

		FOR BHF USE					

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2012
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2012)

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>0021493</u></p> <p>Facility Name: <u>Apostolic Christian Home</u></p> <p>Address: <u>1102 W Randolph Bx 530</u> <u>Roanoke</u> <u>61561</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 923-2071</u> Fax # <u>(309) 923-7919</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1975</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>Richard D. Isaia</u> Telephone Number: <u>(309) 923-2071</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>01/01/2012</u> to <u>12/31/2012</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>Richard D. Isaia</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) () 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) _____ (Date) _____ (Type or Print Name) <u>Richard D. Isaia</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Richard D. Isaia</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		-	3
4		Intermediate/DD		-	4
5		Sheltered Care (SC)		-	5
6		ICF/DD 16 or Less		-	6
7	60	TOTALS	60	21,960	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	9,468	8,420	1,689	19,577	8
9	SNF/PED					9
10	ICF	-	-			10
11	ICF/DD	-	-			11
12	SC	-	-			12
13	DD 16 OR LESS	-	-			13
14	TOTALS	9,468	8,420	1,689	19,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.891484517

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)

Outpatient Part B Therapy

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1975 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 1,689

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	306,152	27,684	5,566	339,402		339,402		339,402		1
2	Food Purchase		198,005		198,005		198,005	(7,672)	190,333		2
3	Housekeeping	247,839	39,479	8,959	296,277		296,277		296,277		3
4	Laundry		6,919		6,919		6,919		6,919		4
5	Heat and Other Utilities			97,946	97,946		97,946		97,946		5
6	Maintenance	64,512	35,212	34,301	134,025		134,025		134,025		6
7	Other (specify):*										7
8	TOTAL General Services	618,503	307,299	146,772	1,072,574		1,072,574	(7,672)	1,064,902		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,675,875	87,266	8,410	1,771,551		1,771,551		1,771,551		10
10a	Therapy	123,004	901	96,174	220,079		220,079		220,079		10a
11	Activities	101,563	12,747	752	115,062		115,062		115,062		11
12	Social Services	44,201	181	790	45,172		45,172		45,172		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,944,643	101,095	106,126	2,151,864		2,151,864		2,151,864		16
	C. General Administration										
17	Administrative	80,840			80,840		80,840		80,840		17
18	Directors Fees										18
19	Professional Services			69,157	69,157		69,157		69,157		19
20	Dues, Fees, Subscriptions & Promotions			8,040	8,040	14	8,054		8,054		20
21	Clerical & General Office Expenses	170,319	40,688	52,675	263,682	(14)	263,668		263,668		21
22	Employee Benefits & Payroll Taxes			578,511	578,511		578,511		578,511		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,899	42,899		42,899		42,899		26
27	Other (specify):*										27
28	TOTAL General Administration	251,159	40,688	751,282	1,043,129		1,043,129		1,043,129		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,814,305	449,082	1,004,180	4,267,567		4,267,567	(7,672)	4,259,895		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 Home of Roanoke #0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			176,857	176,857		176,857	5,309	182,166			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,270	1,270		1,270		1,270			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			178,127	178,127		178,127	5,309	183,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,092		106,092		106,092		106,092			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,824	225,824		225,824		225,824			42
43	Other (specify):*		3,708	281,929	285,637		285,637	(285,637)				43
44	TOTAL Special Cost Centers		109,800	507,753	617,553		617,553	(285,637)	331,916			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,814,305	558,882	1,690,060	5,063,247		5,063,247	(288,000)	4,775,247			45

