

		FOR BHF USE					

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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>0006353</u></p> <p>Facility Name: <u>Apostolic Christian Skylines</u></p> <p>Address: <u>7023 North East Skyline Drive</u> <u>Peoria</u> <u>61614</u> <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 691-8091</u> Fax # <u>(309) 683-2505</u></p> <p>HFS ID Number: <u>37-0716056002</u></p> <p>Date of Initial License for Current Owners: <u>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>Matt Feucht</u> Telephone Number: <u>(309)691-8091</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>Matt Feucht</u> (Title) <u>Administrator</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & 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>Matt Feucht</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Matt Feucht</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 Skylines

0006353 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 _____

	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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	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	943	3,281	520	4,744	8
9	SNF/PED					9
10	ICF	3,605	13,133		16,738	10
11	ICF/DD					11
12	SC	27	8,591		8,618	12
13	DD 16 OR LESS					13
14	TOTALS	4,575	25,005	520	30,100	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.89%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 14 and days of care provided 520

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL 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 Skylines # 0006353 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
	A. General Services										
1	Dietary	284,492	13,588	28,133	326,213	6,197	332,410	(4,156)	328,254		1
2	Food Purchase		219,731		219,731	(7,827)	211,904	(30,788)	181,116		2
3	Housekeeping	113,639	23,726		137,365		137,365		137,365		3
4	Laundry	47,858	10,663		58,521		58,521		58,521		4
5	Heat and Other Utilities			153,007	153,007		153,007		153,007		5
6	Maintenance	138,983	27,560	55,466	222,009		222,009	(14,700)	207,309		6
7	Other (specify):*										7
8	TOTAL General Services	584,972	295,268	236,606	1,116,846	(1,630)	1,115,216	(49,644)	1,065,572		8
	B. Health Care and Programs										
9	Medical Director			450	450		450		450		9
10	Nursing and Medical Records	1,989,069	103,918	71,420	2,164,407	(17,818)	2,146,589	(36,650)	2,109,939		10
10a	Therapy	32,183		70,031	102,214		102,214		102,214		10a
11	Activities	194,920		4,215	199,135		199,135	(2,627)	196,508		11
12	Social Services	73,857			73,857		73,857		73,857		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,290,029	103,918	146,116	2,540,063	(17,818)	2,522,245	(39,277)	2,482,968		16
	C. General Administration										
17	Administrative	85,848			85,848		85,848		85,848		17
18	Directors Fees										18
19	Professional Services			27,797	27,797	(3,362)	24,435		24,435		19
20	Dues, Fees, Subscriptions & Promotions			16,650	16,650	(2,939)	13,711		13,711		20
21	Clerical & General Office Expenses	175,584	55,780	162,489	393,853	7,597	401,450	(33,138)	368,312		21
22	Employee Benefits & Payroll Taxes			732,898	732,898	19,447	752,345		752,345		22
23	Inservice Training & Education			651	651		651		651		23
24	Travel and Seminar			15,204	15,204	(1,296)	13,908	(223)	13,685		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			84,865	84,865		84,865		84,865		26
27	Other (specify):*										27
28	TOTAL General Administration	261,432	55,780	1,040,554	1,357,766	19,447	1,377,213	(33,361)	1,343,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,136,433	454,966	1,423,276	5,014,675	(1)	5,014,674	(122,282)	4,892,392		29

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

Facility Name & ID Number Apostolic Christian Skylines

#0006353

Report Period Beginning:

01/01/2009

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			265,652	265,652		265,652	(63,264)	202,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,229	1,229		1,229	(1,229)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			266,881	266,881		266,881	(64,493)	202,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,533	9,402	42,935	1	42,936		42,936			39
40	Barber and Beauty Shops			31,892	31,892		31,892		31,892			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		33,533	72,502	106,035	1	106,036		106,036			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,136,433	488,499	1,762,659	5,387,591		5,387,591	(186,775)	5,200,816			45

