

		FOR BHF USE					

LL1

**2009**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2009)

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 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>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  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>501c(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other         </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 checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Thomas A. Hoffman</u>            (Title) <u>Administrator</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # ( )         </td> </tr> </table> <p align="right">       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) _____ (Type or Print Name) <u>Thomas A. Hoffman</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Thomas A. Hoffman</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )							

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 4/13/09

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>67</u>	<u>24,863</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>38</u>	Intermediate (ICF)	<u>38</u>	<u>13,870</u>	3
4		Intermediate/DD			4
5	<u>10</u>	Sheltered Care (SC)	<u>10</u>	<u>3,650</u>	5
6		ICF/DD 16 or Less			6
7	119	TOTALS	115	42,383	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,785</u>	<u>15,771</u>	<u>716</u>	<u>23,272</u>	8
9	SNF/PED					9
10	ICF	<u>2,145</u>	<u>10,311</u>		<u>12,456</u>	10
11	ICF/DD					11
12	SC		<u>2,877</u>		<u>2,877</u>	12
13	DD 16 OR LESS					13
14	TOTALS	8,930	28,959	716	38,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.09%

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 1966

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1966 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 32 and days of care provided 716

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: 12/31/2009 Fiscal Year: 12/31/2009

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	342,123	12,470	17,920	372,513		372,513		372,513		1
2	Food Purchase		249,904		249,904		249,904	(16,067)	233,837		2
3	Housekeeping	138,262	27,792	2,167	168,221		168,221	(4,420)	163,801		3
4	Laundry	143,341	17,275	3,052	163,668		163,668		163,668		4
5	Heat and Other Utilities			251,185	251,185		251,185	(42,909)	208,276		5
6	Maintenance	162,991	13,038	75,203	251,232		251,232	(29,896)	221,336		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	786,717	320,479	349,527	1,456,723		1,456,723	(93,292)	1,363,431		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	2,913,942	36,310	104,100	3,054,352	45,779	3,100,131		3,100,131		10
10a	Therapy	53,784	3,555	164,761	222,100		222,100	(42)	222,058		10a
11	Activities	193,185	6,179	5,962	205,326		205,326	(625)	204,701		11
12	Social Services	61,945		1,188	63,133		63,133		63,133		12
13	CNA Training					4,919	4,919		4,919		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,222,856	46,044	280,811	3,549,711	50,698	3,600,409	(667)	3,599,742		16
	<b>C. General Administration</b>										
17	Administrative	181,829			181,829		181,829	(22,783)	159,046		17
18	Directors Fees										18
19	Professional Services			13,202	13,202	(284)	12,918		12,918		19
20	Dues, Fees, Subscriptions & Promotions			17,259	17,259	(1,193)	16,066	(827)	15,239		20
21	Clerical & General Office Expenses	117,524	8,432	44,351	170,307	1,495	171,802	(26,997)	144,805		21
22	Employee Benefits & Payroll Taxes			982,321	982,321		982,321	37,548	1,019,869		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,304	8,304	(2,183)	6,121		6,121		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			132,305	132,305		132,305	(23,835)	108,470		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	299,353	8,432	1,197,742	1,505,527	(2,165)	1,503,362	(36,894)	1,466,468		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,308,926	374,955	1,828,080	6,511,961	48,533	6,560,494	(130,853)	6,429,641		29

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

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

Facility Name &amp; ID Number

Apostolic Christian Home of Eureka

#0012328

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			365,057	365,057		365,057	(76,850)	288,207			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			4,739	4,739		4,739	(4,739)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			369,796	369,796		369,796	(81,589)	288,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,343	4,528	120,871	(48,533)	72,338		72,338			39
40	Barber and Beauty Shops			24,570	24,570		24,570		24,570			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,100	58,100		58,100		58,100			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		116,343	87,198	203,541	(48,533)	155,008		155,008			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,308,926	491,298	2,285,074	7,085,298		7,085,298	(212,442)	6,872,856			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: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,067)	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	200	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	(827)	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	(195,748)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (212,442)		\$	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) )	\$ (212,442)		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 Physician		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

Facility Name & ID Number

Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	2	3	4	5	6		8	9	10				
						Amount of Note						Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
						Original	Balance							
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note									
YES	NO													
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. \$ \_\_\_\_\_ 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.)



Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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	<b>TOTALS</b>	<b>63,500</b>		<b>\$ 58,945</b>	3

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	507,986	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	599,122	6
7	4		1994	1994	226,582	6,237	39	5,810	(427)	87,240	7
8				1989	3,512	88	20	80	(8)	3,512	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			69,201	24
25		Kitchen Addition		1989	12,677	317	20	314	(3)	12,677	25
26		Bldg Improvement		1989	10,281		10			10,281	26
27		Water Heater		1990	2,272		20	114	114	2,261	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		488	30
31		Sprinkler Heads		1990	1,504	75	20	75		1,475	31
32		Blacktopping		1990	3,000	150	20	150		2,975	32
33		Cubicle Curtain Track		1991	850	43	20	43		814	33
34		Carpeting/Woodwork		1991	795	40	20	40		756	34
35		Key Pads/Door System		1991	2,670	134	20	134		2,513	35
36		Thermo Mixing Valves		1991	3,310	166	20	166		3,106	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:

01/01/2009

Ending:

12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Air Conditioning Unit	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		2,007	39
40	Asphalt Parking	1992	8,938	447	20	447		7,863	40
41	Trees & Shrubs	1992	403	20	20	20		352	41
42	Radiator Covers	1992	5,500	275	20	275		4,943	42
43	Plumbing Upgrade	1992	2,348	117	20	117		2,102	43
44	Shed	1992	2,000	100	20	100		1,756	44
45	Alarm System	1992	4,520	226	20	226		3,956	45
46	Lock Sets	1992	1,207	60	20	60		1,025	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	722	55
56	Hallway Remodeling	1993	2,383	119	20	119		1,987	56
57	Kitchen Flooring	1993	2,441	122	20	122		2,019	57
58	Office Addition	1994	57,234	1,431	39	1,468	37	23,001	58
59	Roof	1994	17,577	879	20	879		13,404	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		15,229	67
68	Building Improvements	1995	7,787		10			7,787	68
69	Life Safety Code	1995	21,125	1,056	20	1,056		14,830	69
70	TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 66,471		\$ 67,201	\$ 730	\$ 2,093,751	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:

01/01/2009

Ending:

12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,308,343	\$ 66,471		\$ 67,201	\$ 730	\$ 2,093,751	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)	2,269	6
7	Life Safety Code	1996	8,113	336	20	406	70	5,293	7
8	Life Safety Door	1996	5,061	253	20	253		3,491	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		1,657	11
12	Guttering System	1996	3,355	168	20	168		2,275	12
13	Air Conditioning	1996	9,314	466	20	466		6,312	13
14	Air Conditioning	1996	1,008	50	20	50		669	14
15	Cabinetry in Tub Room	1996	2,945		10			2,945	15
16	Air Conditioning & Ventilation System	1996	8,942	447	20	447		5,942	16
17	Speaker System	1996	3,798		10			3,798	17
18	Life Safety Ventilation System	1996	798	40	20	40		528	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		2,141	24
25	Hall Remodeling	1997	16,641	832	20	832		10,123	25
26	Five Air Conditioners	1998	2,447		10			2,447	26
27	Water Heater	1998	2,940		10			2,940	27
28	Air Conditioner	1998	5,415		10			5,415	28
29	Room Door Guards	1999	2,139	107	10	43	(64)	2,139	29
30	Door Alarm Keypads	1999	2,293	115	10	125	10	2,293	30
31	Seven Air Conditioners	1999	3,182	160	10	29	(131)	3,182	31
32	Kitchen Shelving Units	1999	2,838	142	10	111	(31)	2,838	32
33	Three Air Conditioners	1999	1,425	71	10	85	14	1,425	33
34	TOTAL (lines 1 thru 33)		\$ 3,430,064	\$ 70,163		\$ 70,692	\$ 529	\$ 2,194,233	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:

01/01/2009 Ending:

