

Facility Name & ID Number Apostolic Christian Skylines

0006353 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	115	3,386	1,135	4,636	8
9	SNF/PED					9
10	ICF	3,758	11,509		15,267	10
11	ICF/DD					11
12	SC	497	7,838		8,335	12
13	DD 16 OR LESS					13
14	TOTALS	4,370	22,733	1,135	28,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.96%

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, Assisted Living

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started Aug-66

J. Was the facility purchased or leased after January 1, 1978?
YES Date Aug-66 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 1,135

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Apostolic Christian Skylines

0006353

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	203,850	14,782	3,870	222,502	(3,774)	218,728	-	218,728		1
2	Food Purchase		174,624		174,624	(2,961)	171,663	(21,346)	150,317		2
3	Housekeeping	76,406	19,385	-	95,791	-	95,791	-	95,791		3
4	Laundry	61,651	7,206	-	68,857	-	68,857	-	68,857		4
5	Heat and Other Utilities			115,984	115,984	-	115,984	-	115,984		5
6	Maintenance	104,006	30,037	42,546	176,589	-	176,589	(2,857)	173,732		6
7	Other (specify):*				-		-		-		7
8	TOTAL General Services	445,913	246,034	162,400	854,347	(6,735)	847,612	(24,203)	823,409		8
	B. Health Care and Programs										
9	Medical Director	-	-	263	263	-	263	-	263		9
10	Nursing and Medical Records	1,783,722	99,015	3,061	1,885,798	4,826	1,890,624	(6,440)	1,884,184		10
10a	Therapy	109,069	-	60,564	169,633	-	169,633	-	169,633		10a
11	Activities	122,749	-	6,200	128,949	-	128,949	(2,235)	126,714		11
12	Social Services	24,731	-	1,996	26,727	-	26,727	-	26,727		12
13	CNA Training	-	-	-	-	-	-	-	-		13
14	Program Transportation	-	-	-	-	-	-	-	-		14
15	Other (specify):*				-		-		-		15
16	TOTAL Health Care and Programs	2,040,271	99,015	72,084	2,211,370	4,826	2,216,196	(8,675)	2,207,521		16
	C. General Administration										
17	Administrative	95,731	-	-	95,731	-	95,731	-	95,731		17
18	Directors Fees			-	-	-	-	-	-		18
19	Professional Services			25,039	25,039	1,518	26,557	-	26,557		19
20	Dues, Fees, Subscriptions & Promotions			14,243	14,243	(5,194)	9,049	-	9,049		20
21	Clerical & General Office Expenses	84,423	16,062	106,774	207,259	3,676	210,935	(21,209)	189,726		21
22	Employee Benefits & Payroll Taxes			695,121	695,121	6,735	701,856	-	701,856		22
23	Inservice Training & Education			-	-	2,084	2,084	-	2,084		23
24	Travel and Seminar			8,533	8,533	(2,084)	6,449	-	6,449		24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-		25
26	Insurance-Prop.Liab.Malpractice			85,875	85,875	-	85,875	-	85,875		26
27	Other (specify):*				-		-		-		27
28	TOTAL General Administration	180,154	16,062	935,585	1,131,801	6,735	1,138,536	(21,209)	1,117,327		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,666,338	361,111	1,170,069	4,197,518	4,826	4,202,344	(54,087)	4,148,257		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

Facility Name & ID Number Apostolic Christian Skylines #0006353 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			286,018	286,018		286,018	(148,480)	137,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,743	1,743		1,743	(1,743)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			287,761	287,761		287,761	(150,223)	137,538			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			175,981	175,981	(4,826)	171,155		171,155			39
40	Barber and Beauty Shops			23,238	23,238		23,238		23,238			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			230,427	230,427	(4,826)	225,601		225,601			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,666,338	361,111	1,688,257	4,715,706		4,715,706	(204,310)	4,511,396			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: 01/01/2006 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	(16,302)	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	15,993	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	(204,001)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (204,310)		\$	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))	\$ (204,310)		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			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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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 Skylines # 0006353 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

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.)

