

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493 Report Period Beginning: 01-01-09 Ending: 12-31-09

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		Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,737	7,248	1,829	19,814	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,737	7,248	1,829	19,814	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.99%

D. How many bed-hold days during this year were paid by the Department? NONE (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)

OUTPATIENT PART B THERAPY

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 05/05/75

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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 1,829

Medicare Intermediary WISCONSIN PHYSICIAN SERVICE (WPS)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

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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
	A. General Services										
1	Dietary	263,038	21,183	10,957	295,178		295,178		295,178		1
2	Food Purchase		149,083		149,083		149,083	(15,200)	133,883		2
3	Housekeeping	128,694	1,677	593	130,964		130,964		130,964		3
4	Laundry	71,287	4,370	420	76,077		76,077		76,077		4
5	Heat and Other Utilities			75,913	75,913		75,913		75,913		5
6	Maintenance	61,659	20,948	42,803	125,410		125,410		125,410		6
7	Other (specify):*		4,100	151,774	155,874		155,874	(155,874)			7
8	TOTAL General Services	524,678	201,361	282,460	1,008,499		1,008,499	(171,074)	837,425		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,475,290	199,932	96,768	1,771,990		1,771,990		1,771,990		10
10a	Therapy	98,866	1,397	9,457	109,720		109,720		109,720		10a
11	Activities	72,284	10,189	1,575	84,048		84,048		84,048		11
12	Social Services	44,237	345	1,741	46,323		46,323		46,323		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,690,677	211,863	109,541	2,012,081		2,012,081		2,012,081		16
	C. General Administration										
17	Administrative	73,522			73,522		73,522		73,522		17
18	Directors Fees										18
19	Professional Services			21,446	21,446		21,446		21,446		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	139,341	413	27,777	167,531		167,531		167,531		21
22	Employee Benefits & Payroll Taxes			513,150	513,150		513,150		513,150		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,608	34,608		34,608		34,608		26
27	Other (specify):*										27
28	TOTAL General Administration	212,863	413	596,981	810,257		810,257		810,257		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,428,218	413,637	988,982	3,830,837		3,830,837	(171,074)	3,659,763		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			342,529	342,529		342,529	(155,126)	187,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,050	38,050		38,050	(21,855)	16,195			32
33	Real Estate Taxes			591	591		591	(591)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			381,170	381,170		381,170	(177,572)	203,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8,928	8,928		8,928		8,928			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,398	33,398		33,398		33,398			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			42,326	42,326		42,326		42,326			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,428,218	413,637	1,412,478	4,254,333		4,254,333	(348,646)	3,905,687			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,200)			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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(21,855)			14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,055)		\$	30

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	(311,591)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (311,591)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (348,646)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		74,618	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 74,618		47

BHF USE ONLY							
48		49		50		51	52

APOSTOLIC CHRISTIAN HOME

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	NON-ALLOWABLE REAL ESTATE TAXES	\$ (591)	1
2	COUNTRY VIEW EXPENSES	(115,046)	2
3	COUNTRY VIEW DEPRECIATION	(34,029)	3
4	DUPLEX EXPENSES	(40,828)	4
5	DUPLEX DEPRECIATION	(121,097)	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
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32			32
33			33
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35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(311,591)	49

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
	NONE					

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.

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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	NONE								\$	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

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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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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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	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	APOSTOLIC CHRISTIAN	X		COVERAGE FOR STATE		VARIOUS	\$ 359,000	\$ 359,000	UNKNOWN		\$	16,195	1						
2	CHURCH			SHORTFALL									2						
3													3						
4													4						
5													5						
Working Capital																			
6	MORTON COMMUNITY		X	WORKING CAPITAL	VARIOUS	VARIOUS			VARIOUS	6.0000		16,195	6						
7	BANK			STATE SHORTFALL									7						
8													8						
9	TOTAL Facility Related						\$ 359,000	\$ 359,000			\$	16,195	9						
B. Non-Facility Related*																			
10	COMMERCE BANK		X	COUNTRY VIEW LOAN	\$7,800.00	3/28/00	875,000	363,376	4/10/15	5.4300		21,855	10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related				\$7,800.00		\$ 875,000	\$ 363,376			\$	21,855	14						
15	TOTALS (line 9+line14)						\$ 1,234,000	\$ 722,376			\$	38,050	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,601 B. General Construction Type: Exterior BRICK Frame BLOCK & WOOD 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).

