

		FOR BHF USE				

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2007
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT FOR
 LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2007)

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 License 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 <u> </u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co. <u> </u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Other <u> </u></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 <u> </u>		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. <u> </u>		<input type="checkbox"/> Trust	<input type="checkbox"/> Other <u> </u>	<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>01/01/2007</u> to <u>12/31/2007</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Thomas A. Hoffman</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Administrator</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) () 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) () Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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	(Firm Name & Address) _____																																
	(Telephone) () Fax # ()																																

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	6,977	15,713	1,685	24,375	8
9	SNF/PED					9
10	ICF	2,116	11,053		13,169	10
11	ICF/DD					11
12	SC		3,105		3,105	12
13	DD 16 OR LESS					13
14	TOTALS	9,093	29,871	1,685	40,649	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.59%

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, Condominium

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 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 1,685

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	324,790	14,068	12,872	351,730		351,730		351,730		1
2	Food Purchase		241,277		241,277		241,277	(16,804)	224,473		2
3	Housekeeping	141,635	23,247	1,969	166,851		166,851	(4,087)	162,764		3
4	Laundry	131,782	14,471	2,052	148,305		148,305		148,305		4
5	Heat and Other Utilities			241,274	241,274		241,274	(41,694)	199,580		5
6	Maintenance	153,831	14,659	53,596	222,086		222,086	(24,880)	197,206		6
7	Other (specify):*										7
8	TOTAL General Services	752,038	307,722	311,763	1,371,523		1,371,523	(87,465)	1,284,058		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,856,132	31,207	130,751	3,018,090	42,103	3,060,193	623	3,060,816		10
10a	Therapy	56,662	1,688	161,558	219,908		219,908	3,759	223,667		10a
11	Activities	140,470	7,077	4,910	152,457		152,457	(768)	151,689		11
12	Social Services	48,399	112	603	49,114		49,114		49,114		12
13	CNA Training					12,183	12,183		12,183		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,101,663	40,084	303,822	3,445,569	54,286	3,499,855	3,614	3,503,469		16
	C. General Administration										
17	Administrative	173,469			173,469		173,469	(21,480)	151,989		17
18	Directors Fees										18
19	Professional Services			13,873	13,873	(575)	13,298		13,298		19
20	Dues, Fees, Subscriptions & Promotions			21,520	21,520	(3)	21,517	(16)	21,501		20
21	Clerical & General Office Expenses	112,521	8,464	55,441	176,426	1,078	177,504	(19,811)	157,693		21
22	Employee Benefits & Payroll Taxes			942,381	942,381		942,381	3,031	945,412		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,306	8,306	(2,069)	6,237		6,237		24
25	Other Admin. Staff Transportation					25	25		25		25
26	Insurance-Prop.Liab.Malpractice			126,820	126,820		126,820	(21,784)	105,036		26
27	Other (specify):*										27
28	TOTAL General Administration	285,990	8,464	1,168,341	1,462,795	(1,544)	1,461,251	(60,060)	1,401,191		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,139,691	356,270	1,783,926	6,279,887	52,742	6,332,629	(143,911)	6,188,718		29

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

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

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Apostolic Christian Home of Eureka #0012328 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			346,325	346,325		346,325	(74,064)	272,261			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			4,860	4,860		4,860	(4,860)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			351,185	351,185		351,185	(78,924)	272,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,204	6,871	162,075	(52,742)	109,333		109,333			39
40	Barber and Beauty Shops			28,169	28,169		28,169		28,169			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		155,204	94,718	249,922	(52,742)	197,180		197,180			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,139,691	511,474	2,229,829	6,880,994		6,880,994	(222,835)	6,658,159			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: 01/01/2007

Ending: 12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,804)	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	2,171	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(208,202)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (222,835)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (222,835)		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						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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007 Ending: 12/31/2007

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Home of Eureka

0012328

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,865 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire R 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:

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

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	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	477,724	5
6	11	Aug-94	Aug-94	1,522,126	38,053	39	39,029	976	521,064	6
7	8	Dec-94	Dec-94	226,582	6,237	39	5,810	(427)	75,620	7
8			Feb-89	3,512	176	20	176		3,256	8
Improvement Type**										
9			Dec-67	17,605	206	40	29	(177)	17,605	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		20	3,460	3,460	69,200	24
25	Kitchen Addition		Dec-89	12,677	634	20	634		11,729	25
26	Bldg Improvement		Dec-89	10,281		10			10,281	26
27	Water Heater		Dec-90	2,272		20	114	114	2,033	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		438	30
31	Sprinkler Heads		Dec-90	1,504	75	20	75		1,325	31
32	Blacktopping		Dec-90	3,000	150	20	150		2,675	32
33	Cubicle Curtain Track		Jan-91	850	43	20	43		728	33
34	Carpeting/Woodwork		Jan-91	795	40	20	40		676	34
35	Key Pads/Door System		Mar-91	2,670	134	20	134		2,245	35
36	Thermo Mixing Valves		Apr-91	3,310	166	20	166		2,774	36