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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	(28,397)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,295	30.3		9
10	Interest and Other Investment Income	(1,229)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(160,444)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,775)		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (186,775)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39	Medical Supplies		x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology	x		1	10.3	42
43	Prescription Drugs		x			43
44	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)			\$ 1		47

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2009

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

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

Facility Name & ID Number

Apostolic Christian Skylines

0006353

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									
					Name of Lender	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						\$	\$			\$ -	1							
2										-	2							
3										-	3							
4										-	4							
5										-	5							
Working Capital																		
6	Promissory Note		x	Operations		31-Jul-03	41,891		Jul-08	4.000%	1,229.00	6						
7										-	7							
8										-	8							
9	TOTAL Facility Related					\$	41,891	\$		\$	1,229	9						
B. Non-Facility Related*																		
10										-	10							
11										-	11							
12										-	12							
13										-	13							
14	TOTAL Non-Facility Related					\$		\$		\$		14						
15	TOTALS (line 9+line14)					\$	41,891	\$		\$	1,229	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 Skylines

0006353

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

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	29		1966	1965	\$ 348,310	\$ 8,708	40	\$ 8,708	\$	\$ 308,256	4
5	21		1971	1970	396,963	9,924	40	9,924		311,616	5
6	16		1985	1985	750,000	18,750	40	18,750		378,750	6
7	3		1989	1988	205,070	5,127	40	5,127		87,156	7
8	17		1995	1995	870,388	21,760	40	21,760		287,229	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		226,157	9
10	Shelter care remodel			1974	6,594	165	40	165		5,535	10
11	Fire prevention system			1977	23,804	952	25	952		19,367	11
12	Dining room addition			1978	38,922	973	40	973		31,496	12
13	Fire prevention system			1979	35,330	1,413	25	1,413		30,937	13
14	Windows replacement			1981	23,820	953	25	953		20,418	14
15	Kitchen remodel			1982	21,631	541	40	541		16,701	15
16	Energy conservation			1983	8,413	255	15	561	306	8,159	16
17	Shelter care remodel			1984	7,742	194	40	194		5,808	17
18	Cabinets			1986	1,618	108	15	108		1,511	18
19	Air conditioning units			1987	6,427		10	88	88	6,427	19
20	Physical therapy remodel			1989	11,503	288	40	288		7,830	20
21	Office Addition			1991	50,297	1,257	40	1,257		32,440	21
22	New roof			1993	14,210	309	10	1,421	1,112	13,901	22
23	Room remodel			1994	5,154	206	25	206		3,373	23
24	Front entrance, front office, ceiling back hall			1996	62,294	3,115	20	3,115		40,492	24
25	Guttering System			1996	89,096	3,564	25	3,564		46,331	25
26	Fencing, soffit/ fascia, new door			1997	28,036	1,121	25	1,121		13,783	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978	332	15	332		2,263	28
29	Flooring, lighting, wall covering			2000	97,127		5	3,251	3,251	97,127	29
30	Flooring, lighting, wall covering			2001	28,745		5			28,745	30
31	Lobby windows			2001	3,577	143	25	143		1,431	31
32	Blacktopping			2001	13,967	1,746	8	1,746		10,039	32
33	Balcony repair			2001	6,605	544	20	330	(214)	4,042	33
34	Insulation installation			2001	9,970	665	15	665		4,259	34
35	Lawn sprinkler system			2001		643	15		(643)		35
36				2001	2,178	218	10	218		1,262	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2009

