

		FOR BHF USE				

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2011
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2011)

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 N.E. 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: _____</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>01/01/2011</u> to <u>12/31/2011</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) _____ (Date) _____ (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) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # () </td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Matt Feucht</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Matt Feucht</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Skylines

0006353 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 9/30/11

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	
14	Skilled (SNF)	57	9,109	1
	Skilled Pediatric (SNF/PED)			2
43	Intermediate (ICF)		11,696	3
	Intermediate/DD			4
29	Sheltered Care (SC)	29	10,585	5
	ICF/DD 16 or Less			6
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	2,119	5,378	1,310	8,807	8
9 SNF/PED					9
10 ICF	3,431	7,989		11,420	10
11 ICF/DD	-	-			11
12 SC	274	7,801		8,075	12
13 DD 16 OR LESS	-	-			13
14 TOTALS	5,824	21,168	1,310	28,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.901624721

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 1,310

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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: 01/01/2011 Ending: 12/31/2011

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
1	A. General Services										
1	Dietary	267,736	14,417	108,375	390,528	(18,622)	371,906	-	371,906		1
2	Food Purchase		224,653		224,653	(10,713)	213,940	(36,473)	177,467		2
3	Housekeeping	95,057	21,407	-	116,464	-	116,464	-	116,464		3
4	Laundry	52,338	6,092	-	58,430	-	58,430	-	58,430		4
5	Heat and Other Utilities			147,827	147,827	-	147,827	-	147,827		5
6	Maintenance	164,693	34,707	48,094	247,494	-	247,494	(26,733)	220,761		6
7	Other (specify):*	-	-	-	-	-	-	-	-		7
8	TOTAL General Services	579,824	301,276	304,296	1,185,396	(29,335)	1,156,061	(63,206)	1,092,855		8
9	B. Health Care and Programs										
9	Medical Director			281	281	-	281		281		9
10	Nursing and Medical Records	2,209,929	106,230	87,446	2,403,605	(1)	2,403,604	(9,053)	2,394,551		10
10a	Therapy		4,242	153,305	157,547	-	157,547		157,547		10a
11	Activities	197,427		5,676	203,103	-	203,103	(2,896)	200,207		11
12	Social Services	44,437		1,640	46,077	-	46,077		46,077		12
13	CNA Training				-	-	-		-		13
14	Program Transportation				-	-	-		-		14
15	Other (specify):*				-	-	-		-		15
16	TOTAL Health Care and Programs	2,451,793	110,472	248,348	2,810,613	(1)	2,810,612	(11,949)	2,798,663		16
17	C. General Administration										
17	Administrative	-	-	-	-	85,748	85,748	-	85,748		17
18	Directors Fees				-	-	-		-		18
19	Professional Services			39,294	39,294	(1,009)	38,285	-	38,285		19
20	Dues, Fees, Subscriptions & Promotions			56,170	56,170	-	56,170	(7,119)	49,051		20
21	Clerical & General Office Expenses	264,316	37,188	178,854	480,358	(84,739)	395,619	(24,222)	371,397		21
22	Employee Benefits & Payroll Taxes			826,557	826,557	29,335	855,892	-	855,892		22
23	Inservice Training & Education			2,640	2,640	4,142	6,782	-	6,782		23
24	Travel and Seminar			9,280	9,280	(4,142)	5,138	-	5,138		24
25	Other Admin. Staff Transportation				-	-	-		-		25
26	Insurance-Prop.Liab.Malpractice			75,708	75,708	-	75,708	-	75,708		26
27	Other (specify):*				-	-	-		-		27
28	TOTAL General Administration	264,316	37,188	1,188,503	1,490,007	29,335	1,519,342	(31,341)	1,488,001		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,295,933	448,936	1,741,147	5,486,016	(1)	5,486,015	(106,496)	5,379,519		29