APOSTOLIC CHRISTIAN HOME OF ROANOKE DUPLEXES - 20 UNITS

APOSTOLIC CHRISTIAN HOME OF ROANOKE COUNTRY VIEW APARTMENTS - INDEPENDENT LIVING APARTMENTS - 14 UNITS

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>BLDG. & GROUNDS</u>	<u>100,000</u>	<u>1975</u>	<u>\$ 35,875</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	100,000		\$ 35,875	3

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			1975	1958	\$ 202,000	\$	30	\$	\$	\$ 202,000	4
5			1976	1976	22,708		30			22,708	5
6			1991	1991	671,286	22,376	30	22,376		404,633	6
7			1992	1992	129,607	4,469	30	4,469		78,207	7
8											8
	Improvement Type**										
9	Land & Bldg Improvements		1976		105,004						9
10			1977		6,591						10
11			1978		10,960						11
12			1979		9,124						12
13			1980		8,166						13
14			1981		6,506						14
15			1982		18,087						15
16			1983		36,023						16
17			1984		12,947						17
18			1985		13,333		VARIOUS			577,013	18
19			1986		8,595						19
20			1987		87,248						20
21			1988		43,526						21
22			1989		64,604						22
23			1990		11,217						23
24			1991		3,700						24
25			1992		5,410						25
26			1993		36,135						26
27			1994		14,661						27
28			1995		30,372						28
29		Soiled Utility Remodeling	1996		680					680	29
30		Fixed TV Monitoring System	1996		278					278	30
31		Remodel 14 East	1996		2,781					2,781	31
32		New Sidewalk	1996		1,375					1,375	32
33		Room Remodeling (9,21,17)	1997		11,487					11,487	33
34		Room Remodeling (11,8,10,19,5,6)	1997		17,049					17,049	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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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	FIRE ALARM SYSTEM COSTS	1998	\$ 12,671	\$	7	\$	\$	\$ 12,671	37
38	ROOM REMODELING (3,12,14)	1998	13,953		7			13,953	38
39	GAS LINE WORK	1998	1,033		7			1,033	39
40	PARKING LOT	1998	19,397		7			19,397	40
41	COURTYARD	1998	15,971		7			15,971	41
42	FIRE ALARM SYSTEM COSTS	1999	87,698		7			87,698	42
43	CALL LIGHT SYSTEM COSTS	1999	40,500		7			40,500	43
44	EAST ROOM REMODELING	1999	23,345		7			23,345	44
45	PT RESTROOM REMODELING	1999	605		7			605	45
46	MULTI-PURPOSE ROOM REMODELING	1999	1,438		7			1,438	46
47	SPRINKLER SYSTEM ADDITIONS	1999	3,166		7			3,166	47
48	STORM SEWER WORK	1999	2,396		7			2,396	48
49	DOOR ALARM SYSTEM	1999	2,075		7			2,075	49
50	WEST STATION ARCHITECT FEES	1999	4,742		7			4,742	50
51	EAST SIDE STATION REMODELING	2000	43,536		7			43,536	51
52	WEST SIDE STATION	2000	4,637		7			4,637	52
53	CALL LIGHT SYSTEM COSTS	2000	11,500		7			11,500	53
54	DOOR ALARM SYSTEM REMODEL	2000	2,093		7			2,093	54
55	RESIDENT ROOM REMODEL	2000	7,066		7			7,066	55
56	LANDSCAPING	2000	3,152		7			3,152	56
57	WATER MAIN EXTENSION	2000	1,675		7			1,675	57
58	SPRINKLER WORK	2001	19,622		7			19,622	58
59	NURSING AND SOCIAL SERVICE OFFICES	2001	1,587		7			1,587	59
60	NEW PARKING AREA	2001	2,363		7			2,363	60
61	ROOM REMODELING (12W)	2001	2,612		7			2,612	61
62	NEW WATER LINES	2001	4,581		7			4,581	62
63	ROOM REMODELED (8W)	2001	3,422		7			3,422	63
64	TUB ROOM ROOF	2001	27,941		7			27,941	64
65	WEST TUB REMODEL	2001	25,454		7			25,454	65
66	EAST HALL REMODEL	2001	23,052		7			23,052	66
67	EAST PARK AREA	2001	1,687		7			1,687	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,006,430	\$ 26,845		\$ 26,845	\$	\$ 1,733,181	70