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	Locks	2002	\$ 691	\$ 35	20	\$ 35	\$	\$ 219	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	5,726	38
39	Flooring, wall covering	2002	9,786		5	560	560	9,786	39
40	Balcony repair	2002	7,403	370	20	370		2,908	40
41	Carpeting in dining room	2002	5,446		5	842	842	5,446	41
42	Water heater	2002	4,197	420	10	420		2,327	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		320	20		(320)		44
45	Air Conditioning unit	2003	1,700	85	20	85		556	45
46	Sewer system upgrade	2003		320	20		(320)		46
47	Countertops in kitchen	2003	6,594	440	15	440		2,353	47
48	Carpeting	2004	5,878	784	5	1,176	392	5,096	48
49	Wiremesh	2004	1,825	122	15	122		610	49
50	Sewer system upgrade	2004		450	20		(450)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		644	51
52	Water heater	2004	7,646	765	10	765		3,442	52
53	Rewiring	2004	1,327	66	20	66		275	53
54	Roofing	2005	4,858	486	10	486		2,227	54
55	Tub room remodel	2005	3,855	154	25	154		680	55
56	Carpeting	2005	2,128	426	5	426		1,846	56
57	Alarm system	2005	2,357	157	15	157		654	57
58	External water carryoff system	2005	512	21	25	20	(1)	80	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	31,876	59
60	Door latches	2006	7,110	178	40	178		684	60
61	Automatic Doors	2006	2,886	192	15	192		673	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		1,207	62
63	Fire safety improvements	2007	19,182	480	40	480		977	63
64	Garage	2007	5,944	149	40	149		307	64
65	Locks	2007	691	69	10	69		207	65
66	Office expansion - social services	2007	2,346	59	40	59		170	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		5,095	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		653	68
69	Wood door	2007	942	63	15	63		140	69
70			\$ 4,584,882	123,939		\$ 127,375	\$ 3,436	\$ 2,227,766	70

**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 12A, Carried Forward		\$ 4,584,882	\$ 123,939		\$ 127,375	\$ 3,436	\$ 2,227,766	1
2	Air conditioner compressor	2007	8,418	842	10	842		1,875	2
3	Sprinklers	2007	1,230	62	20	62		137	3
4	Maglock outswing door	2007	1,173	117	10	117		345	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		1,573	5
6	Heat exchangers	2007	8,455	423	20	423		1,116	6
7	Disposer 3 hp	2007	3,472	347	10	347		831	7
8	Door monitoring unit	2007	1,103	110	10	110		231	8
9	Sprinkler-kitchen; flooring-306; fire safety improv	2008	60,117	1,393	48	1,252	(141)	1,595	9
10	Walkway and snow melt	2008	5,357	357	15	357		455	10
11	Septic field St. Luke Ct	2008	10,726	215	50	215		324	11
12	Iron guard hand railings	2008	6,781	452	15	452		495	12
13	Commercial disposal	2008	1,487	149	10	149		231	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			\$ 4,698,998	128,986		\$ 132,281	\$ 3,295	\$ 2,236,974	34

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

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	\$ 814,508	\$ 60,364	\$ 60,364	\$	Various	\$ 440,048	71
72	Current Year Purchases	26,180	2,506	2,506		Various	2,506	72
73	Fully Depreciated Assets	139,956					139,956	73
74								74
75	TOTALS	\$ 980,644	\$ 62,870	\$ 62,870	\$		\$ 582,510	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	2005	\$ 58,988	\$	\$	\$	4	\$ 58,988	76
77	Maintenance	02 John Deere	2005	6,475				3	6,475	77
78										78
79	Patient Transport	06 Ford Van	2006	36,187	7,237	7,237		5	22,326	79
80	TOTALS			\$ 101,650	\$ 7,237	\$ 7,237	\$		\$ 87,789	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)		\$ 5,782,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 199,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 202,388	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 3,295	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,907,273	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	\$ 1,685,956	\$ 47,951	\$ 892,970	86
87	Equipment	161,764	15,736	74,156	87
88	Vehicle	22,254	2,872	36,617	88
89	Land	112,446			89
90					90
91	TOTALS	\$ 1,982,420	\$ 66,559	\$ 1,003,743	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 217,764	92
93			93
94			94
95		\$ 217,764	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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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

- (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	\$	239	\$ 15,305	\$	239	\$ 15,305	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		175	10,489		175	10,489	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		209	13,358		209	13,358	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits		24	1,800		24	1,800	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				33,533		33,533	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								13
14	TOTAL			\$	647	\$ 40,952	\$ 33,533	647	\$ 74,485	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Skylines