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

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

Facility Name & ID Number

Apostolic Christian Skylines

#0006353

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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			291,660	291,660	-	291,660	(74,653)	217,007			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			934	934	-	934	(541)	393			32
33	Real Estate Taxes			-	-	-	-	-	-			33
34	Rent-Facility & Grounds			-	-	-	-	-	-			34
35	Rent-Equipment & Vehicles			-	-	-	-	-	-			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			292,594	292,594	-	292,594	(75,194)	217,400			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	31,192	6,285	37,477	1	37,478	-	37,478			39
40	Barber and Beauty Shops	-	-	30,979	30,979	-	30,979	-	30,979			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	88,361	88,361	-	88,361	-	88,361			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	31,192	125,625	156,817	1	156,818	-	156,818			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,295,933	480,128	2,159,366	5,935,427	-	5,935,427	(181,690)	5,753,737			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	(36,412)	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	(2,468)	30.3		9
10	Interest and Other Investment Income	(541)	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,654)	20.3		28
29	Other-Attach Schedule	(140,615)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (181,690)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (181,690)		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			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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: 01/01/2011

Ending: 12/31/2011

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: 01/01/2011 Ending: 12/31/2011

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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									
						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	-	July-03	41,891		Jul-08	0.0400	934	6								
7				-							7									
8				-							8									
9	TOTAL Facility Related					\$	41,891	\$			934	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	\$			934	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
 RE: 2010 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matt Feucht

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	29		1966	1965	\$ 348,310	\$ 8,708	40	\$ 8,708	\$	\$ 325,672	4
5	21		1971	1970	396,963	9,924	40	9,924		331,464	5
6	16		1985	1985	750,000	18,750	40	18,750		416,250	6
7	3		1989	1988	205,070	5,127	40	5,127		97,410	7
8	17		1995	1995	870,388	21,760	40	21,760		330,749	8
Improvement Type**											
9	17 bed room addition			1996	793,538	19,838	40	19,838		265,833	9
10	Shelter care remodel			1974	6,594	165	40	165		5,865	10
11	Fire prevention system			1977	23,804	952	25	952		21,271	11
12	Dining room addition			1978	38,922	973	40	973		33,442	12
13	Fire prevention system			1979	35,330	1,413	25	1,413		33,763	13
14	Windows replacement			1981	23,820	953	25	953		22,324	14
15	Kitchen remodel			1982	21,631	541	40	541		17,783	15
16	Energy conservation			1983	8,413		15			8,413	16
17	Shelter care remodel			1984	7,742	194	40	194		6,196	17
18	Cabinets			1986	1,618		15			1,618	18
19	Air conditioning units			1987	6,427		10			6,427	19
20	Physical therapy remodel			1989	11,503	288	40	288		8,406	20
21	Office Addition			1991	50,297	1,257	40	1,257		34,954	21
22	New roof			1993	14,210		10			14,210	22
23	Room remodel			1994	5,154	206	25	206		3,785	23
24	Front entrance, front office, ceiling back hall			1996	62,294	3,115	20	3,115		46,722	24
25	Guttering System			1996	89,096	3,564	25	3,564		53,459	25
26	Fencing, soffit/acia, new door			1997	28,036	1,121	25	1,121		16,025	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978	332	15	332		2,927	28
29	Flooring, lighting, wall covering			2000	97,127		5			97,127	29
30	Flooring, lighting, wall covering			2001	28,745		5			28,745	30
31	Lobby windows			2001	3,577	143	25	143		1,717	31
32	Blacktopping			2001	13,967	436	8	1,746	1,310	13,531	32
33	Balcony repair			2001	6,605	544	20	330	(214)	4,702	33
34	Insulation installation			2001	9,970	665	15	665		5,589	34
35	Lawn sprinkler system			2001		643	15		(643)		35
36	Air Conditioning Unit			2001	2,178	218	10	218		1,698	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

