

		FOR BHF USE				

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2008
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2008)

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>2/16/1966</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501c(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Thomas A. Hoffman</u> Telephone Number: <u>(309) 467-2311</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: 1px solid black; padding: 5px;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Thomas A. Hoffman</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Administrator</u></td> </tr> <tr> <td style="border: 1px solid black; padding: 5px;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(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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	(Telephone) () _____ Fax # () _____																																						

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	25,986	1
2		Skilled Pediatric (SNF/PED)			2
3	38	Intermediate (ICF)	38	13,908	3
4		Intermediate/DD			4
5	10	Sheltered Care (SC)	10	3,660	5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	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	7,296	16,133	1,048	24,477	8
9	SNF/PED					9
10	ICF	1,827	11,497		13,324	10
11	ICF/DD					11
12	SC		2,969		2,969	12
13	DD 16 OR LESS					13
14	TOTALS	9,123	30,599	1,048	40,770	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.61%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Apartment, Duplex, 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 1,048

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: 12/31/2008 Fiscal Year: 12/31/2008

* 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: 01/01/2008 Ending: 12/31/2008

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	337,414	15,272	14,320	367,006		367,006		367,006		1
2	Food Purchase		250,836		250,836	(1,513)	249,323	(15,907)	233,416		2
3	Housekeeping	144,537	27,205	1,642	173,384		173,384	(4,316)	169,068		3
4	Laundry	143,571	18,348	1,720	163,639		163,639		163,639		4
5	Heat and Other Utilities			267,624	267,624		267,624	(44,031)	223,593		5
6	Maintenance	155,125	13,386	63,502	232,013		232,013	(29,583)	202,430		6
7	Other (specify):*										7
8	TOTAL General Services	780,647	325,047	348,808	1,454,502	(1,513)	1,452,989	(93,837)	1,359,152		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,858,140	35,233	183,257	3,076,630	1,571	3,078,201		3,078,201		10
10a	Therapy	51,462	2,746	156,711	210,919		210,919		210,919		10a
11	Activities	192,316	7,106	5,660	205,082		205,082	(804)	204,278		11
12	Social Services	56,902	203	690	57,795		57,795		57,795		12
13	CNA Training					1,490	1,490	(230)	1,260		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,158,820	45,288	352,318	3,556,426	3,061	3,559,487	(1,034)	3,558,453		16
	C. General Administration										
17	Administrative	176,571			176,571		176,571	(22,236)	154,335		17
18	Directors Fees										18
19	Professional Services			15,070	15,070	(150)	14,920		14,920		19
20	Dues, Fees, Subscriptions & Promotions			20,920	20,920	(28)	20,892	(275)	20,617		20
21	Clerical & General Office Expenses	118,115	9,326	55,553	182,994	178	183,172	(37,439)	145,733		21
22	Employee Benefits & Payroll Taxes			945,998	945,998		945,998	31,412	977,410		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,451	8,451	(2,180)	6,271		6,271		24
25	Other Admin. Staff Transportation					690	690		690		25
26	Insurance-Prop.Liab.Malpractice			136,560	136,560		136,560	(24,135)	112,425		26
27	Other (specify):*										27
28	TOTAL General Administration	294,686	9,326	1,182,552	1,486,564	(1,490)	1,485,074	(52,673)	1,432,401		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,234,153	379,661	1,883,678	6,497,492	58	6,497,550	(147,544)	6,350,006		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: 01/01/2008 Ending: 12/31/2008

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			352,375	352,375		352,375	(74,284)	278,091			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			5,004	5,004		5,004	(5,004)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			357,379	357,379		357,379	(79,288)	278,091			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,334	10,322	158,656	(58)	158,598		158,598			39
40	Barber and Beauty Shops			22,811	22,811		22,811		22,811			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		148,334	92,975	241,309	(58)	241,251		241,251			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,234,153	527,995	2,334,032	7,096,180		7,096,180	(226,832)	6,869,348			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:

01/01/2008

Ending: 12/31/2008

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	(15,907)	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	3,404	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	(275)	20.3		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	(214,054)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,832)		\$	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))	\$ (226,832)		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 Medical Supplies		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 Dental Care		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:

01/01/2008

Ending:

12/31/2008

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: 01/01/2008 Ending: 12/31/2008

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: 01/01/2008 Ending: 12/31/2008

