

		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>0006353</u></p> <p>Facility Name: <u>Apostolic Christian Skylines</u></p> <p>Address: <u>7023 North East Skyline Drive</u> <u>Peoria</u> <u>61614</u> <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 691-8091</u> Fax # <u>(309) 683-2505</u></p> <p>HFS ID Number: <u>37-0716056002</u></p> <p>Date of Initial License for Current Owners: <u>Aug-66</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501c(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Matt Feucht</u> Telephone Number: <u>(309) 691-8091</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:25%; 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>Matt Feucht</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>Matt Feucht</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 Skylines# 0006353 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	<u>14</u>	Skilled (SNF)	<u>14</u>	<u>5,124</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>43</u>	Intermediate (ICF)	<u>43</u>	<u>15,738</u>	3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,614</u>	5
6		ICF/DD 16 or Less			6
7	<u>86</u>	TOTALS	<u>86</u>	<u>31,476</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	<u>110</u>	<u>3,450</u>	<u>1,055</u>	<u>4,615</u>	8
9	SNF/PED					9
10	ICF	<u>3,971</u>	<u>11,129</u>		<u>15,100</u>	10
11	ICF/DD					11
12	SC	<u>534</u>	<u>8,312</u>		<u>8,846</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,615</u>	<u>22,891</u>	<u>1,055</u>	<u>28,561</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.74%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 1,055

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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	244,788	22,218	13,297	280,303	(9,538)	270,765	(4,243)	266,522		1
2	Food Purchase		240,202		240,202	(8,174)	232,028	(31,865)	200,163		2
3	Housekeeping	89,687	22,546		112,233		112,233		112,233		3
4	Laundry	46,599	7,976		54,575		54,575		54,575		4
5	Heat and Other Utilities			155,047	155,047		155,047		155,047		5
6	Maintenance	164,711	37,307	62,747	264,765		264,765	(12,799)	251,966		6
7	Other (specify):*										7
8	TOTAL General Services	545,785	330,249	231,091	1,107,125	(17,712)	1,089,413	(48,907)	1,040,506		8
	B. Health Care and Programs										
9	Medical Director			260	260		260		260		9
10	Nursing and Medical Records	1,905,567	112,859	1,601	2,020,027	(1)	2,020,026	(32,975)	1,987,051		10
10a	Therapy	34,156		97,007	131,163		131,163		131,163		10a
11	Activities	178,174		4,385	182,559		182,559	(2,861)	179,698		11
12	Social Services	64,451		690	65,141		65,141		65,141		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,182,348	112,859	103,943	2,399,150	(1)	2,399,149	(35,836)	2,363,313		16
	C. General Administration										
17	Administrative	75,000			75,000		75,000		75,000		17
18	Directors Fees										18
19	Professional Services			51,089	51,089	(15,352)	35,737		35,737		19
20	Dues, Fees, Subscriptions & Promotions			17,148	17,148		17,148		17,148		20
21	Clerical & General Office Expenses	157,326	63,663	194,067	415,056	15,779	430,835	(24,272)	406,563		21
22	Employee Benefits & Payroll Taxes			783,368	783,368	17,712	801,080		801,080		22
23	Inservice Training & Education			180	180		180		180		23
24	Travel and Seminar			7,525	7,525	(427)	7,098		7,098		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,661	96,661		96,661		96,661		26
27	Other (specify):*										27
28	TOTAL General Administration	232,326	63,663	1,150,038	1,446,027	17,712	1,463,739	(24,272)	1,439,467		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,960,459	506,771	1,485,072	4,952,302	(1)	4,952,301	(109,015)	4,843,286		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 Skylines #0006353 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			271,840	271,840		271,840	(36,919)	234,921		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,957	1,957		1,957	(1,223)	734		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			273,797	273,797		273,797	(38,142)	235,655		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		110,629	8,357	118,986	1	118,987		118,987		39
40	Barber and Beauty Shops			26,946	26,946		26,946		26,946		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			31,294	31,294		31,294		31,294		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		110,629	66,597	177,226	1	177,227		177,227		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,960,459	617,400	1,825,466	5,403,325		5,403,325	(147,157)	5,256,168		45

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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	(26,513)	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	22,202	30.3		9
10 Interest and Other Investment Income	(1,223)	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		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	(141,623)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (147,157)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (147,157)		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		1	10.3	42
43 Prescription Drugs		x			43
44		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$ 1		47

Facility Name & ID Number Apostolic Christian Skylines # 0006353 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.