0006353

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 108,155	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	560,349		3
4	Supply Inventory (priced at <u>FIFO</u>)			4
5	Short-Term Investments	211,038		5
6	Prepaid Insurance	99,425		6
7	Other Prepaid Expenses	20,446		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)	\$ 999,413	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	6,455,847		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,292,440		16
17	Accumulated Depreciation (book methods)	(4,073,989)		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>	217,764		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,005,251	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,004,664	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 210,487	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,229		29
30	Accrued Salaries Payable	237,693		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 449,409	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Contingency Payable</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 449,409	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,555,255	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,004,664	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,675,989	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	41,257	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,717,246	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(161,991)	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)	\$ (161,991)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,555,255	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines# 0006353Report Period Beginning: 01/01/2009Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,730,516	1
2	Discounts and Allowances for all Levels	(317,484)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,413,032	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,671	6
7	Oxygen	16,079	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 137,750	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	31,952	13
14	Non-Patient Meals	30,767	14
15	Telephone, Television and Radio	12,964	15
16	Rental of Facility Space		16
17	Sale of Drugs	27,587	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,090	19
20	Radiology and X-Ray	3,265	20
21	Other Medical Services	88,845	21
22	Laundry	627	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 198,097	23
D. Non-Operating Revenue			
24	Contributions	340,712	24
25	Interest and Other Investment Income***	4,255	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 344,967	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	92,740	27
28	Non-Care Facility	12,062	28
28a		26,952	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131,754	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,225,600	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,116,846	31
32	Health Care	2,540,063	32
33	General Administration	1,357,766	33
B. Capital Expense			
34	Ownership	266,881	34
C. Ancillary Expense			
35	Special Cost Centers	74,827	35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,387,591	40
41	Income before Income Taxes (line 30 minus line 40)**	(161,991)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (161,991)	43

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

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

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

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

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	\$ 65,540	\$ 31.51	1
2	Assistant Director of Nursing	1,562	1,728	55,420	32.07	2
3	Registered Nurses	15,038	16,146	435,475	26.97	3
4	Licensed Practical Nurses	17,044	18,208	344,094	18.90	4
5	CNAs & Orderlies	70,627	74,836	1,016,354	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,462	1,600	32,183	20.11	8
9	Activity Director	3,817	3,937	55,401	14.07	9
10	Activity Assistants	14,891	14,633	139,519	9.53	10
11	Social Service Workers	4,069	4,323	73,857	17.08	11
12	Dietician					12
13	Food Service Supervisor	2,087	2,271	59,572	26.23	13
14	Head Cook	1,298	1,350	17,084	12.65	14
15	Cook Helpers/Assistants	16,326	17,405	203,680	11.70	15
16	Dishwashers					16
17	Maintenance Workers	7,771	8,303	136,204	16.41	17
18	Housekeepers	10,963	11,570	113,639	9.82	18
19	Laundry	5,522	5,936	47,858	8.06	19
20	Administrator	2,080	2,080	85,848	41.27	20
21	Assistant Administrator	1,272	1,280	35,465	27.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,672	6,234	127,749	20.49	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	2,970	3,095	35,536	11.48	31
32	Other Health Car <u>Home Care Director</u>	536	552	12,371	22.41	32
33						
34	TOTAL (lines 1 - 33)	187,087	197,567	\$ 3,092,848 *	\$ 15.65	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	159	\$ 6,360	1.3	35
36	Medical Director	6	450	9.3	36
37	Medical Records Consultant	34	2,204	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	14	1,120	10.3	39
40	Physical Therapy Consultant	24	1,542	10a.3	40
41	Occupational Therapy Consultant	79	5,081	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	316	\$ 16,757		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	72	\$ 2,345	10.3	50
51	Licensed Practical Nurses	1,228	38,696	10.3	51
52	Certified Nurse Assistants/Aides	350	6,744	10.3	52
53	TOTAL (lines 50 - 52)	1,651	\$ 47,785		53

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

** 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 4,658
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,412 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,208
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. \$ 19,447 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 28,397
- (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