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

See Page 12A, Line 70 for total

**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:

01/01/2007 Ending: 12/31/2007

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		
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	1,791	39	
40	Asphalt Parking	May-92	8,938	447	20	447	6,969	40	
41	Trees & Shrubs	May-92	403	20	20	20	312	41	
42	Radiator Covers	Jan-92	5,500	275	20	275	4,393	42	
43	Plumbing Upgrade	Jan-92	2,348	117	20	117	1,868	43	
44	Shed	Jun-92	2,000	100	20	100	1,556	44	
45	Alarm System	Jun-92	4,520	226	20	226	3,504	45	
46	Lock Sets	Nov-92	1,207	60	20	60	905	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	636	55
56	Hallway Remodeling	Apr-93	2,383	119	20	119		1,749	56
57	Kitchen Flooring	Jun-93	2,441	122	20	122		1,775	57
58	Office Addition	May-94	57,234	1,431	39	1,468	37	20,065	58
59	Roof	Oct-94	17,577	879	20	879		11,646	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		13,129	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		12,718	69
70	TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 67,852		\$ 71,106	\$ 3,254	\$ 1,958,932	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:

01/01/2007 Ending: 12/31/2007

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	\$ 67,852		\$ 71,106	\$ 3,254	\$ 1,958,932	1
2	Air Conditioner	Feb-96	485		10			485	2
3	Phone System-Social Service	Feb-96	1,201		10			1,201	3
4	Air Conditioner	May-96	2,886		10			2,886	4
5	Water Softner	Jun-96	3,442		10			3,442	5
6	Social Service Office Remodel	Jan-96	2,750	207	20	138	(69)	1,993	6
7	Life Safety Code	Feb-96	8,113	336	20	406	70	4,481	7
8	Life Safety Door	Mar-96	5,061	253	20	253		2,985	8
9	Front Room Wallpaper	May-96	1,008		10			1,008	9
10	Ventilation & A/C System	May-96	5,990		10			5,990	10
11	Front Room Carpet	May-96	2,432	122	20	122		1,413	11
12	Guttering System	Jun-96	3,355	168	20	168		1,939	12
13	Air Conditioning	Jun-96	9,314	466	20	466		5,380	13
14	Air Conditioning	Aug-96	1,008	50	20	50		569	14
15	Cabinetry in Tub Room	Sep-96	2,945		10			2,945	15
16	Air Conditioning & Ventilation System	Sep-96	8,942	447	20	447		5,048	16
17	Speaker System	Oct-96	3,798		10			3,798	17
18	Life Safety Ventilation System	Oct-96	798	40	20	40		448	18
19	Six Air Conditioners	Feb-97	2,882	144	10	48	(96)	2,882	19
20	Water Heater	May-97	5,871	294	10	244	(50)	5,871	20
21	Wall Fountain	Oct-97	653	33	10	57	24	653	21
22	Draperys	Oct-97	2,839	142	10	236	94	2,839	22
23	Smoke Detectors	Jan-97	3,103	155	10	29	(126)	3,103	23
24	Carpeting	Oct-97	3,525	176	20	176		1,789	24
25	Hall Remodeling	Oct-97	16,641	832	20	832		8,459	25
26	Five Air Conditioners	Mar-98	2,447	245	10	245		2,397	26
27	Water Heater	Oct-98	2,940	294	10	294		2,710	27
28	Air Conditioner	Nov-98	5,415	542	10	542		4,924	28
29	Room Door Guards	Mar-99	2,139	214	10	214		1,882	29
30	Door Alarm Keypads	Jul-99	2,293	229	10	229		1,939	30
31	Seven Air Conditioners	Jan-99	3,182	318	10	318		2,835	31
32	Kitchen Shelving Units	May-99	2,838	283	10	284	1	2,443	32
33	Three Air Conditioners	Aug-99	1,425	143	10	143		1,197	33
34	TOTAL (lines 1 thru 33)		\$ 3,430,064	\$ 73,985		\$ 77,087	\$ 3,102	\$ 2,050,866	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:

01/01/2007 Ending: 12/31/2007

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	\$ 73,985		\$ 77,087	\$ 3,102	\$ 2,050,866	1
2	Room Door Guards	Dec-99	2,610	261	10	261		2,101	2
3	Seven Air Conditioners	Jan-00	3,626	362	10	363	1	2,874	3
4	Air Conditioner	Sep-00	1,508	151	10	151		1,101	4
5	Generator & Building	Jan-00	303,143	7,579	40	7,579		60,009	5
6	Wall Carpet	Jan-00	3,630	363	10	363		2,904	6
7	Carpeting	Mar-00	21,956	2,196	10	2,196		17,026	7
8	Courtyard Improvements	May-00	5,312	306	10	531	225	3,717	8
9	Courtyard improvements	May-99	11,738	1,444	10	1,174	(270)	9,244	9
10	Air conditioner	May-01	632	63	10	63		418	10
11	Lighting	Jul-01	2,233		5			2,233	11
12	Attached wash stations	Aug-01	849	85	10	85		542	12
13	Hot water heater	Oct-01	939		5			939	13
14	Counter top	Dec-01	550	55	10	55		335	14
15	Air conditioner	Aug-01	9,725	486	20	486		3,118	15
16	Installation of sinks	Sep-01	1,050	105	10	105		661	16
17	New dumpster door	Mar-02	928	46	20	46		265	17
18	Flooring for 2002 addition and remodel	Dec-02	85,333	4,267	20	4,267		21,335	18
19	2002 addition and remodel	Dec-02	2,247,842	56,196	40	56,196		280,980	19
20	Room designation	Feb-02	627	63	10	63		370	20
21	Water heater	Feb-02	4,147	415	10	415		2,423	21
22	Drapes and blinds for dining, activity, therapy	Dec-02	15,437	1,544	10	1,544		7,720	22
23	Courtyard sprinkler system	Jun-02	8,800	880	10	880		4,914	23
24	Gravel driveway	Jun-02	634	63	5	52	(11)	634	24
25	Landscaping for 2002 addition	Dec-02	198,700	9,935	20	9,935		49,675	25
26	Sprinkler system for 2002 addition	Dec-02	9,600	960	10	960		4,800	26
27	Surveillance camera	Feb-03	1,750	350	5	350		1,693	27
28	Water heater	Feb-03	4,965	496	10	497	1	2,404	28
29	Signage	Feb-03	895	90	10	90		435	29
30	Valances	Mar-03	662	66	10	66		314	30
31	Electrical work addition	Feb-03	8,185	205	40	205		992	31
32	Addition painting	Mar-03	5,289	132	40	132		628	32
33	Remodel breakroom	Mar-03	3,085	154	20	154		732	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,444	\$ 163,303		\$ 166,351	\$ 3,048	\$ 2,538,402	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:

01/01/2007 Ending: 12/31/2007

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	\$ 163,303		\$ 166,351	\$ 3,048	\$ 2,538,402	1
2	Thermostats in addition	Jun-03	560	56	10	56		252	2
3	Steel Doors	Jul-03	1,095	55	20	55		243	3
4	Oxygen room exhaust fan	Aug-03	2,062	52	40	52		225	4
5	Storm sewer work	Jul-03	3,500	350	10	350		1,547	5
6	Door alert system	Jan-04	1,342	134	10	134		525	6
7	Hot water heater	Nov-04	2,977	298	10	298		919	7
8	Smoke detectors, roller latches, fire window	Jan-04	8,913	797	13	686	(111)	2,687	8
9	Life safety, wall repair, carpeting	Feb-04	9,202	633	15	613	(20)	2,353	9
10	Handrails	Mar-04	1,472	147	10	147		552	10
11	Roofing	May-04	6,500	325	20	325		1,166	11
12	Remodel tubroom, room 121 & 123, hallways	Jun-04	47,702	2,385	20	2,385		8,357	12
13	Carpeting room 255-257, office renovations	Nov-04	13,647	683	20	682	(1)	2,104	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	Dec-04	8,348	485	17	491	6	1,473	14
15	Water softner for kitchen	Apr-05	3,708	371	10	371		991	15
16	Cabinet for dining	Jun-05	719	72	10	72		180	16
17	ADON office remodel	Feb-05	1,841	92	20	92		261	17
18	Living room remodel	Feb-05	1,615	81	20	81		230	18
19	Door for laundry room	Mar-05	536	27	20	27		74	19
20	Water lines for water softner	May-05	780	39	20	39		101	20
21	Central air conditioning unit	Jun-05	4,902	245	20	245		614	21
22	Remodel tub rooms	Jul-05	47,940	2,397	20	2,397		5,799	22
23	Kitchen hood and light fixtures	Aug-05	9,076	454	20	454		1,060	23
24	Replace floor in walk-in cooler	Sep-05	2,160	108	20	108		243	24
25	Doors for east hall room	Nov-05	1,280	64	20	64		133	25
26	Wall carpet and corner guards	Nov-05	2,278	176	15	152	(24)	317	26
27	Water Heater	Dec-06	3,566	357	10	357		357	27
28	Hot water delivery system	Feb-06	2,142	214	10	214		394	28
29	Carpeting	Mar-06	969	97	10	97		170	29
30	Storage area	Mar-06	1,228	123	10	123		216	30
31	Plumbing & electrical for dishwasher	Aug-06	1,089	109	10	109		145	31
32	Soffit work	Oct-06	4,268	427	10	427		498	32
33	Floor & wall tiling	Oct-06	13,669	683	20	683		797	33
34	TOTAL (lines 1 thru 33)		\$ 6,607,530	\$ 175,839		\$ 178,737	\$ 2,898	\$ 2,573,385	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:

01/01/2007

Ending: 12/31/2007

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	\$ 6,607,530	\$ 175,839		\$ 178,737	\$ 2,898	\$ 2,573,385	1
2	West entrance automatic door	1,736	174	10	174		203	2
3	Sheltered care and tub room renovations	16,029	801	20	801		869	3
4	Sealcoat front parking area	420	84	5	84		105	4
5	Garbage Disposal	942	94	5	63	(31)	63	5
6	Cabinets	679	34	10	11	(23)	11	6
7	Draperies	946	47	10	8	(39)	8	7
8	Automatic door	4,979	249	10	456	207	456	8
9	Drywall in stairwell	1,973	49	20	83	34	83	9
10	Sprinkler system	802	20	20	34	14	34	10
11	Fireproofing of stairwell	1,951	49	20	65	16	65	11
12	Carpeting & cabinets rm 200	2,172	109	10	127	18	127	12
13	Fire panel	2,311	116	10	77	(39)	77	13
14	Flooring rooms 134, 135, 136	5,628	281	10	142	(139)	142	14
15	Flooring in quad	52,194	1,305	20	436	(869)	436	15
16	Front entrance hallway renovations	2,374	119	10	40	(79)	40	16
17	Exterior quad soffit replacement	10,400	260	20	87	(173)	87	17
18	Smoke detectors	569	28	10		(28)		18
19	Flooring	2,910	146	10		(146)		19
20	Sprinkler system	10,644	266	20		(266)		20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,727,189	\$ 180,070		\$ 181,425	\$ 1,355	\$ 2,576,191	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: 01/01/2007 Ending: 12/31/2007

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	\$ 465,259	\$ 77,950	\$ 77,950	\$	10	\$ 203,231	71
72	Current Year Purchases	30,017	2,506	2,506		10	2,506	72
73	Fully Depreciated Assets	1,005,312					1,005,312	73
74								74
75	TOTALS	\$ 1,500,588	\$ 80,456	\$ 80,456	\$		\$ 1,211,049	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	\$ 66,716	76
77	Maintenance	86 Chevy Pickup	1996	8,159		816	816	10	7,955	77
78	Maintenance	98 Dodge Truck	1999	13,280	1,328	1,328		10	11,828	78
79	Patient Transport	05 Chevy bus	2005	46,122	4,612	4,612		10	13,836	79
80	TOTALS			\$ 141,264	\$ 10,864	\$ 11,680	\$ 816		\$ 100,335	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 8,427,986	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 271,390	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 273,561	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,171	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,887,575	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	\$ 364,590	\$ 4,130	\$ 346,443	86
87	Condos	1,419,288	37,610	618,549	87
88	Duplexes	930,714	30,932	719,252	88
89	Rental Units	592,998	1,358	1,887	89
90	Garages	29,956	906	25,960	90
91	TOTALS	\$ 3,337,546	\$ 74,936	\$ 1,712,091	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 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: \$ - Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		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		10,733		10,733
8	CNA Competency Tests		1,450		1,450
9	TOTALS	\$	\$ 12,183	\$	\$ 12,183
10	SUM OF line 9, col. 1 and 2 (e)	\$	12,183		

C. CONTRACTUAL INCOME

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

\$ 5,400

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>20</u>
2. From other facilities (f)	<u>9</u>
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>29</u>

- (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:

01/01/2007 Ending: 12/31/2007

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	181	\$ 14,437	\$	181	\$ 14,437	1		
2	Licensed Speech and Language Development Therapist	10a.3	hrs		418	24,252		418	24,252	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a.3	hrs		236	19,814		236	19,814	4		
5	Physician Care	39.3	visits							5		
6	Dental Care	39.3	visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39.2	# of prescrpts				59,612		59,612	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					43,424		43,424	13		
14	TOTAL			\$	836	\$ 58,503	\$ 103,036	836	\$ 161,538	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: 01/01/2007Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007 (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	\$ 2,362,548	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	576,199		3
4	Supply Inventory (priced at <u>FIFO</u>)	43,650		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,603		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)	\$ 3,030,000	\$	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	9,136,538		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,924,108		16
17	Accumulated Depreciation (book methods)	(5,561,398)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>	44,364		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,415,305	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,445,305	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (56,879)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(333,387)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(99)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	(21,368)		36
37	<u>Life Lease Deferred Income</u>	(150,461)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (562,194)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Life Lease Equity</u>	(2,078,189)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,078,189)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,640,383)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,804,922)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (9,445,305)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,021,690	1
2	Restatements (describe):		2
3	Prior Period Adjustments	4,572	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,026,262	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	778,660	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 778,660	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)	\$ 6,804,922	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2007Ending: 12/31/2007

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,659,884	1
2	Discounts and Allowances for all Levels	(719,192)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,940,692	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	390,458	6
7	Oxygen	16,400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 406,858	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	28,307	13
14	Non-Patient Meals	18,772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,124	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,296	19
20	Radiology and X-Ray		20
21	Other Medical Services	172,636	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 324,135	23
D. Non-Operating Revenue			
24	Contributions	637,893	24
25	Interest and Other Investment Income***	101,014	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 738,907	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,775	28
28a	Non-Care Facility	242,287	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 249,062	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,659,654	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,371,523	31
32	Health Care	3,445,569	32
33	General Administration	1,462,795	33
B. Capital Expense			
34	Ownership	351,185	34
C. Ancillary Expense			
35	Special Cost Centers	190,244	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)*	\$ 6,880,994	40
41	Income before Income Taxes (line 30 minus line 40)**	778,660	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 778,660	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: 01/01/2007

Ending: 12/31/2007

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	2,080	2,080	\$ 63,810	\$ 30.68	1
2	Assistant Director of Nursing	1,872	1,872	45,614	24.37	2
3	Registered Nurses	25,397	27,638	751,075	27.18	3
4	Licensed Practical Nurses	21,662	24,052	477,302	19.84	4
5	CNAs & Orderlies	113,852	123,803	1,518,331	12.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,561	3,897	56,662	14.54	8
9	Activity Director	2,080	2,080	27,578	13.26	9
10	Activity Assistants	11,157	12,257	112,892	9.21	10
11	Social Service Workers	3,427	3,573	48,399	13.55	11
12	Dietician					12
13	Food Service Supervisor	3,740	3,861	66,624	17.26	13
14	Head Cook	4,010	4,326	46,991	10.86	14
15	Cook Helpers/Assistants	9,636	10,550	103,965	9.85	15
16	Dishwashers	11,470	12,204	107,210	8.78	16
17	Maintenance Workers	7,737	8,464	142,985	16.89	17
18	Housekeepers	12,931	14,349	137,635	9.59	18
19	Laundry	12,363	13,420	131,782	9.82	19
20	Administrator	1,822	1,822	90,400	49.62	20
21	Assistant Administrator					21
22	Other Administrative	7,628	8,511	81,579	9.59	22
23	Office Manager	1,822	1,822	61,589	33.80	23
24	Clerical	1,720	1,906	18,195	9.55	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)	259,967	282,487	\$ 4,090,618 *	\$ 14.48	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	166	\$ 7,862	1.3	35
36	Medical Director	34	6,000	9.3	36
37	Medical Records Consultant	33	2,176	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,668	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	19	1,101	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	54	3,145	10a.3	43
44	Activity Consultant	8	461	11.3	44
45	Social Service Consultant	8	461	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	358	\$ 24,873		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	9	289	10.3	51
52	Certified Nurse Assistants/Aides	4,620	90,237	10.3	52
53	TOTAL (lines 50 - 52)	4,629	\$ 90,526		53

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 7,150
- (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? N/A
- (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? 6.25
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 52,168 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. N/A
- (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.
N/A
- (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. \$ 16,804
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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? Yes
- 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. \$ N/A
- (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 \$5,000, 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.