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2008 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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	Promissory Note		x	Operations	-	7/31/03	41,891		7/31/08	0.0400	1,957	6
7					-							7
8					-							8
9	TOTAL Facility Related						\$ 41,891	\$			\$ 1,957	9
	B. Non-Facility Related*											
10					-							10
11					-							11
12					-							12
13					-							13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 41,891	\$			\$ 1,957	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 Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matt Feucht

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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 Skylines

0006353

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,400 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories Two

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

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

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

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

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

Apartments & Assisted Living: 18,850 sq. ft., 3 Independent Living Units & 14 Assisted Living Units.

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

01/01/2008

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	29	1966	1965	\$ 348,310	\$ 8,708	40	\$ 8,708	\$	\$ 299,548	4
5	21	1971	1970	396,963	9,924	40	9,924		301,692	5
6	16	1985	1985	750,000	18,750	40	18,750		360,000	6
7	3	1989	1988	205,070	5,127	40	5,127		82,029	7
8	17	1995	1995	870,388	21,760	40	21,760		265,469	8
Improvement Type**										
9	17 bed room addition		1996	793,538	19,838	40	19,838		206,319	9
10	Shelter care remodel		1974	6,594	165	40	165		5,370	10
11	Fire prevention system		1977	23,804	952	25	952		18,415	11
12	Dining room addition		1978	38,922	973	40	973		30,523	12
13	Fire prevention system		1979	35,330	1,413	25	1,413		29,524	13
14	Windows replacement		1981	23,820	953	25	953		19,465	14
15	Kitchen remodel		1982	21,631	541	40	541		16,160	15
16	Energy conservation		1983	8,413	561	15	561		7,598	16
17	Shelter care remodel		1984	7,742	194	40	194		5,614	17
18	Cabinets		1986	1,618	108	15	108		1,403	18
19	Air conditioning units		1987	6,427	89	10	643	554	6,339	19
20	Physical therapy remodel		1989	11,503	288	40	288		7,542	20
21	Office Addition		1991	50,297	1,257	40	1,257		31,183	21
22	New roof		1993	14,210	1,421	10	1,421		12,480	22
23	Room remodel		1994	5,154	206	25	206		3,167	23
24	Front entrance, front office, ceiling back hall		1996	62,294	3,115	20	3,115		37,377	24
25	Guttering System		1996	89,096	3,564	25	3,564		42,767	25
26	Fencing, soffit/facia, new door		1997	28,036	1,121	25	1,121		12,662	26
27	Flooring, lighting, wall covering		1998	88,061		5	12,252	12,252	88,061	27
28	Door & fire alarms		2000	4,978	332	15	332		1,931	28
29	Flooring, lighting, wall covering		2000	97,127	8,732	5	19,425	10,693	93,876	29
30	Flooring, lighting, wall covering		2001	28,745	4,562	5	4,634	72	28,745	30
31	Lobby windows		2001	3,577	143	25	143		1,288	31
32	Blacktopping		2001	13,967	1,746	8	1,746		8,293	32
33	Balcony repair		2001	6,605	544	20	330	(214)	3,712	33
34	Insulation installation		2001	9,970	665	15	665		3,594	34
35	Lawn sprinkler system		2001		643	15		(643)		35
36	Air Conditioning Unit		2001	2,178	218	10	218		1,044	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 Skylines# 0006353