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

B. Real Estate Taxes

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																
1. Real Estate Tax accrual used on 2005 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 2006 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. <i>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</i>	\$	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. <i>(Attach a copy of the real estate tax appeal board's decision.)</i>	\$	6																														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7																														
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td>2001</td><td>_____</td><td style="text-align: center;">8</td></tr> <tr><td>2002</td><td>_____</td><td style="text-align: center;">9</td></tr> <tr><td>2003</td><td>_____</td><td style="text-align: center;">10</td></tr> <tr><td>2004</td><td>_____</td><td style="text-align: center;">11</td></tr> <tr><td>2005</td><td>_____</td><td style="text-align: center;">12</td></tr> </table>	2001	_____	8	2002	_____	9	2003	_____	10	2004	_____	11	2005	_____	12	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td style="text-align: right;">\$</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5</td><td style="text-align: right;">\$</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6</td><td style="text-align: right;">\$</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td style="text-align: right;">\$</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
2001	_____	8																														
2002	_____	9																														
2003	_____	10																														
2004	_____	11																														
2005	_____	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2005	\$																														
14	PLUS APPEAL COST FROM LINE 5	\$																														
15	LESS REFUND FROM LINE 6	\$																														
16	AMOUNT TO USE FOR RATE CALCULATION	\$																														

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.

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 Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Dean Ramseyer

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 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.

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 57,400 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories TwoC. 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 & 14 Assisted Living Units.Duplexes: 1,150 sq. ft. per unit, 16 Units.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	29	Dec-66	Dec-65	\$ 348,310	\$ 8,708	40	\$ 8,708	\$	\$ 282,132	4
5	21	Dec-71	Dec-70	396,963	9,924	40	9,924		281,844	5
6	16	Dec-85	Dec-85	750,000	18,750	40	18,750		322,500	6
7	3	Dec-89	Dec-88	205,070	5,127	40	5,127		71,775	7
8	17	Dec-95	Dec-95	870,388	21,760	40	21,760		221,949	8
	Improvement Type**									
9	17 bed room addition		Jan-96	793,538	19,838	40	19,838		166,643	9
10	Shelter care remodel		Jan-74	6,594	165	40	165		5,040	10
11	Fire prevention system		Jan-77	23,804	952	25	952		16,511	11
12	Dining room addition		Jan-78	38,922	973	40	973		28,577	12
13	Fire prevention system		Jan-79	35,330	1,413	25	1,413		26,698	13
14	Windows replacement		Jan-81	23,820	953	25	953		17,559	14
15	Kitchen remodel		Jan-82	21,631	541	40	541		15,078	15
16	Energy conservation		Jan-83	8,413	561	15	561		6,476	16
17	Shelter care remodel		Jan-84	7,742	194	40	194		5,226	17
18	Cabinets		Jan-86	1,618	108	15	108		1,187	18
19	Air conditioning units		Jan-87	6,427	643	10	643		5,053	19
20	Physical therapy remodel		Jan-89	11,503	288	40	288		6,966	20
21	Office Addition		Jan-91	50,297	1,257	40	1,257		28,669	21
22	New roof		Jan-93	14,210	1,421	10	1,421		9,638	22
23	Room remodel		Jan-94	5,154	206	25	206		2,755	23
24	Front entrance, front office, ceiling back hall		Jan-96	62,294	3,115	20	3,115		31,147	24
25	Guttering System		Jan-96	89,096	3,564	25	3,564		35,639	25
26	Fencing, soffit/facia, new door		Jan-97	28,036	1,121	25	1,121		10,420	26
27	Flooring, lighting, wall covering		Jan-98	88,061	17,612	5	17,612		58,197	27
28	Door & fire alarms		Jan-00	4,978	332	15	332		1,267	28
29	Flooring, lighting, wall covering		Jan-00	110,832	22,166	5	22,166		57,767	29
30	Flooring, lighting, wall covering		Jan-01	42,939	8,588	5	8,588		21,201	30
31	Lobby windows		Jan-01	3,577	143	25	143		1,002	31
32	Blacktopping		Jan-01	13,967	1,746	8	1,746		4,801	32
33	Balcony repair		Jan-01	10,888	544	20	544		3,266	33
34	Insulation installation		Jan-01	9,970	665	15	665		2,264	34
35	Lawn sprinkler system		Jan-01	9,650	643	15	643		2,191	35
36	Air Conditioning Unit		Jan-01	2,178	218	10	218		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 Skylines