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

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

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	1966	1966	\$ 488,404	\$	40	\$	\$	\$ 488,404	4
5	38	1975	1975	605,234	15,091	40	15,131	40	492,855	5
6	11	1994	1994	1,522,126	38,053	39	39,029	976	560,093	6
7	8	1994	1994	226,582	6,237	39	5,810	(427)	81,430	7
8			1989	3,512	176	20	176		3,432	8
Improvement Type**										
9			1967	17,605		40			17,605	9
10			1968	1,508		20			1,508	10
11			1969	11,406		20			11,406	11
12			1970	8,431		20			8,431	12
13			1971	2,975		20			2,975	13
14			1972	550		5			550	14
15			1977	38,346		20			38,346	15
16			1979	1,260		5			1,260	16
17			1981	4,140		10			4,140	17
18			1982	15,776		20			15,776	18
19			1983	4,826		10			4,826	19
20			1984	8,271		10			8,271	20
21			1985	15,630		20			15,630	21
22			1986	8,500		10			8,500	22
23			1987	950		19			950	23
24			1988	69,201		20	1	1	69,201	24
25	Kitchen Addition		1989	12,677	634	20	634		12,363	25
26	Bldg Improvement		1989	10,281		10			10,281	26
27	Water Heater		1990	2,272		20	114	114	2,147	27
28	Central Air		1990	3,978		10			3,978	28
29	Improve Door		1990	2,235		10			2,235	29
30	Remodeling		1990	503	25	20	25		463	30
31	Sprinkler Heads		1990	1,504	75	20	75		1,400	31
32	Blacktopping		1990	3,000	150	20	150		2,825	32
33	Cubicle Curtain Track		1991	850	43	20	43		771	33
34	Carpeting/Woodwork		1991	795	40	20	40		716	34
35	Key Pads/Door System		1991	2,670	134	20	134		2,379	35
36	Thermo Mixing Valves		1991	3,310	166	20	166		2,940	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:

01/01/2008

Ending: 12/31/2008

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	1991	\$ 3,012	\$	10	\$	\$	\$ 3,012	37
38 Wall Air Conditioning Unit	1991	910		10			910	38
39 Patio	1991	2,150	108	20	108		1,899	39
40 Asphalt Parking	1992	8,938	447	20	447		7,416	40
41 Trees & Shrubs	1992	403	20	20	20		332	41
42 Radiator Covers	1992	5,500	275	20	275		4,668	42
43 Plumbing Upgrade	1992	2,348	117	20	117		1,985	43
44 Shed	1992	2,000	100	20	100		1,656	44
45 Alarm System	1992	4,520	226	20	226		3,730	45
46 Lock Sets	1992	1,207	60	20	60		965	46
47 Water Heater	1992	10,252		10			10,252	47
48 Air Conditioner	1992	886		10			886	48
49 Air Conditioner	1992	926		10			926	49
50 Air Conditioner	1992	858		10			858	50
51 Drapes and Rods	1992	1,057		10			1,057	51
52 Fireplace Glass	1992	587		10			587	52
53 Air Conditioner	1993	1,303		10			1,303	53
54 Fountain Lights	1993	1,179		10			1,179	54
55 Exterior Lighting	1993	850	42	20	43	1	679	55
56 Hallway Remodeling	1993	2,383	119	20	119		1,868	56
57 Kitchen Flooring	1993	2,441	122	20	122		1,897	57
58 Office Addition	1994	57,234	1,431	39	1,468	37	21,533	58
59 Roof	1994	17,577	879	20	879		12,525	59
60 Interior Hallway	1994	7,134		10			7,134	60
61								61
62 Phone System	1994	13,120		10			13,120	62
63 Air Conditioner	1995	1,158		10			1,158	63
64 Drapes	1995	529		10			529	64
65 Remodel	1995	5,366		5			5,366	65
66 Improvements	1995	3,293		10			3,293	66
67 Roof & Insulation	1995	21,002	1,050	20	1,050		14,179	67
68 Building Improvements	1995	7,787		10			7,787	68
69 Life Safety Code	1995	21,125	1,056	20	1,056		13,774	69
70 TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 66,876		\$ 67,618	\$ 742	\$ 2,026,550	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:

01/01/2008

Ending: 12/31/2008

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 12A, Carried Forward	\$ 3,308,343	\$ 66,876		\$ 67,618	\$ 742	\$ 2,026,550	1
2	Air Conditioner	1996 485		10			485	2
3	Phone System-Social Service	1996 1,201		10			1,201	3
4	Air Conditioner	1996 2,886		10			2,886	4
5	Water Softner	1996 3,442		10			3,442	5
6	Social Service Office Remodel	1996 2,750	207	20	138	(69)	2,131	6
7	Life Safety Code	1996 8,113	336	20	406	70	4,887	7
8	Life Safety Door	1996 5,061	253	20	253		3,238	8
9	Front Room Wallpaper	1996 1,008		10			1,008	9
10	Ventilation & A/C System	1996 5,990		10			5,990	10
11	Front Room Carpet	1996 2,432	122	20	122		1,535	11
12	Guttering System	1996 3,355	168	20	168		2,107	12
13	Air Conditioning	1996 9,314	466	20	466		5,846	13
14	Air Conditioning	1996 1,008	50	20	50		619	14
15	Cabinetry in Tub Room	1996 2,945		10			2,945	15
16	Air Conditioning & Ventilation System	1996 8,942	447	20	447		5,495	16
17	Speaker System	1996 3,798		10			3,798	17
18	Life Safety Ventilation System	1996 798	40	20	40		488	18
19	Six Air Conditioners	1997 2,882		10			2,882	19
20	Water Heater	1997 5,871		10			5,871	20
21	Wall Fountain	1997 653		10			653	21
22	Draperys	1997 2,839		10			2,839	22
23	Smoke Detectors	1997 3,103		10			3,103	23
24	Carpeting	1997 3,525	176	20	176		1,965	24
25	Hall Remodeling	1997 16,641	832	20	832		9,291	25
26	Five Air Conditioners	1998 2,447	122	10	50	(72)	2,447	26
27	Water Heater	1998 2,940	147	10	230	83	2,940	27
28	Air Conditioner	1998 5,415	271	10	491	220	5,415	28
29	Room Door Guards	1999 2,139	214	10	214		2,096	29
30	Door Alarm Keypads	1999 2,293	229	10	229		2,168	30
31	Seven Air Conditioners	1999 3,182	318	10	318		3,153	31
32	Kitchen Shelving Units	1999 2,838	283	10	284	1	2,727	32
33	Three Air Conditioners	1999 1,425	143	10	143		1,340	33
34	TOTAL (lines 1 thru 33)	\$ 3,430,064	\$ 71,700		\$ 72,675	\$ 975	\$ 2,123,541	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:

01/01/2008

Ending: 12/31/2008

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	\$ 71,700		\$ 72,675	\$ 975	\$ 2,123,541	1
2	Room Door Guards	1999	2,610	261	10	261		2,362	2
3	Seven Air Conditioners	2000	3,626	362	10	363	1	3,237	3
4	Air Conditioner	2000	1,508	151	10	151		1,252	4
5	Generator & Building	2000	303,143	7,579	40	7,579		67,588	5
6	Wall Carpet	2000	3,630	363	10	363		3,267	6
7	Carpeting	2000	21,956	2,196	10	2,196		19,222	7
8	Courtyard Improvements	2000	5,312	306	10	531	225	4,248	8
9	Courtyard improvements	1999	11,738	1,444	10	1,174	(270)	10,418	9
10	Air conditioner	2001	632	63	10	63		481	10
11	Lighting	2001	2,233		5			2,233	11
12	Attached wash stations	2001	849	85	10	85		627	12
13	Hot water heater	2001	939		5			939	13
14	Counter top	2001	550	55	10	55		390	14
15	Air conditioner	2001	9,725	486	20	486		3,604	15
16	Installation of sinks	2001	1,050	105	10	105		766	16
17	New dumpster door	2002	928	46	20	46		311	17
18	Flooring for 2002 addition and remodel	2002	85,333	4,267	20	4,267		25,602	18
19	2002 addition and remodel	2002	2,247,842	56,196	40	56,196		337,176	19
20	Room designation	2002	627	63	10	63		433	20
21	Water heater	2002	4,147	415	10	415		2,838	21
22	Drapes and blinds for dining, activity, therapy	2002	15,437	1,544	10	1,544		9,264	22
23	Courtyard sprinkler system	2002	8,800	880	10	880		5,794	23
24	Gravel driveway	2002	634		5			634	24
25	Landscaping for 2002 addition	2002	198,700	9,935	20	9,935		59,610	25
26	Sprinkler system for 2002 addition	2002	9,600	960	10	960		5,760	26
27	Surveillance camera	2003	1,750	175	5	57	(118)	1,750	27
28	Water heater	2003	4,965	496	10	497	1	2,901	28
29	Signage	2003	895	90	10	90		525	29
30	Valances	2003	662	66	10	66		380	30
31	Electrical work addition	2003	8,185	205	40	205		1,197	31
32	Addition painting	2003	5,289	132	40	132		760	32
33	Remodel breakroom	2003	3,085	154	20	154		886	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,444	\$ 160,780		\$ 161,594	\$ 814	\$ 2,699,996	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:

01/01/2008

Ending: 12/31/2008

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 12C, Carried Forward		\$ 6,396,444	\$ 160,780		\$ 161,594	\$ 814	\$ 2,699,996	1
2	Thermostats in addition	2003	560	56	10	56		308	2
3	Steel Doors	2003	1,095	55	20	55		298	3
4	Oxygen room exhaust fan	2003	2,062	52	40	52		277	4
5	Storm sewer work	2003	3,500	350	10	350		1,897	5
6	Door alert system	2004	1,342	134	10	134		659	6
7	Hot water heater	2004	2,977	298	10	298		1,217	7
8	Smoke detectors, roller latches, fire window	2004	8,913	797	13	686	(111)	3,373	8
9	Life safety, wall repair, carpeting	2004	9,202	633	15	613	(20)	2,966	9
10	Handrails	2004	1,472	147	10	147		699	10
11	Roofing	2004	6,500	325	20	325		1,491	11
12	Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		10,742	12
13	Carpeting room 255-257, office renovations	2004	13,647	683	20	682	(1)	2,786	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	485	17	491	6	1,964	14
15	Water softner for kitchen	2005	3,708	371	10	371		1,362	15
16	Cabinet for dining	2005	719	72	10	72		252	16
17	ADON office remodel	2005	1,841	92	20	92		353	17
18	Living room remodel	2005	1,615	81	20	81		311	18
19	Door for laundry room	2005	536	27	20	27		101	19
20	Water lines for water softner	2005	780	39	20	39		140	20
21	Central air conditioning unit	2005	4,902	245	20	245		859	21
22	Remodel tub rooms	2005	47,940	2,397	20	2,397		8,196	22
23	Kitchen hood and light fixtures	2005	9,076	454	20	454		1,514	23
24	Replace floor in walk-in cooler	2005	2,160	108	20	108		351	24
25	Doors for east hall room	2005	1,280	64	20	64		197	25
26	Wall carpet and corner guards	2005	2,278	176	15	152	(24)	469	26
27	Water Heater	2006	3,566	357	10	357		714	27
28	Hot water delivery system	2006	2,142	214	10	214		608	28
29	Carpeting	2006	969	97	10	97		267	29
30	Storage area	2006	1,228	123	10	123		339	30
31	Plumbing & electrical for dishwasher	2006	1,089	109	10	109		254	31
32	Soffit work	2006	4,268	427	10	427		925	32
33	Floor & wall tiling	2006	13,669	683	20	683		1,480	33
34	TOTAL (lines 1 thru 33)		\$ 6,607,530	\$ 173,316		\$ 173,980	\$ 664	\$ 2,747,365	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:

01/01/2008

Ending: 12/31/2008

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 12D, Carried Forward		\$ 6,607,530	\$ 173,316		\$ 173,980	\$ 664	\$ 2,747,365	1
2	West entrance automatic door	2006	1,736	174	10	174		377	2
3	Sheltered care and tub room renovations	2006	16,029	801	20	801		1,670	3
4	Sealcoat front parking area	2006	420	84	5	84		189	4
5	Garbage Disposal	2007	942	188	5	188		251	5
6	Cabinets	2007	679	68	10	68		79	6
7	Draperies	2007	946	95	10	95		103	7
8	Automatic door	2007	4,979	498	10	498		954	8
9	Drywall in stairwell	2007	1,973	99	20	99		182	9
10	Sprinkler system	2007	802	40	20	40		74	10
11	Fireproofing of stairwell	2007	1,951	98	20	98		163	11
12	Carpeting & cabinets rm 200	2007	2,172	217	10	217		344	12
13	Fire panel	2007	2,311	231	10	231		308	13
14	Flooring rooms 134, 135, 136	2007	5,628	563	10	563		705	14
15	Flooring in quad	2007	52,194	2,610	20	2,610		3,046	15
16	Front entrance hallway renovations	2007	2,374	237	10	237		277	16
17	Exterior quad soffit replacement	2007	10,400	520	20	520		607	17
18	Smoke detectors	2007	569	57	10	57		57	18
19	Flooring	2007	2,910	291	10	291		291	19
20	Sprinkler system	2007	10,644	533	20	532	(1)	532	20
21	Fire grid ceiling	2008	1,725	43	20	79	36	79	21
22	Cabinetry in laundry	2008	561	28	10	51	23	51	22
23	Sprinkler system	2008	19,429	486	20	892	406	892	23
24	Air conditioning system	2008	2,300	58	20	29	(29)	29	24
25	Wood flooring install	2008	9,647	482	10		(482)		25
26	Doors for stairwell	2008	2,472	124	10		(124)		26
27	Wyse terminals	2008	2,546	255	5	467	212	467	27
28	Phone system install	2008	26,715	1,336	10	2,240	904	2,240	28
29	Draperies	2008	1,568	78	10	118	40	118	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	34