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(7,672)	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	5,309	30.3		9
10 Interest and Other Investment Income		32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(285,637)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (288,000)		\$	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))	\$ (288,000)		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 Physician Care		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.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	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	Apostolic Christian Church	x		Coverage for State shortfall	n/a	various	\$ 359,000	\$ 150,000	n/a		\$	1	
2					-							2	
3					-							3	
4					-							4	
5					-							5	
Working Capital													
6	Morton Community Bank		x	Working Capital	Various	Various		363,000	Various	0.0500		1,270	6
7					-							-	7
8					-								8
9	TOTAL Facility Related						\$ 359,000	\$ 513,000			\$	1,270	9
B. Non-Facility Related*													
10	Commerce Bank		x	Building Loan	7800	2000	875,000	115,173	2014	0.0417			10
11													11
12													12
13													13
14	TOTAL Non-Facility Related				7800		\$ 875,000	\$ 115,173			\$		14
15	TOTALS (line 9+line14)						\$ 1,234,000	\$ 628,173			\$	1,270	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	\$	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	3																			
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7																			
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2007	8	<table border="1"> <tr> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2011	\$			13																		
14	PLUS APPEAL COST FROM LINE 5	\$			14																		
15	LESS REFUND FROM LINE 6	\$			15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
	2008	9																					
	2009	10																					
	2010	11																					
	2011	12																					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,601 B. General Construction Type: Exterior Brick Frame Block & Wood Number of Stories One

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

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

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

Apostolic Christian Home of Roanoke Duplex 20 Units
Apostolic Christian Home of Roanoke Independent Living 14 Units

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

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

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	61		1975	1958	\$ 202,000	\$	30	\$	\$	\$ 202,000	4
5			1976	1976	22,708		30			22,708	5
6			1991	1991	671,286	22,376	30	22,376		471,761	6
7			1992	1992	129,607	4,469	30	4,320	(149)	90,571	7
8											8
	Improvement Type**										
9		Building & land improvements - '76		1976	105,004		20			105,004	9
10		Building & land improvements - '77		1977	6,591		20			6,591	10
11		Building & land improvements - '78		1978	10,960		20			10,960	11
12		Building & land improvements - '79		1979	9,124		20			9,124	12
13		Building & land improvements - '80		1980	8,166		20			8,166	13
14		Building & land improvements - '81		1981	6,506		20			6,506	14
15		Building & land improvements - '82		1982	18,087		20			18,087	15
16		Building & land improvements - '83		1983	36,023		20			36,023	16
17		Building & land improvements - '84		1984	12,947		20			12,947	17
18		Building & land improvements - '85		1985	13,333		20			13,333	18
19		Building & land improvements - '86		1986	8,595		20			8,595	19
20		Building & land improvements - '87		1987	87,248		20			87,248	20
21		Building & land improvements - '88		1988	43,526		20			43,526	21
22		Building & land improvements - '89		1989	64,604		20			64,604	22
23		Building & land improvements - '90		1990	11,217		20			11,217	23
24		Building & land improvements - '91		1991	3,700		20			3,700	24
25		Building & land improvements - '92		1992	5,410		20			5,410	25
26		Building & land improvements - '93		1993	36,135		20	1,807	1,807	34,329	26
27		Building & land improvements - '94		1994	14,661		20	733	733	13,928	27
28		Building & land improvements - '95		1995	30,372		20	1,519	1,519	27,335	28
29		Building & land improvements - '96		1996	5,114		20	256	256	4,347	29
30		Building & land improvements - '97		1997	28,536		20	1,427	1,427	22,829	30
31		Building & land improvements - '98		1998	63,025		7			63,025	31
32		Building & land improvements - '99		1999	165,965		7			165,965	32
33		Building & land improvements - '00		2000	73,659		7			73,659	33
34		Building & land improvements - '01		2001	112,321		7			112,321	34
35		Building & land improvements - '02		2002	274,745		7			274,745	35
36		Building & land improvements - '03		2003	58,837		7			58,837	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.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning:

01/01/2012 Ending:

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12/31/2012

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	Building & land improvements - '04	2004	\$ 111,862	\$	7	\$	\$	\$ 111,862		37
38	New Flooring (18W)	2005	1,750	125	7	125		1,750		38
39	Drywall State Survey	2005	8,016	573	7	572	(1)	8,016		39
40	Air Conditioner Relocation	2005	448	32	7	32		448		40
41	West Side Plumbing	2005	4,108	293	7	292	(1)	4,108		41
42	Dining Remodel	2005	67,687	4,835	7	4,819	(16)	67,687		42
43	Water Piping	2006	728	104	7	104		709		43
44	Dining Room Insulation	2006	850	121	7	121		808		44
45	Floor Joist	2006	1,010	144	7	144		957		45
46	Furnace and Ductwork	2006	1,305	187	7	186	(1)	1,235		46
47	Generator	2006	2,496		7	357	357	2,426		47
48	Sprinkler Update	2006	960		7	137	137	931		48
49	Tub	2006	14,095		7	2,014	2,014	13,601		49
50	Activity Window Coverings	2006	558	56	7	80	24	536		50
51	Electrical Wiring	2006	389	54	7	55	1	389		51
52	Canopy Sprinkler Repair	2006	4,866	695	7	695		4,461		52
53	Retaining wall, Rm12 plaster, door latches, draperies	2006	2,625	232	7	375	143	2,345		53
54	Sprinkler system & plumbing upgrade	2006	3,364	481	7	481		3,007		54
55	South elevator improvement & wallguards	2006	2,535		5			2,535		55
56	Basement doors	2007	2,605	372	7	372		2,201		56
57	Water lines and sidewalks	2007	5,542	792	7	792		4,225		57
58	North end fire dampers	2007	11,784	1,683	7	1,683		8,696		58
59	Kitchen plumbing, electrical, carpentry, flooring, insulation	2007	92,132	13,162	7	13,162		68,010		59
60	Kitchen sinks	2007	4,179	418	5	205	(213)	4,179		60
61	Dining room cabinetry	2007	4,375	438	5	288	(150)	4,375		61
62	Kitchen air conditioning	2007	2,500	250	5	374	124	2,500		62
63	Elevator wiring	2007	4,720	472	5	706	234	4,720		63
64	Wallguards	2007	6,578	658	5	1,202	544	6,578		64
65	Kitchen lighting fixtures and ramps	2007	3,262	327	5	325	(2)	3,262		65
66	Exit light upgrade	2008	1,089	156	7	156		767		66
67	Kitchen hot water heater piping	2008	1,658	237	7	237		1,165		67
68	Kitchen doors	2008	12,848	1,835	7	1,835		8,723		68
69	Room 9 west flooring	2008	2,289	327	7	327		1,527		69
70	TOTAL (lines 4 thru 69)		\$ 2,725,225	\$ 55,904		\$ 64,691	\$ 8,787	\$ 2,438,140		70

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

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning:

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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		\$ 2,725,225	\$ 55,904		\$ 64,691	\$ 8,787	\$ 2,438,140		1
2	South basement wall, lighting, sink & vanity	2008	3,404	486	7	486		2,270		2
3	Sprinkler system upgrade	2008	3,250	576	7	464	(112)	2,168		3
4	Basement sewer & plumbing system repair	2008	10,354	1,479	7	1,479		6,909		4
5	Maintenance garage sewer hook-up	2008	1,075	154	7	154		680		5
6	Water heater upgrade	2008	10,898	2,180	5	2,180		10,362		6
7	Elevator and pole light	2008	4,777	956	5	955	(1)	4,061		7
8	Kitchen grease trap replacement	2008	3,972	795	5	794	(1)	3,176		8
9	East & West end flooring	2008	14,675	2,935	5	2,935		14,201		9
10	Door replacements	2008	3,253	651	5	651		2,932		10
11	Northeast exit sidewalk replacement	2008	16,218	1,622	10	1,622		6,759		11
12	Front sewer line installation and repair	2008	4,216	422	10	422		1,758		12
13	Sprinkler system upgrade	2009	5,023	1,005	5	1,005		3,015		13
14	Water heaters, fresh air hook-up, door upgrade w/ramps	2009	16,309	3,262	5	3,262		11,975		14
15	Wiring/installation of digital cable system	2009	21,718	4,344	5	4,344		15,948		15
16	Roofing project	2009	68,922	2,297	30	2,297		7,470		16
17	Kitchen cabinets, countertop, plumbing	2009	2,798	560	5	560		2,149		17
18	Nurse station & med rm counter top, insulation	2010	11,322	2,264	5	2,264		5,856		18
19	Sprinkler system upgrade	2010	13,072	2,614	5	2,614		5,665		19
20	Doors, openers, exit lighting	2010	3,783	757	5	757		1,831		20
21	Furnace, air conditioners, disposal	2010	6,475	1,295	5	1,295		3,133		21
22	Asphalt parking lot	2010	20,152	2,015	10	2,015		4,367		22
23	Basement ceiling drywall & rm 11 carpeting	2011	4,912	591	10	491	(100)	779		23
24	Basement ceiling drywall & rewiring	2011	4,231	846	5	846		1,059		24
25	Resident rm wall mounted box holders	2011	3,422	684	5	684		684		25
26	Water heater	2011	6,999	1,400	5	1,400		2,574		26
27	West flooring, furnace, electrical, ceiling	2011	18,806	2,512	5	3,761	1,249	4,390		27
28	West Doors	2011	61,657	6,166	10	6,166		6,166		28
29	Wall mounted nursing stations	2011	6,486	1,297	5	1,297		1,407		29
30	West air conditioner	2012	3,914	391	5	262	(129)	262		30
31	West room signage, plumbing, electrical, sprinklers, curtains, wall mount hold	2012	18,015	2,334	5	2,112	(222)	2,112		31
32	West & basement floors, walls, ceiling, electrical, plumbing	2012	134,735	6,638	10	3,396	(3,242)	3,396		32
33	West & east floors, walls, ceiling, electrical, plumbing	2012	17,854	893	10	298	(595)	298		33
34	TOTAL (lines 1 thru 33)		\$ 3,251,922	\$ 112,325		\$ 117,959	\$ 5,634	\$ 2,577,952		34