12/31/2009

## 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 12B, Carried Forward		\$ 3,430,064	\$ 70,163		\$ 70,692	\$ 529	\$ 2,194,233	1
2	Room Door Guards	1999	2,610	131	10	248	117	2,610	2
3	Seven Air Conditioners	2000	3,626	362	10	363	1	3,600	3
4	Air Conditioner	2000	1,508	151	10	151		1,403	4
5	Generator & Building	2000	303,143	7,579	40	7,579		75,167	5
6	Wall Carpet	2000	3,630	363	10	363		3,630	6
7	Carpeting	2000	21,956	2,196	10	2,196		21,418	7
8	Courtyard Improvements	2000	5,312	306	10	531	225	4,779	8
9	Courtyard improvements	1999	11,738	1,444	10	1,174	(270)	11,592	9
10	Air conditioner	2001	632	63	10	63		544	10
11	Lighting	2001	2,233		5			2,233	11
12	Attached wash stations	2001	849	85	10	85		712	12
13	Hot water heater	2001	939		5			939	13
14	Counter top	2001	550	55	10	55		445	14
15	Air conditioner	2001	9,725	486	20	486		4,090	15
16	Installation of sinks	2001	1,050	105	10	105		871	16
17	New dumpster door	2002	928	46	20	46		357	17
18	Flooring for 2002 addition and remodel	2002	85,333	4,267	20	4,267		29,869	18
19	2002 addition and remodel	2002	2,247,842	56,196	40	56,196		393,372	19
20	Room designation	2002	627	63	10	63		496	20
21	Water heater	2002	4,147	415	10	415		3,253	21
22	Drapes and blinds for dining, activity, therapy	2002	15,437	1,544	10	1,544		10,808	22
23	Courtyard sprinkler system	2002	8,800	880	10	880		6,674	23
24	Gravel driveway	2002	634		5			634	24
25	Landscaping for 2002 addition	2002	198,700	9,935	20	9,935		69,545	25
26	Sprinkler system for 2002 addition	2002	9,600	960	10	960		6,720	26
27	Surveillance camera	2003	1,750		5			1,750	27
28	Water heater	2003	4,965	496	10	497	1	3,398	28
29	Signage	2003	895	90	10	90		615	29
30	Valances	2003	662	66	10	66		446	30
31	Electrical work addition	2003	8,185	205	40	205		1,402	31
32	Addition painting	2003	5,289	132	40	132		892	32
33	Remodel breakroom	2003	3,085	154	20	154		1,040	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,444	\$ 158,938		\$ 159,541	\$ 603	\$ 2,859,537	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:

01/01/2009

Ending:

12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,396,444	\$ 158,938		\$ 159,541	\$ 603	\$ 2,859,537	1
2	Thermostats in addition	2003	560	56	10	56		364	2
3	Steel Doors	2003	1,095	55	20	55		353	3
4	Oxygen room exhaust fan	2003	2,062	52	40	52		329	4
5	Storm sewer work	2003	3,500	350	10	350		2,247	5
6	Door alert system	2004	1,342	134	10	134		793	6
7	Hot water heater	2004	2,977	298	10	298		1,515	7
8	Smoke detectors, roller latches, fire window	2004	8,913	797	13	686	(111)	4,059	8
9	Life safety, wall repair, carpeting	2004	9,202	633	15	613	(20)	3,579	9
10	Handrails	2004	1,472	147	10	147		846	10
11	Roofing	2004	6,500	325	20	325		1,816	11
12	Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		13,127	12
13	Carpeting room 255-257, office renovations	2004	13,647	683	20	682	(1)	3,468	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	485	17	491	6	2,455	14
15	Water softner for kitchen	2005	3,708	371	10	371		1,733	15
16	Cabinet for dining	2005	719	72	10	72		324	16
17	ADON office remodel	2005	1,841	92	20	92		445	17
18	Living room remodel	2005	1,615	81	20	81		392	18
19	Door for laundry room	2005	536	27	20	27		128	19
20	Water lines for water softner	2005	780	39	20	39		179	20
21	Central air conditioning unit	2005	4,902	245	20	245		1,104	21
22	Remodel tub rooms	2005	47,940	2,397	20	2,397		10,593	22
23	Kitchen hood and light fixtures	2005	9,076	454	20	454		1,968	23
24	Replace floor in walk-in cooler	2005	2,160	108	20	108		459	24
25	Doors for east hall room	2005	1,280	64	20	64		261	25
26	Wall carpet and corner guards	2005	2,278	176	15	152	(24)	621	26
27	Water Heater	2006	3,566	357	10	357		1,071	27
28	Hot water delivery system	2006	2,142	214	10	214		822	28
29	Carpeting	2006	969	97	10	97		364	29
30	Storage area	2006	1,228	123	10	123		462	30
31	Plumbing & electrical for diswasher	2006	1,089	109	10	109		363	31
32	Soffit work	2006	4,268	427	10	427		1,352	32
33	Floor & wall tiling	2006	13,669	683	20	683		2,163	33
34	TOTAL (lines 1 thru 33)		\$ 6,607,530	\$ 171,474		\$ 171,927	\$ 453	\$ 2,919,292	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:

01/01/2009

Ending:

12/31/2009

## 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	\$ 171,474		\$ 171,927	\$ 453	\$ 2,919,292	1
2	West entrance automatic door	2006	1,736	174	10	174		551	2
3	Sheltered care and tub room renovations	2006	16,029	801	20	801		2,471	3
4	Sealcoat front parking area	2006	420	84	5	84		273	4
5	Garbage Disposal	2007	942	188	5	188		439	5
6	Cabinets	2007	679	68	10	68		147	6
7	Draperies	2007	946	95	10	95		198	7
8	Automatic door	2007	4,979	498	10	498		1,452	8
9	Drywall in stairwell	2007	1,973	99	20	99		281	9
10	Sprinkler system	2007	802	40	20	40		114	10
11	Fireproofing of stairwell	2007	1,951	98	20	98		261	11
12	Carpeting & cabinets rm 200	2007	2,172	217	10	217		561	12
13	Fire panel	2007	2,311	231	10	231		539	13
14	Flooring rooms 134, 135, 136	2007	5,628	563	10	563		1,268	14
15	Flooring in quad	2007	52,194	2,610	20	2,610		5,656	15
16	Front entrance hallway renovations	2007	2,374	237	10	237		514	16
17	Exterior quad soffit replacement	2007	10,400	520	20	520		1,127	17
18	Smoke detectors	2007	569	57	10	57		114	18
19	Flooring	2007	2,910	291	10	291		582	19
20	Sprinkler system	2007	10,644	533	20	532	(1)	1,064	20
21	Fire grid ceiling	2008	1,725	86	20	86		165	21
22	Cabinetry in laundry	2008	561	56	10	56		107	22
23	Sprinkler system	2008	19,429	971	20	971		1,863	23
24	Air conditioning system	2008	2,300	115	20	115		144	24
25	Wood flooring install	2008	9,647	965	10	965		965	25
26	Doors for stairwell	2008	2,472	247	10	247		247	26
27	Wyse terminals	2008	2,546	509	5	509		976	27
28	Phone system install	2008	26,715	2,672	10	2,672		4,912	28
29	Draperies	2008	1,568	157	10	157		275	29
30	Tub for upstairs w.s. room	2009	15,241	762	10	509	(253)	509	30
31	Sprinklers, fire damper updates w/caulking	2009	13,436	616	12	939	323	939	31
32	Flooring rms 109,110,111,112	2009	5,800	290	10	437	147	437	32
33	Auto doors, elevator & phone, walls, floors east rms.	2009	267,524	6,804	20	7,842	1,038	7,842	33
34	TOTAL (lines 1 thru 33)		\$ 7,096,153	\$ 193,128		\$ 194,835	\$ 1,707	\$ 2,956,285	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,096,153	\$ 193,128		\$ 194,835	\$ 1,707	\$ 2,956,285	1
2	Water heater	2009	6,216	311	10	208	(103)	208	2
3	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009	15,716	785	10	396	(389)	396	3
4	Cabinets kitchen, water line n. hall & wing	2009	4,711	163	16	74	(89)	74	4
5	Flooring rm 253	2009	1,845	92	10	16	(76)	16	5
6	Exit lighting	2009	2,304	115	10		(115)		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)		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	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)		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	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)		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	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:

01/01/2009 Ending:

12/31/2009

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 12H, Carried Forward		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	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)		\$ 7,126,945	\$ 194,594		\$ 195,529	\$ 935	\$ 2,956,979	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: 01/01/2009 Ending: 12/31/2009

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	\$ 420,258	\$ 74,310	\$ 74,310	\$	10	\$ 261,826	71
72	Current Year Purchases	67,549	6,754	6,754		10	6,754	72
73	Fully Depreciated Assets	933,245					933,245	73
74								74
75	TOTALS	\$ 1,421,052	\$ 81,064	\$ 81,064	\$		\$ 1,201,825	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	1999	\$ 49,239	\$ 2,462	\$ 2,063	\$ (399)	10	\$ 49,239	76
77	Maintenance	86 Chevy, 98 Dodge Pickup	1996 & 1999	21,439	664	328	(336)	10	21,439	77
78	Patient Transport	07 Chevy Van	2008	35,100	3,510	3,510		10	7,020	78
79	Patient Transport	05 Chevy bus	2005	46,122	4,612	4,612		10	23,060	79
80	TOTALS			\$ 151,900	\$ 11,248	\$ 10,513	\$ (735)		\$ 100,758	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 8,758,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 286,906	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 287,106	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 200	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,259,562	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	\$ 402,171	\$ 6,219	\$ 358,096	86
87	Condos	1,431,173	38,857	695,669	87
88	Duplexes	949,817	30,511	780,639	88
89	Rental Units	592,998	1,658	5,204	89
90	Garages	29,956	906	27,771	90
91	TOTALS	\$ 3,406,115	\$ 78,151	\$ 1,867,379	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 115,181	92
93			93
94			94
95		\$ 115,181	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.	_____/2010	\$ _____
13.	_____/2011	\$ _____
14.	_____/2012	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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)				
6	Transportation				
7	Contractual Payments		3,479		3,479
8	CNA Competency Tests		1,440		1,440
9	TOTALS	\$	\$ 4,919	\$	\$ 4,919
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,919		

- (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.

\$ 1,830

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>21</u>
2. From other facilities (f)	<u>3</u>
DROP-OUTS	
1. From this facility	<u>5</u>
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>29</b>

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	192	\$ 16,607	\$	192	\$ 16,607	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		415	26,558		415	26,558	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		312	26,971		312	26,971	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				37,405		37,405	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					30,405		30,405	13
14	TOTAL			\$	919	\$ 70,136	\$ 67,810	919	\$ 137,946	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

# 0012328

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009 (last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,758,083	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	291,732	3
4	Supply Inventory (priced at <u>FIFO</u> )	46,169	4
5	Short-Term Investments		5
6	Prepaid Insurance	93,827	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>A/R Other</u>		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,189,811	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	871,693	13
14	Buildings, at Historical Cost	9,548,141	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	2,033,093	16
17	Accumulated Depreciation (book methods)	(6,208,219)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): <u>Construction in Progress</u>	115,181	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,359,889	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,549,700	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 72,893	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	189,307	30
31	Accrued Taxes Payable (excluding real estate taxes)	47,310	31
32	Accrued Real Estate Taxes(Sch.IX-B)	566	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	21,318	36
37	<u>Life Lease Deferred Income</u>	180,695	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 512,089	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Life Lease Equity</u>	2,221,691	43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,221,691	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,733,780	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,815,920	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,549,700	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,161,850	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,161,850	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	654,070	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)	\$ 654,070	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 7,815,920	24 *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,647,185	1
2	Discounts and Allowances for all Levels	(676,090)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,971,095	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,434	6
7	Oxygen	21,324	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 355,758	8
<b>C. Other Operating Revenue</b>			
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	23,949	13
14	Non-Patient Meals	18,353	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,152	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,519	19
20	Radiology and X-Ray		20
21	Other Medical Services	152,154	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,127	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	801,250	24
25	Interest and Other Investment Income***	117,009	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 918,259	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,873	28
28a	Non-Care Facility	235,256	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 242,129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,739,368	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,456,723	31
32	Health Care	3,549,711	32
33	General Administration	1,505,527	33
<b>B. Capital Expense</b>			
34	Ownership	369,796	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	145,441	35
36	Provider Participation Fee	58,100	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,085,298	40
41	Income before Income Taxes (line 30 minus line 40)**	654,070	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 654,070	43