0006353

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	Locks	Jan-02	\$ 691	\$ 35	20	\$ 35	\$	\$ 114		37
38	Flooring, tub, wall covering	Jan-02	14,570	728	20	729	1	3,539		38
39	Flooring, wall covering	Jan-02	9,786	1,957	5	1,957		5,312		39
40	Balcony repair	Jan-02	7,403	370	20	370		1,798		40
41	Carpeting in dining room	Jan-02	5,446	1,089	5	1,089		2,426		41
42	Water heater	Jan-02	4,197	420	10	420		1,067		42
43	Lawn sprinkler system	Jan-02	8,888	593	15	593		1,759		43
44	Sewer system upgrade	Jan-02	6,400	320	20	320		1,053		44
45	Air Conditioning unit	Jan-03	1,700	85	20	85		301		45
46	Sewer system upgrade	Jan-03	6,400	320	20	320		853		46
47	Countertops in kitchen	Jan-03	6,594	440	15	440		1,033		47
48	Carpeting	Jan-04	5,878	1,176	5	1,176		1,568		48
49	Wiremesh	Jan-04	1,825	122	15	122		244		49
50	Sewer system upgrade	Jan-04	9,000	450	20	450		720		50
51	Electrical panel upgrade	Jan-04	2,068	138	15	138		230		51
52	Water heater	Jan-04	7,646	765	10	765		1,147		52
53	Rewiring	Jan-04	1,327	66	20	66		77		53
54	Roofing	Jan-05	4,858	486	10	486		769		54
55	Tub room remodel	Jan-05	3,855	154	25	154		218		55
56	Carpeting	Jan-05	2,128	426	5	426		568		56
57	Alarm system	Jan-05	2,357	157	15	157		183		57
58	External water carrvoff system	Jan-05	512	21	25	20	(1)	20		58
59	Nurses Station Connector	Jul-06	387,154	4,839	40	4,853	14	4,853		59
60	Door latches	Feb-06	7,110	148	40	150	2	150		60
61	Automatic Doors	Jun-06	2,886	96	15	97	1	97		61
62	Walk-in Cooler upgrades	Feb-06	3,135	261	10	265	4	265		62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410		70

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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 12A, Carried Forward		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	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
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19									19
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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)		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	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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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)		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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	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		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	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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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)		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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	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 12D, Carried Forward		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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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)		\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410	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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410		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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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)	\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410		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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410		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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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)	\$ 4,610,014	\$ 169,901		\$ 169,922	\$ 21	\$ 1,782,410		34

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

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	\$ 841,076	\$ 64,733	\$ 64,733	\$	Various	\$ 332,967	71
72	Current Year Purchases	23,501	1,862	1,862		Various	1,862	72
73	Fully Depreciated Assets	56,925					56,925	73
74								74
75	TOTALS	\$ 921,502	\$ 66,595	\$ 66,595	\$		\$ 391,754	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	99 Ford Bus	Jun-05	\$ 58,988	\$	\$ 14,747	\$ 14,747	4	\$ 58,988	76
77	Maintenance	02 John Deere	Jun-05	6,475	862	2,075	1,213	3	6,475	77
78	Maintenance	79 John Deere	Jun-05	4,400				3	4,400	78
79	Patient Transport	06 Ford Van	Nov-06	36,187	603	615	12	5	615	79
80	TOTALS			\$ 106,050	\$ 1,465	\$ 17,437	\$ 15,972		\$ 70,478	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)	\$ 5,638,309	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 237,961	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,954	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,993	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,244,642	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	\$ 1,512,114	\$ 39,679	\$ 757,207	86
87	Equipment	91,339	7,820	39,388	87
88	Vehicle	7,450	558	30,031	88
89	Land	112,446			89
90					90
91	TOTALS	\$ 1,723,349	\$ 48,057	\$ 826,626	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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>	\$ _____

