Accumulated Depreciation (book methods)	(5,215,073)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Process</u>	44,364		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,601,889	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,648,105	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (91,247)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(307,310)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(548)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(21,368)		36
37	Life Lease Deferred Income	(194,691)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (615,164)	\$	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	(2,011,251)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,011,251)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,626,415)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,021,690)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (8,648,105)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,871,257	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,871,257	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	150,433	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)	\$ 150,433	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)	\$ 6,021,690	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2006Ending: 12/31/2006**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		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,385,376	1
2	Discounts and Allowances for all Levels	(635,107)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,750,269	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	324,241	6
7	Oxygen	20,660	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 344,901	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	30,835	13
14	Non-Patient Meals	16,715	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,756	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,415	19
20	Radiology and X-Ray		20
21	Other Medical Services	153,058	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 268,779	23
	D. Non-Operating Revenue		
24	Contributions	357,651	24
25	Interest and Other Investment Income***	59,761	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 417,412	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	7,203	28
28a	Non-Care Facility	244,875	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 252,078	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,033,439	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,332,794	31
32	Health Care	3,469,462	32
33	General Administration	1,496,016	33
	B. Capital Expense		
34	Ownership	358,366	34
	C. Ancillary Expense		
35	Special Cost Centers	166,690	35
36	Provider Participation Fee	59,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,883,006	40
41	Income before Income Taxes (line 30 minus line 40)**	150,433	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 150,433	43

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

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

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,163	2,163	\$ 68,062	\$ 31.47	1
2	Assistant Director of Nursing	1,772	1,772	43,021	24.28	2
3	Registered Nurses	25,639	27,970	738,967	26.42	3
4	Licensed Practical Nurses	20,667	22,906	447,774	19.55	4
5	CNAs & Orderlies	112,541	122,779	1,511,796	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,827	4,245	59,107	13.92	8
9	Activity Director	1,621	1,805	24,104	13.35	9
10	Activity Assistants	11,305	12,475	115,141	9.23	10
11	Social Service Workers	3,679	3,724	54,844	14.73	11
12	Dietician					12
13	Food Service Supervisor	3,554	3,706	60,020	16.20	13
14	Head Cook	3,426	3,775	38,478	10.19	14
15	Cook Helpers/Assistants	10,820	11,779	109,517	9.30	15
16	Dishwashers	11,547	12,464	107,665	8.64	16
17	Maintenance Workers	8,066	8,770	144,219	16.44	17
18	Housekeepers	12,817	14,282	129,597	9.07	18
19	Laundry	12,206	13,545	128,401	9.48	19
20	Administrator	1,823	1,823	84,524	46.37	20
21	Assistant Administrator					21
22	Other Administrative	8,570	9,848	83,809	8.51	22
23	Office Manager	1,823	1,823	55,827	30.62	23
24	Clerical	1,677	1,897	15,741	8.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,543	283,551	\$ 4,020,614 *	\$ 14.18	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	168	\$ 7,786	1.3	35
36	Medical Director	12	2,100	9.3	36
37	Medical Records Consultant	24	1,605	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,370	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	39	2,298	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	51	2,933	10a.3	43
44	Activity Consultant	23	1,297	11.3	44
45	Social Service Consultant	25	1,420	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	\$ 22,809		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	168	\$ 5,485	10.3	50
51	Licensed Practical Nurses	617	20,228	10.3	51
52	Certified Nurse Assistants/Aides	7,705	150,745	10.3	52
53	TOTAL (lines 50 - 52)	8,489	\$ 176,458		53

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 6,933
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,198 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,420
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of Program
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.