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

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

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

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

Facility Name & ID Number      Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 70,110	\$ 33.71	1
2	Assistant Director of Nursing	1,904	1,904	50,996	26.78	2
3	Registered Nurses	26,549	28,760	826,730	28.75	3
4	Licensed Practical Nurses	20,073	21,888	460,676	21.05	4
5	CNAs & Orderlies	104,872	113,356	1,505,430	13.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,152	3,535	53,784	15.21	8
9	Activity Director	2,080	2,080	29,282	14.08	9
10	Activity Assistants	15,715	16,959	163,903	9.66	10
11	Social Service Workers	3,544	3,734	61,945	16.59	11
12	Dietician					12
13	Food Service Supervisor	4,081	4,311	67,386	15.63	13
14	Head Cook	4,036	4,374	51,482	11.77	14
15	Cook Helpers/Assistants	9,959	10,824	117,780	10.88	15
16	Dishwashers	10,244	10,975	105,475	9.61	16
17	Maintenance Workers	7,807	8,469	152,675	18.03	17
18	Housekeepers	12,162	13,237	133,891	10.11	18
19	Laundry	12,459	13,631	143,341	10.52	19
20	Administrator	1,819	1,819	94,027	51.69	20
21	Assistant Administrator					21
22	Other Administrative	9,231	10,056	88,124	8.76	22
23	Office Manager	1,819	1,819	65,019	35.74	23
24	Clerical	1,629	1,821	16,115	8.85	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)	255,215	275,632	\$ 4,258,171 *	\$ 15.45	34

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	180	\$ 7,575	1.3	35
36	Medical Director	24	4,800	9.3	36
37	Medical Records Consultant	30	1,934	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,570	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	22	1,439	10a.3	43
44	Activity Consultant	10	500	11.3	44
45	Social Service Consultant	10	500	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	336	\$ 21,817		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	3,926	71,895	10.3	52
53	TOTAL (lines 50 - 52)	3,926	\$ 71,895		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2009

Ending: 12/31/2009

**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		107,497	Workers' Compensation Insurance	\$ 210,089	IDPH License Fee	\$	
Kim Joos	Business		74,332	Unemployment Compensation Insurance	2,982	Advertising: Employee Recruitment	4,014	
				FICA Taxes	313,449	Health Care Worker Background Check	710	
				Employee Health Insurance	385,910	(Indicate # of checks performed <u>71</u> )		
				Employee Meals		Patient Background Checks	44	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network Dues	7,383	
See Schedule				Hepatitis Immunization	550	Journal Star & Pantagraph Newspaper	983	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Life/Disability	10,653	Nursing Manuals & Oth Subscriptions	543	
(List each licensed administrator separately.)			\$ 181,829	Employee Physicals	15,129	Other Membership Dues \ Licenses	1,705	
				Uniform Allowance		Activity Manuals & Oth Subscriptions	288	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount	Tax Deferred Annuity	92,251	Non-allowable advertising	(827)	
			\$	Non-Care Employee Benefits	(11,143)	Yellow page advertising	( )	
				Rounding	(1)			
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,019,869	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,239	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount			Description	Amount	
Heinold-Banwart, Ltd	Accounting		2,285			Out-of-State Travel	\$	
J.L. Hubbard Insurance	Surety Bond		200					
Robert Rein, CPA	Consulting		5,509			In-State Travel	932	
Benefit Planning Consultants	Consulting		3,093					
Polsinelli Shalton Flanigan Suelthaus	Legal		1,350			Seminar Expense	5,189	
FR&R Healthcare	Consulting		183					
Heyl, Royster, Voelker & Allen			299			Entertainment Expense	( )	
						(agree to Sch. V, line 24, col. 8)		
Reclassifications			284	TOTAL	\$	TOTAL	\$ 6,121	
Rounding			(1)					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 13,202					

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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 7,383
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,324 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. \$ 58,100  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 16,067
- (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: \_\_\_\_\_
- (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.