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

* 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?</p> <p><input type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			4 Total
	1 Drop-outs	2 Completed	3 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 CNA Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a.3	hrs	\$	170	\$ 10,026						170	\$ 10,026	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		73	4,530						73	4,530	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a.3	hrs		181	11,248						181	11,248	4
5	Physician Care	39.3	visits		120	5,975						120	5,975	5
6	Dental Care	39.3	visits		11	1,687						11	1,687	6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39.2	# of prescripts						156,232				156,232	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							7,261				7,261	13
14	TOTAL			\$	554	\$ 33,465	\$	163,493				554	\$ 196,958	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report 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	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 339,313	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	493,081		3
4 Supply Inventory (priced at FIFO)			4
5 Short-Term Investments	173,741		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	5,585		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,011,720	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	1,470,869		12
13 Land	113,189		13
14 Buildings, at Historical Cost	6,118,992		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	1,133,116		16
17 Accumulated Depreciation (book methods)	(3,245,006)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,591,160	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,602,880	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ (71,956)	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	(174,285)		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
36 Other Current Liabilities(specify):			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (246,241)	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
43 Other Long-Term Liabilities(specify):			43
44 Contingency Payable	(55,679)		44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (55,679)	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (301,920)	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (6,300,960)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (6,602,880)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,160,657	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,160,657	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	140,303	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)	\$ 140,303	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)	\$ 6,300,960	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Revenue	Amount	
A. Inpatient Care				
1		Gross Revenue -- All Levels of Care	\$ 3,781,514	1
2		Discounts and Allowances for all Levels	(222,533)	2
3		SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,558,981	3
B. Ancillary Revenue				
4		Day Care		4
5		Other Care for Outpatients		5
6		Therapy	85,062	6
7		Oxygen	8,102	7
8		SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 93,164	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	22,714	13
14		Non-Patient Meals	26,427	14
15		Telephone, Television and Radic	10,386	15
16		Rental of Facility Space		16
17		Sale of Drugs	13,305	17
18		Sale of Supplies to Non-Patients	2,235	18
19		Laboratory	944	19
20		Radiology and X-Ray		20
21		Other Medical Services	216,962	21
22		Laundry		22
23		SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 292,973	23
D. Non-Operating Revenue				
24		Contributions	470,227	24
25		Interest and Other Investment Income***	99,141	25
26		SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 569,368	26
E. Other Revenue (specify):****				
27		Settlement Income (Insurance, Legal, Etc.)	6,440	27
28		Non-Care Facility	204,740	28
28a		Miscellaneous Income	130,343	28a
29		SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 341,523	29
30		TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,856,009	30

2		Expenses	Amount	
A. Operating Expenses				
31		General Services	854,347	31
32		Health Care	2,211,370	32
33		General Administration	1,131,801	33
B. Capital Expense				
34		Ownership	287,761	34
C. Ancillary Expense				
35		Special Cost Centers	199,219	35
36		Provider Participation Fee	31,208	36
D. Other Expenses (specify):				
37				37
38				38
39				39
40		TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,715,706	40
41		Income before Income Taxes (line 30 minus line 40)**	140,303	41
42		Income Taxes		42
43		NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 140,303	43

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

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

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

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

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

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,944	2,080	\$ 62,876	\$ 30.23	1
2	Assistant Director of Nursing	1,930	2,080	55,618	26.74	2
3	Registered Nurses	15,647	16,625	367,536	22.11	3
4	Licensed Practical Nurses	16,435	17,672	329,236	18.63	4
5	CNAs & Orderlies	70,408	73,832	900,457	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,901	7,480	109,069	14.58	8
9	Activity Director	3,157	3,422	41,777	12.21	9
10	Activity Assistants	8,794	9,122	80,972	8.88	10
11	Social Service Workers	2,174	2,480	24,731	9.97	11
12	Dietician					12
13	Food Service Supervisor	2,253	2,365	32,254	13.64	13
14	Head Cook	3,727	3,967	41,879	10.56	14
15	Cook Helpers/Assistants	11,515	12,182	129,717	10.65	15
16	Dishwashers					16
17	Maintenance Workers	6,813	6,845	104,006	15.19	17
18	Housekeepers	6,081	6,469	76,406	11.81	18
19	Laundry	6,786	7,327	61,651	8.41	19
20	Administrator	2,256	2,672	95,731	35.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,695	8,538	84,423	9.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,028	2,120	39,006	18.40	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,762	2,887	28,993	10.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,304	190,164	\$ 2,666,338 *	\$ 14.02	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	97	\$ 3,870	1.3	35
36	Medical Director	2	263	9.3	36
37	Medical Records Consultant	12	720	10.3	37
38	Nurse Consultant	32	1,417	10.3	38
39	Pharmacist Consultant	7	609	10.3	39
40	Physical Therapy Consultant	37	2,327	10a.3	40
41	Occupational Therapy Consultant	1	88	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	3	160	11.3	44
45	Social Service Consultant	40	1,996	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	232	\$ 11,449		49

C. CONTRACT NURSES

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

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 4,567
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 33,838 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. \$ 31,208
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 benefit on Schedule V. \$ 6,735 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 16,302
- (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.