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Locks	2002	\$ 691	\$ 35	20	\$ 35	\$	\$ 289	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	7,184	38
39	Flooring, wall covering	2002	9,786		5			9,786	39
40	Balcony repair	2002	7,403	370	20	370		3,648	40
41	Carpeting in dining room	2002	5,446		5			5,446	41
42	Water heater	2002	4,197	420	10	420		3,167	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		256	20		(256)		44
45	Air Conditioning unit	2003	1,700	85	20	85		726	45
46	Sewer system upgrade	2003		256	20		(256)		46
47	Countertops in kitchen	2003	6,594	440	15	440		3,233	47
48	Carpeting	2004	5,878		5			5,878	48
49	Wiremesh	2004	1,825	122	15	122		854	49
50	Sewer system upgrade	2004		360	20		(360)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		920	51
52	Water heater	2004	7,646	510	10	765	255	4,972	52
53	Rewiring	2004	1,327	66	20	66		407	53
54	Roofing	2005	4,858	486	10	486		3,199	54
55	Tub room remodel	2005	3,855	154	25	154		988	55
56	Carpeting	2005	2,128		5			2,128	56
57	Alarm system	2005	2,357	157	15	157		968	57
58	External water carryoff system	2005	512	21	25	20	(1)	120	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	50,084	59
60	Door latches	2006	7,110	178	40	178		1,040	60
61	Automatic Doors	2006	2,886	192	15	192		1,057	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		1,835	62
63	Fire safety improvements	2007	19,182	480	40	480		1,937	63
64	Garage	2007	5,944	149	40	149		605	64
65	Locks	2007	691	69	10	69		345	65
66	Office expansion - social services	2007	2,346	59	40	59		288	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		8,651	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		1,225	68
69	Wood door	2007	942	63	15	63		266	69
70	TOTAL (lines 4 thru 69)		\$ 4,584,882	\$ 120,274		\$ 118,942	\$ (1,332)	\$ 2,467,384	70

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

Facility Name & ID Number Apostolic Christian Skylines# 0006353

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,584,882	\$ 120,274		\$ 118,942	\$ (1,332)	\$ 2,467,384	1
2	Air conditioner compressor	2007	8,418	842	10	842		3,559	2
3	Sprinklers	2007	1,230	62	20	62		261	3
4	Maglock outswing door	2007	1,173	117	10	117		579	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		2,733	5
6	Heat exchangers	2007	8,455	423	20	423		1,962	6
7	Disposer 3 hp	2007	3,472	347	10	347		1,525	7
8	Door monitoring unit	2007	1,103	110	10	110		451	8
9	Sprinkler-kitchen; flooring-306; fire safety improv	2008	60,117	1,839	48	1,252	(587)	4,099	9
10	Walkway and snow melt	2008	5,357	357	15	357		1,169	10
11	Septic field St. Luke Ct	2008	10,726	268	50	215	(53)	754	11
12	Iron guard hand railings	2008	6,781	452	15	452		1,399	12
13	Commercial disposal	2008	1,487	149	10	149		529	13
14	Rm flooring, wall	2008	6,604	165	40	165		495	14
15	Internet wiring	2009	4,849	242	20	242		625	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		1,316	16
17	Water heater	2009	13,950	930	20	698	(232)	1,474	17
18	Air conditioning units	2009	2,673	267	25	107	(160)	315	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		905	19
20	Dining room walls	2009	5,391	216	40	135	(81)	362	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	294	20	316	22	933	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		442	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		673	23
24	Senior TV hook-up	2009	250	13	20	13		27	24
25	Salem architectural	2009	3,392	136	25	136		340	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		2,322	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		812	27
28	Flooring Salem lounge	2009	14,443	578	25	578		1,252	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		1,522	29
30	Social room tv cabinetry	2009	990	50	20	50		100	30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		222	31
32	Maglock outswing door, sensor push bars	2009	2,999	182	20	150	(32)	449	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	882	40	539	(343)	1,283	33
34	TOTAL (lines 1 thru 33)		\$ 4,868,786	\$ 133,419		\$ 130,621	\$ (2,798)	\$ 2,502,273	34