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

01-01-09

Ending:

12-31-09

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		\$ 2,006,430	\$ 26,845		\$ 26,845	\$	\$ 1,733,181	1
2	VINYL FLOORING - HSKG	2002	1,001	71	7	71		1,001	2
3	NURSING OFFICE	2002	1,068	80	7	80		1,068	3
4	EAST HALL REMODEL	2002	12,749	380	7	380		12,749	4
5	DELAYED EGRESS LOCK	2002	1,934	140	7	140		1,934	5
6	ROOM 5 REMODEL	2002	2,999	217	7	217		2,999	6
7	ROOM REMODEL	2002	3,173	228	7	228		3,173	7
8	WATER LINE REPAIRS	2002	15,959	1,139	7	1,139		15,959	8
9	TUB ROOM REMODEL	2002	235,862	16,845	7	16,845		235,862	9
10	WEST NURSES STATION	2003	21,472	3,067	7	3,067		19,936	10
11	WATER LINE REPAIRS	2003	4,424	632	7	632		4,108	11
12	ROOM REMODEL - 2 ROOMS	2003	3,808	543	7	543		3,530	12
13	NORTH CEILING REPAIR	2003	2,980	425	7	425		2,763	13
14	MIXING VALVES	2003	679	97	7	97		630	14
15	BASEMENT STAIRS	2003	6,956	994	7	994		6,461	15
16	CANOPY SPRINKLER	2003	1,425	204	7	204		1,325	16
17	ALARM SYSTEMS	2003	3,017	431	7	431		2,801	17
18	MECHANICAL ROOM WORK	2003	2,907	415	7	415		2,697	18
19	SPRINKLER IMPROVEMENTS	2003	6,428	918	7	918		5,967	19
20	LANDSCAPING SIDEWALK	2003	4,741	611	7	611		4,741	20
21	DRYWALL REPAIR/FIRE DRYWALL	2004	13,476	1,925	7	1,925		10,587	21
22	FIRE DAMPERS	2004	2,100	300	7	300		1,650	22
23	EXIT LIGHTS	2004	4,011	573	7	573		3,151	23
24	DRAIN LINES - EAST WING	2004	1,504	214	7	214		1,177	24
25	ELEVATOR WORK	2004	8,359	1,194	7	1,194		6,567	25
26	CONCRETE EXIT	2004	850	121	7	121		666	26
27	NORTH BASEMENT IMPROVEMENTS	2004	15,554	2,222	7	2,222		12,221	27
28	FENCING	2004	10,980	1,569	7	1,569		8,629	28
29	PLUMBING UPDATE	2004	3,949	564	7	564		3,102	29
30	KITCHEN FLOOR	2004	3,713	530	7	530		2,915	30
31	GENERATOR SHED - ELECTRIC	2004	2,380	340	7	340		1,870	31
32	BASEMENT ELECTRIC PANELS	2004	1,056	150	7	150		825	32
33	WEST HALL & DINING ROOM	2004	6,600	943	7	943		5,186	33
34	TOTAL (lines 1 thru 33)		\$ 2,414,544	\$ 64,927		\$ 64,927	\$	\$ 2,121,431	34

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

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

01-01-09

Ending:

12-31-09

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		\$ 2,414,544	\$ 64,927		\$ 64,927	\$	\$ 2,121,431	1
2	KTICHEN STEAMER WIRING	2004	614	88	7	88		484	2
3	MAINTENANCE SHED	2004	34,020	4,860	7	4,860		26,730	3
4	CANOPY SPRINKLER REPAIR	2004	2,696	385	7	385		2,117	4
5	NEW FLOOR 18W	2005	1,750	250	7	250		1,125	5
6	DRYWALL STATE SURVEY	2005	8,016	1,145	7	1,145		5,152	6
7	AC RELOCATE	2005	448	64	7	64		288	7
8	WEST SIDE PLUMBING	2005	4,108	587	7	587		2,641	8
9	DINING REMODEL	2005	67,687	9,670	7	9,670		43,515	9
10	WATER LINE REPAIR	2006	728	104	7	104		364	10
11	DINING INSTALLATION	2006	850	121	7	121		424	11
12	WEST FLOOR JOIST WORK	2006	2,315	330	7	330		1,155	12
13	CANOPY UPGRADE SPRINKLER	2006	4,866	695	7	695		2,433	13
14	WEST STEPS RETAINING WALL	2006	700	100	7	100		350	14
15	SPRINKLER SYSTEM REPAIRS	2006	1,524	218	7	218		763	15
16	LAUNDRY PLUMING UPGRADE	2006	1,840	263	7	263		920	16
17	ROOM 12 REMODEL	2006	926	132	7	132		462	17
18	SIDEWALK	2007	1,008	144	7	144		360	18
19	WATER LINE REPAIRS	2007	3,300	471	7	471		1,178	19
20	NORTH END FIRE DAMPERS	2007	11,784	1,683	7	1,683		4,208	20
21	KITCHEN REMODEL	2007	92,132	13,084	7	13,084		32,625	21
22	WATER LINES WEST WING	2007	1,234	176	7	176		440	22
23	BASEMENT DOORS	2007	2,605	372	7	372		930	23
24	SIDEWALK DOOR H	2008	16,218	1,622	10	1,622		2,433	24
25	FRONT SEWER REPAIR	2008	4,216	422	10	422		633	25
26	EXIT LIGHT UPGRADE	2008	1,089	156	7	156		233	26
27	REPIPING KITCHEN HOT WATER	2008	1,658	236	7	236		354	27
28	KITCHEN DOORS	2008	12,848	1,835	7	1,835		2,752	28
29	ROOM 9 REMODEL	2008	2,289	327	7	327		490	29
30	SOUTH BASEMENT UPGRADE	2008	3,404	486	7	486		729	30
31	ACTIVITY CANOPY SPRINKLER	2008	1,295	185	7	185		277	31
32	BASEMENT SEWER IMPROVEMENT	2008	4,282	612	7	612		917	32
33	PLUMBING UPGRADE	2008	6,072	867	7	867		1,300	33
34	TOTAL (lines 1 thru 33)		\$ 2,713,066	\$ 106,617		\$ 106,617	\$	\$ 2,260,213	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	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		\$ 2,713,066	\$ 106,617		\$ 106,617	\$	\$ 2,260,213	1
2	2008	1,075	153		153		229	2
3	2009	368	26		26		26	3
4	2009	68,922	1,149		1,149		1,149	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)	\$ 2,783,431	\$ 107,945		\$ 107,945	\$	\$ 2,261,617	34

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

Facility Name & ID Number **APOSTOLIC CHRISTIAN HOME**

0021493

Report Period Beginning:

01-01-09

Ending:

12-31-09

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	\$ 373,681	\$ 66,003	\$ 66,003	\$		\$ 301,816	71
72	Current Year Purchases	105,627	10,759	10,759			10,759	72
73	Fully Depreciated Assets	728,015					728,015	73
74								74
75	TOTALS	\$ 1,207,323	\$ 76,762	\$ 76,762	\$		\$ 1,040,590	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	Resident Trips	Ford Bus	1999	\$ 49,239	\$	\$			\$ 49,239	76
77	Resident Trips	Ford Montana Minivan	2005	12,500	2,500	2,500		5	11,250	77
78	Resident Trips	BEAU VAN	2009	1,964	196	196		5	196	78
79										79
80	TOTALS			\$ 63,703	\$ 2,696	\$ 2,696	\$		\$ 60,685	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)	\$ 4,090,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,403	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,362,892	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	DUPLEXES	\$ 2,722,801	\$ 91,101	\$ 864,120	86
87	COUNTRY VIEW APARTMENTS	1,097,269	23,426	243,976	87
88	DUPLEX FURN & FIX	75,660	8,535	58,099	88
89	COUNTRY VIEW FURN & FIX	118,487	10,603	90,718	89
90	DUPLEX LAND IMPROVEMENTS	381,386	21,461	156,815	90
91	TOTALS	\$ 4,395,603	\$ 155,126	\$ 1,413,728	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" 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				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	NONE	hrs	\$												1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$				\$		\$			\$			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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12-31-09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 137,063	\$	1
2	Cash-Patient Deposits	1,214		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	385,884		3
4	Supply Inventory (priced at)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,972		6
7	Other Prepaid Expenses	(1,156)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 560,977	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,603		13
14	Buildings, at Historical Cost	6,984,889		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,465,174		16
17	Accumulated Depreciation (book methods)	(4,779,087)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,795,579	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,356,556	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 75,435	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,214		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,015		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	639		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)	\$ 297,303	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	903,674		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	DUPLEX EQUITY	2,357,534		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,261,208	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,558,511	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 798,045	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,356,556	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 554,769	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 554,769	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,640)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	482,916	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)	\$ 243,276	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)	\$ 798,045	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning: 01-01-09