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	Locks	2002	\$ 691	\$ 35	20	\$ 35	\$	\$ 184	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	4,997	38
39	Flooring, wall covering	2002	9,786	559	5	1,957	1,398	9,226	39
40	Balcony repair	2002	7,403	370	20	370		2,538	40
41	Carpeting in dining room	2002	5,446	842	5	1,089	247	4,604	41
42	Water heater	2002	4,197	420	10	420		1,907	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		320	20		(320)		44
45	Air Conditioning unit	2003	1,700	85	20	85		471	45
46	Sewer system upgrade	2003		320	20		(320)		46
47	Countertops in kitchen	2003	6,594	440	15	440		1,913	47
48	Carpeting	2004	5,878	1,176	5	1,176		3,920	48
49	Wiremesh	2004	1,825	122	15	122		488	49
50	Sewer system upgrade	2004		450	20		(450)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		506	51
52	Water heater	2004	7,646	765	10	765		2,677	52
53	Rewiring	2004	1,327	66	20	66		209	53
54	Roofing	2005	4,858	486	10	486		1,741	54
55	Tub room remodel	2005	3,855	154	25	154		526	55
56	Carpeting	2005	2,128	426	5	426		1,420	56
57	Alarm system	2005	2,357	157	15	157		497	57
58	External water carryoff system	2005	512	21	25	20	(1)	60	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	22,772	59
60	Door latches	2006	7,110	178	40	178		506	60
61	Automatic Doors	2006	2,886	192	15	192		481	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		893	62
63	Fire safety improvements	2007	19,182	480	40	480		497	63
64	Garage	2007	5,944	149	40	149		158	64
65	Locks	2007	691	69	10	69		138	65
66	Office expansion - social services	2007	2,346	59	40	59		111	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		3,317	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		367	68
69	Wood door	2007	942	63	15	63		77	69
70	TOTAL (lines 4 thru 69)		\$ 4,584,882	\$ 140,533		\$ 162,634	\$ 22,101	\$ 2,100,391	70

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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	\$ 4,584,882	\$ 140,533		\$ 162,634	\$ 22,101	\$ 2,100,391	1
2	Air conditioner compressor	2007 8,418	842	10	842		1,033	2
3	Sprinklers	2007 1,230	62	20	62		75	3
4	Maglock outswing door	2007 1,173	117	10	117		228	4
5	81 gal water heater - kitchen	2007 5,797	580	10	580		993	5
6	Heat exchangers	2007 8,455	423	20	423		693	6
7	Disposer 3 hp	2007 3,472	347	10	347		484	7
8	Door monitoring unit	2007 1,103	9	10	110	101	121	8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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 12B, Carried Forward	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
3								3
4								4
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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 12C, Carried Forward	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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 12D, Carried Forward	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
3								3
4								4
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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		\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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		\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
3								3
4								4
5								5
6								6
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

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	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	1
2								2
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,614,530	\$ 142,913		\$ 165,115	\$ 22,202	\$ 2,104,018	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2008 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	\$ 842,883	\$ 63,269	\$ 63,269		Various	\$ 408,059	71
72	Current Year Purchases					Various		72
73	Fully Depreciated Assets	111,581					111,581	73
74								74
75	TOTALS	\$ 954,464	\$ 63,269	\$ 63,269	\$		\$ 519,640	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	99 Ford Bus	1905	\$ 58,988	\$	\$		4	\$ 58,988	76
77	Maintenance	02 John Deere	1905	6,475				3	6,475	77
78	Maintenance	79 John Deere	1905	4,400				3	4,400	78
79	Patient Transport	06 Ford Van	2006	36,187	7,237	7,237		5	15,089	79
80	TOTALS			\$ 106,050	\$ 7,237	\$ 7,237	\$		\$ 84,952	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)	\$ 5,675,787	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 213,419	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 235,621	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,202	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,708,610	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	\$ 1,636,192	\$ 46,469	\$ 845,019	86
87	Equipment	103,581	10,095	58,420	87
88	Vehicle	15,150	1,857	33,745	88
89	Land	112,446			89
90					90
91	TOTALS	\$ 1,867,369	\$ 58,421	\$ 937,184	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 230,365	92
93			93
94			94
95		\$ 230,365	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.