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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 12E, Carried Forward	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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:

01/01/2008

Ending: 12/31/2008

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		\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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:

01/01/2008

Ending: 12/31/2008

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		\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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:

01/01/2008

Ending: 12/31/2008

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 12H, Carried Forward	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,794,152	\$ 183,610		\$ 185,259	\$ 1,649	\$ 2,761,450	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: 01/01/2008 Ending: 12/31/2008

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	\$ 439,828	\$ 76,787	\$ 76,787		10	\$ 227,076	71
72	Current Year Purchases	22,212	2,222	2,222		10	2,222	72
73	Fully Depreciated Assets	1,060,760					1,060,760	73
74								74
75	TOTALS	\$ 1,522,800	\$ 79,009	\$ 79,009	\$		\$ 1,290,058	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	\$ 71,640	76
77	Maintenance	86 Chevy, 98 Dodge Pickup	1996 & 1999	21,439	1,328	1,328		10	21,111	77
78	Patient Transport	07 Chevy Van	2008	35,100	1,755	3,510	1,755	10	3,510	78
79	Patient Transport	05 Chevy bus	2005	46,122	4,612	4,612		10	18,448	79
80	TOTALS			\$ 176,364	\$ 12,619	\$ 14,374	\$ 1,755		\$ 114,709	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)	\$ 8,552,261 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 275,238 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 278,642 83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,404 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,166,217 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	\$ 397,708	\$ 5,434	\$ 351,877	86
87	Condos	1,424,739	38,262	656,811	87
88	Duplexes	939,248	30,877	750,129	88
89	Rental Units	592,998	1,658	3,545	89
90	Garages	29,956	906	26,866	90
91	TOTALS	\$ 3,384,649	\$ 77,137	\$ 1,789,228	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 68,161	92
93			93
94			94
95		\$ 68,161	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)			9,725	9,725
6	Transportation				
7	Contractual Payments			785	785
8	CNA Competency Tests		1,260	230	1,490
9	TOTALS	\$	\$ 1,260	\$ 10,740	\$ 12,000
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,260		

C. CONTRACTUAL INCOME

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

\$ 1,210

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>22</u>
2. From other facilities (f)	<u>4</u>
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>26</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:

01/01/2008

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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	\$	189	\$ 16,234				189	\$ 16,234	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		315	20,916				315	20,916	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		221	19,076				221	19,076	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					62,616			62,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Exceptional Care</u>	39.2										12
13	Other (specify): <u>Medical Supplies</u>	39.2						85,718			85,718	13
14	TOTAL			\$	726	\$ 56,226		\$ 148,334		726	\$ 204,559	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: 01/01/2008Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008 (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	\$ 2,837,861	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	606,419		3
4	Supply Inventory (priced at FIFO)	48,754		4
5	Short-Term Investments			5
6	Prepaid Insurance	74,901		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)	\$ 3,567,935	\$	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	9,215,406		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,016,620		16
17	Accumulated Depreciation (book methods)	(5,913,773)		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 (sp)			22
23	Other(specify): <u>Construction in Progress</u>	68,161		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,258,107	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,826,042	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 114,275	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	359,889		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	489		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>	21,318		36
37	<u>Life Lease Deferred Income</u>	117,430		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 613,401	\$	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>	2,050,791		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,050,791	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,664,192	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,161,850	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,826,042	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,804,922	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,804,922	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	356,928	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)	\$ 356,928	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,161,850	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2008Ending: 12/31/2008