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

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,868,786	\$ 133,419		\$ 130,621	\$ (2,798)	\$ 2,502,273	1
2	Roofing, flooring rm 226	2009	8,432	878	15	562	(316)	1,231	2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	1,095	10	1,094	(1)	1,316	3
4	Elevator repair	2010	12,698	635	10	1,270	635	2,279	4
5	Salem flooring, baseboards	2010	14,826	593	25	593		892	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	175	25	175		219	6
7	Nurses Station	2010	2,533	101	10	253	152	295	7
8	Flooring Canaan room	2010	870	174	5	174		262	8
9	Dining room flooring	2010	1,190	48	15	79	31	139	9
10	New burner boiler 1	2010	12,225	489	25	489		588	10
11	Commercial water heater	2010	4,900	327	15	327		373	11
12	Surveillance hardware & smoke detector	2010	5,421	497	10	542	45	679	12
13	Rebuild \ replace heat exchangers	2010	4,129	275	15	275		298	13
14	Zion & Galilee tubs, fire safety wall	2011	43,210	2,099	10	1,444	(655)	1,444	14
15	South bath plumbing piping & fixtures	2011	6,824	85	25	168	83	168	15
16	Judea bath walls, floor, doors, plumbing, drapes	2011	62,365	468	25	834	366	834	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)		\$ 5,063,722	\$ 141,358		\$ 138,900	\$ (2,458)	\$ 2,513,290	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	1 Category of Equipment	2 Cost	3 Current Book Depreciation	4 Straight Line Depreciation	5 Adjustments	6 Component Life	7 Accumulated Depreciation	8
71	Purchased in Prior Years	\$ 927,102	\$ 66,225	\$ 66,225		Various	\$ 559,614	71
72	Current Year Purchases	132,973	5,258	5,258		Various	5,258	72
73	Fully Depreciated Assets	156,048					156,048	73
74								74
75	TOTALS	\$ 1,216,123	\$ 71,483	\$ 71,483			\$ 720,920	75

D. Vehicle Costs. (See instructions.)*

	1 Use	2 Model, Make and Year	3 Year Acquired	4 Cost	5 Current Book Depreciation	6 Straight Line Depreciation	7 Adjustments	8 Life in Years	9 Accumulated Depreciation	10
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	39051	36,187	6,634	6,624	(10)	5	36,187	79
80	TOTALS			\$ 101,650	\$ 6,634	\$ 6,624	\$ (10)		\$ 101,650	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	3	
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)	\$ 6,382,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 219,475	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 217,007	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,468)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,335,860	85

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

	1 Description & Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	5
86	Building Various	\$ 1,829,492	\$ 51,845	\$ 994,058	86
87	Equipment Various	225,298	17,468	106,924	87
88	Vehicle Various	22,254	2,872	42,361	88
89	Land Various	112,446			89
90					90
91	TOTALS	\$ 2,189,490	\$ 72,185	\$ 1,143,343	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 19,321	92
93			93
94			94
95		\$ 19,321	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.	_____/2012	\$ _____
13.	_____/2013	\$ _____
14.	_____/2014	\$ _____

* 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	301	\$ 16,212				301	\$ 16,212	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		774	49,510				774	49,510	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		390	20,197				390	20,197	4
5	Physician Care	39.3	visits									5
6	Dental Care	39.3	visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39.2	# of prescripts					29,232			29,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Exceptional Care</u>	39.2										12
13	Other (specify): <u>Medical Supplies</u>	39.2						1,960			1,960	13
14	TOTAL			\$	1,465	\$ 85,919		\$ 31,192		1,465	\$ 117,111	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.