Ending: 12-31-09

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	\$ 5,020,914	1
2	Discounts and Allowances for all Levels	(1,041,099)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,979,815	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	10,963	13
14	Non-Patient Meals	15,200	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,163	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,715	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,715	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,014,693	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,008,499	31
32	Health Care	2,012,081	32
33	General Administration	810,257	33
B. Capital Expense			
34	Ownership	381,170	34
C. Ancillary Expense			
35	Special Cost Centers	8,928	35
36	Provider Participation Fee	33,398	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,254,333	40
41	Income before Income Taxes (line 30 minus line 40)**	(239,640)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (239,640)	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**

0021493

Report Period Beginning:

01-01-09

Ending:

12-31-09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,635	1,784	\$ 55,078	\$ 30.87	1
2	Assistant Director of Nursing	1,411	1,595	42,444	26.61	2
3	Registered Nurses	11,879	12,891	347,829	26.98	3
4	Licensed Practical Nurses	6,540	6,992	175,494	25.10	4
5	CNAs & Orderlies	57,841	61,756	854,445	13.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,494	4,864	98,866	20.33	8
9	Activity Director	1,926	2,103	29,552	14.05	9
10	Activity Assistants	3,734	4,084	42,732	10.46	10
11	Social Service Workers	3,499	3,642	44,237	12.15	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	41,441	19.92	13
14	Head Cook	7,103	7,773	92,456	11.89	14
15	Cook Helpers/Assistants	12,337	13,079	129,141	9.87	15
16	Dishwashers					16
17	Maintenance Workers	2,091	2,321	61,659	26.57	17
18	Housekeepers	9,766	10,683	101,094	9.46	18
19	Laundry	5,774	6,255	71,287	11.40	19
20	Administrator	1,878	2,080	73,522	35.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,263	9,126	139,341	15.27	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) HSKG. SUPER	1,577	1,876	27,600	14.71	33
34	TOTAL (lines 1 - 33)	143,588	154,984	\$ 2,428,218 *	\$ 15.67	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

Facility Name & ID Number **APOSTOLIC CHRISTIAN HOME**

Report Period Beginning: **01-01-09**

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	
RICHARD D. ISAIA	ADMIN.	NONE	\$ 73,522	Workers' Compensation Insurance	\$ 62,258	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	175,246	Health Care Worker Background Check		
				Employee Health Insurance	275,646	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 73,522					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount		\$ 513,150	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Sch. V, line 20, col. 8)			\$	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
HEALTH OUTCOMES	COMP. SERVICES		\$ 7,740			\$	Out-of-State Travel	\$
HEINOLD-BANWART	ACCTG. SERVICES		3,835					
BOB REIN -CPA	ACCTG. SERVICES		3,906				In-State Travel	
ROUTE 24 -COMPUTERS	COMP. SERVICES		1,894					
HOWARD & HOWARD	LEGAL SERVICES		3,501				Seminar Expense	
MICHAEL ARENDS	COMP. SERVICES		570					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 21,446				(agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

01-01-09

Ending:

12-31-09

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. LSN \$2,587, AAHSA \$1136
- (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. \$ 34,368 Line 10
- (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. \$ 33,398
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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 15,200
- (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. \$ NONE
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.