Facility Name & ID Number

Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2008

12/31/2008

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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Apostolic Christian Skylines# 0006353 Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	\$	175	\$ 13,744	\$	175	\$ 13,744	1		
2	Licensed Speech and Language Development Therapist	10a.3	hrs		308	18,464		308	18,464	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a.3	hrs		172	14,257		172	14,257	4		
5	Physician Care	39.3	visits							5		
6	Dental Care	39.3	visits		26	1,950		26	1,950	6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39.2	# of prescrpts				108,974		108,974	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					1,655		1,655	13		
14	TOTAL			\$	681	\$ 48,415	\$ 110,629	681	\$ 159,044	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 Skylines# 0006353Report 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	\$ 92,035	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	581,432		3
4	Supply Inventory (priced at <u>FIFO</u>)			4
5	Short-Term Investments	176,926		5
6	Prepaid Insurance	64,091		6
7	Other Prepaid Expenses	5,498		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 919,982	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	6,323,103		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,201,618		16
17	Accumulated Depreciation (book methods)	(3,803,606)		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>	230,365		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,064,669	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,984,651	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 198,029	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	14,500		29
30	Accrued Salaries Payable	97,882		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 310,411	\$	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>Contingency Payable</u>	(1,749)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,749)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 308,662	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,675,989	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,984,651	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,163,174	1
2	Restatements (describe):		2
3	Prior period adjustment	(1,666,753)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,496,421	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	179,568	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)	\$ 179,568	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)	\$ 4,675,989	24 *

* This must agree with page 17, line 47.

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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	\$ 4,532,840	1
2	Discounts and Allowances for all Levels	(255,975)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,276,865	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,012	6
7	Oxygen	11,588	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 233,600	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	28,653	13
14	Non-Patient Meals	31,708	14
15	Telephone, Television and Radio	12,406	15
16	Rental of Facility Space		16
17	Sale of Drugs	35,657	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,716	19
20	Radiology and X-Ray	160	20
21	Other Medical Services	118,928	21
22	Laundry	9	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 231,237	23
D. Non-Operating Revenue			
24	Contributions	797,186	24
25	Interest and Other Investment Income***	9,323	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 806,509	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	6,720	27
28	Non-Care Facility	11,964	28
28a	Miscellaneous Income	15,998	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,682	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,582,893	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,107,125	31
32	Health Care	2,399,150	32
33	General Administration	1,446,027	33
B. Capital Expense			
34	Ownership	273,797	34
C. Ancillary Expense			
35	Special Cost Centers	145,932	35
36	Provider Participation Fee	31,294	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,403,325	40
41	Income before Income Taxes (line 30 minus line 40)**	179,568	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 179,568	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 Skylines# 0006353

Report Period Beginning:

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Ending:

12/31/2008

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	2,032	2,160	\$ 71,061	\$ 32.90	1
2	Assistant Director of Nursing	1,992	2,112	58,595	27.74	2
3	Registered Nurses	15,388	16,447	397,605	24.17	3
4	Licensed Practical Nurses	15,188	16,250	361,107	22.22	4
5	CNAs & Orderlies	72,555	77,143	963,345	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,566	1,719	34,156	19.87	8
9	Activity Director	2,003	2,108	37,981	18.02	9
10	Activity Assistants	14,348	15,174	140,193	9.24	10
11	Social Service Workers	3,915	4,043	64,451	15.94	11
12	Dietician					12
13	Food Service Supervisor	3,281	3,444	54,831	15.92	13
14	Head Cook	3,793	4,081	46,393	11.37	14
15	Cook Helpers/Assistants	11,740	12,614	139,321	11.04	15
16	Dishwashers					16
17	Maintenance Workers	8,815	9,089	161,512	17.77	17
18	Housekeepers	9,946	10,433	89,687	8.60	18
19	Laundry	4,879	5,370	46,599	8.68	19
20	Administrator	2,012	2,160	75,000	34.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,403	9,752	157,326	16.13	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	1,974	1,991	20,879	10.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,830	196,090	\$ 2,920,042 *	\$ 14.89	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	140	\$ 5,613	1.3	35
36	Medical Director	3	260	9.3	36
37	Medical Records Consultant	25	1,601	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	33	2,089	10a.3	40
41	Occupational Therapy Consultant	18	1,134	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	22	1,297	10a.3	43
44	Activity Consultant	7	280	11.3	44
45	Social Service Consultant	17	690	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	\$ 12,964		49

C. CONTRACT NURSES

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2008

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 4,658
- (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) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 33,956 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,294
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. \$ 17,712 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 26,513
- (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.