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	\$ 122,793	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	695,753		3
4	Supply Inventory (priced at <u>FIFO</u>)	24,080		4
5	Short-Term Investments	687,679		5
6	Prepaid Insurance	114,953		6
7	Other Prepaid Expenses	49,863		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,695,121	\$	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	6,994,588		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,581,210		16
17	Accumulated Depreciation (book methods)	(4,651,654)		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>	19,321		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,056,654	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,751,775	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 259,259	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	143,934		29
30	Accrued Salaries Payable	70,880		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)	\$ 474,073	\$	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)	\$ 474,073	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,277,702	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,751,775	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,576,291	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>	28,833	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,605,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	672,578	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)	\$ 672,578	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)	\$ 5,277,702	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines# 0006353Report Period Beginning: 01/01/2011Ending: 12/31/2011

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	\$ 5,074,628	1
2	Discounts and Allowances for all Levels	(394,648)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,679,980	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	254,168	6
7	Oxygen	23,844	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 278,012	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	481	12
13	Barber and Beauty Care	31,321	13
14	Non-Patient Meals	36,412	14
15	Telephone, Television and Radio	11,148	15
16	Rental of Facility Space		16
17	Sale of Drugs	22,601	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,424	19
20	Radiology and X-Ray	4,828	20
21	Other Medical Services	341,705	21
22	Laundry	811	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 452,731	23
D. Non-Operating Revenue			
24	Contributions	1,067,463	24
25	Interest and Other Investment Income***	894	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,068,357	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	77,750	27
28	Non-Care Facility	18,519	28
28a	Miscellaneous Income	32,656	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 128,925	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,608,005	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,185,396	31
32	Health Care	2,810,613	32
33	General Administration	1,490,007	33
B. Capital Expense			
34	Ownership	292,594	34
C. Ancillary Expense			
35	Special Cost Centers	68,456	35
36	Provider Participation Fee	88,361	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,935,427	40
41	Income before Income Taxes (line 30 minus line 40)**	672,578	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 672,578	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

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,946	2,080	\$ 79,036	\$ 38.00	1
2	Assistant Director of Nursing	1,086	1,198	42,979	35.88	2
3	Registered Nurses	16,382	17,305	464,194	26.82	3
4	Licensed Practical Nurses	17,338	18,324	388,247	21.19	4
5	CNAs & Orderlies	77,965	81,468	1,041,460	12.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,868	4,024	62,614	15.56	9
10	Activity Assistants	12,735	13,221	134,813	10.20	10
11	Social Service Workers	2,259	2,395	44,437	18.55	11
12	Dietician					12
13	Food Service Supervisor	1,901	2,089	31,563	15.11	13
14	Head Cook	7,013	7,486	76,163	10.17	14
15	Cook Helpers/Assistants	11,929	12,564	135,487	10.78	15
16	Dishwashers	2,180	2,375	24,523	10.33	16
17	Maintenance Workers	7,329	8,087	149,718	18.51	17
18	Housekeepers	8,516	9,210	94,579	10.27	18
19	Laundry	5,590	5,933	52,338	8.82	19
20	Administrator	2,009	2,080	85,748	41.23	20
21	Assistant Administrator	2,048	2,080	62,320	29.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,953	6,246	116,248	18.61	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	2,359	2,467	37,875	15.35	31
32	Other Health Care(specify)	11,599	11,692	147,085	12.58	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,005	212,324	\$ 3,271,427 *	\$ 15.41	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	218	\$ 8,730	1.3	35
36	Medical Director	4	281	9.3	36
37	Medical Records Consultant	32	2,099	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	41	3,300	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	35	1,410	11.3	44
45	Social Service Consultant	41	1,640	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	372	\$ 17,460		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	184	\$ 7,352	10.3	50
51	Licensed Practical Nurses	1,131	40,724	10.3	51
52	Certified Nurse Assistants/Aides	1,177	26,069	10.3	52
53	TOTAL (lines 50 - 52)	2,492	\$ 74,145		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
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19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Skylines

0006353

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 7,002
- (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? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,005 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. \$ 88,361
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. \$ 29,335 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 36,412
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.