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	\$ 6,840,649	1
2	Discounts and Allowances for all Levels	(703,251)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,137,398	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	369,051	6
7	Oxygen	19,938	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 388,989	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	22,871	13
14	Non-Patient Meals	17,947	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,020	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,067	19
20	Radiology and X-Ray		20
21	Other Medical Services	175,452	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 316,357	23
D. Non-Operating Revenue			
24	Contributions	326,167	24
25	Interest and Other Investment Income***	37,729	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 363,896	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	7,382	28
28a	Non-Care Facility	239,086	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 246,468	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,453,108	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,454,502	31
32	Health Care	3,556,426	32
33	General Administration	1,486,564	33
B. Capital Expense			
34	Ownership	357,379	34
C. Ancillary Expense			
35	Special Cost Centers	181,467	35
36	Provider Participation Fee	59,842	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,096,180	40
41	Income before Income Taxes (line 30 minus line 40)**	356,928	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 356,928	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.

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0012328

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Ending:

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 67,202	\$ 32.31	1
2	Assistant Director of Nursing	1,872	1,872	47,785	25.53	2
3	Registered Nurses	25,667	28,040	777,328	27.72	3
4	Licensed Practical Nurses	21,203	23,386	470,368	20.11	4
5	CNAs & Orderlies	106,003	116,245	1,495,457	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,087	3,525	51,462	14.60	8
9	Activity Director	2,144	2,144	30,512	14.23	9
10	Activity Assistants	15,281	16,615	161,804	9.74	10
11	Social Service Workers	3,880	3,969	56,902	14.34	11
12	Dietician					12
13	Food Service Supervisor	3,675	3,882	59,683	15.37	13
14	Head Cook	3,614	4,015	45,475	11.33	14
15	Cook Helpers/Assistants	11,656	12,823	134,117	10.46	15
16	Dishwashers	9,609	10,435	98,139	9.40	16
17	Maintenance Workers	7,202	7,714	141,453	18.34	17
18	Housekeepers	12,601	13,991	140,221	10.02	18
19	Laundry	12,596	13,931	143,571	10.31	19
20	Administrator	1,818	1,818	92,508	50.88	20
21	Assistant Administrator					21
22	Other Administrative	9,464	10,171	89,004	8.75	22
23	Office Manager	1,818	1,818	61,827	34.01	23
24	Clerical	1,691	1,909	16,349	8.56	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)	256,961	280,383	\$ 4,181,167 *	\$ 14.91	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	167	\$ 8,148	1.3	35
36	Medical Director	34	6,000	9.3	36
37	Medical Records Consultant	33	2,225	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,708	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	24	1,499	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	3,546	10a.3	43
44	Activity Consultant	8	500	11.3	44
45	Social Service Consultant	8	500	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	368	\$ 26,126		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	7,683	141,881	10.3	52
53	TOTAL (lines 50 - 52)	7,683	\$ 141,881		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Thomas A. Hoffman	Administrator		105,837	Workers' Compensation Insurance	\$ 162,864	IDPH License Fee	\$ 105	
Kim Joos	Business		70,734	Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,542	
				FICA Taxes	308,144	Health Care Worker Background Check	690	
				Employee Health Insurance	400,968	(Indicate # of checks performed <u>69</u>)		
				Employee Meals		Patient Background Checks	56 560	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network Dues	7,337	
				Hepatitis Immunization	1,875	Journal Star & Pantagraph Newspaper	926	
				Employee Life/Disability	6,135	Nursing Manuals & Oth Subscriptions	1,602	
				Employee Physicals	13,896	Other Membership Dues \ Licenses	3,130	
				Uniform Allowance				
				Tax Deferred Annuity	94,811	Less: Public Relations Expense	()	
				Non-Care Employee Benefits	(11,283)	Non-allowable advertising	(275)	
				Rounding		Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 176,571	\$ 977,410		\$ 20,617		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
						\$	Out-of-State Travel	\$
							In-State Travel	424
							Seminar Expense	5,847
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL		\$	Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type		Amount				\$ 6,271	
Heinold-Banwart, Ltd	Accounting		1,600					
J.L. Hubbard Insurance	Surety Bond		534					
Robert Rein, CPA	Consulting		5,493					
Benefit Planning Consultants	Consulting		2,151					
Polsinelli Shalton Flanigan Suelthaus	Legal		14					
FR&R Healthcare	Consulting		331					
Foley & Lardner LLP	Legal		4,742					
Mark J. McGrath	Legal		56					
Reclassifications			150					
Rounding			(1)					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,070					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 7,337
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 55,881 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,842
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. \$ 15,907
- (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%
- 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 \$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.