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

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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		\$ 3,251,922	\$ 112,325		\$ 117,959	\$ 5,634	\$ 2,577,952	1
2	South floors, walls, ceiling, electrical, plumbing	2012	6,500	325	10		(325)		2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 3,258,422	\$ 112,650		\$ 117,959	\$ 5,309	\$ 2,577,952	34

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 538,682	\$ 51,389	\$ 51,389		5	\$ 280,203	71
72	Current Year Purchases	76,760	7,562	7,562		5	7,562	72
73	Fully Depreciated Assets	990,670					990,670	73
74								74
75	TOTALS	\$ 1,606,112	\$ 58,951	\$ 58,951			\$ 1,278,435	75

D. Vehicle Costs. (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	1999 Ford Bus	1999	\$ 49,239				5	\$ 49,239	76
77	Patient Transport	2005 Ford Montana	2005	12,500				5	12,500	77
78	Patient Transport	2009 Beau Van	2009	1,964	393	393		5	1,375	78
79	Patient Transport	2011 Dodge Caravan	2011	48,628	4,863	4,863		10	7,294	79
80	TOTALS			\$ 112,331	\$ 5,256	\$ 5,256			\$ 70,408	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)	\$ 5,012,740	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,857	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 182,166	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,309	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,926,795	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplexes Various	\$ 2,749,275	\$ 92,333	\$ 1,138,048	86
87	Country View Apartments Various	1,097,269	23,426	314,255	87
88	Duplex Furniture & Fixtures Various	165,592	15,883	96,200	88
89	Country View Furniture & Fixt Various	214,133	22,225	151,048	89
90	Duplex Land & Improvements Various	466,751	24,262	228,084	90
91	TOTALS	\$ 4,693,020	\$ 178,129	\$ 1,927,635	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95			95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

* 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.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$ 12,199	\$	1
2	Cash-Patient Deposits	230		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,011,488		3
4	Supply Inventory (priced at FIFO)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,564		6
7	Other Prepaid Expenses	(3,257)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,059,224	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,626		13
14	Buildings, at Historical Cost	7,441,561		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,894,616		16
17	Accumulated Depreciation (book methods)	(5,812,480)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,588,323	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,647,547	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 338,972	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	230		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,575		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,643		31
32	Accrued Real Estate Taxes(Sch.IX-B)	677		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Expenses	151,846		36
37	Life Lease Deferred Income			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 583,943	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	806,471		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Life Lease Equity	2,203,308		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,009,779	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,593,722	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,053,825	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,647,547	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		I Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,303,075	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,303,075	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(696,799)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	447,549	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)	\$ (249,250)	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)	\$ 1,053,825	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,538,490	1
2	Discounts and Allowances for all Levels	(805,688)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,732,802	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,399	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 233,399	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	9,705	13
14	Non-Patient Meals	7,672	14
15	Telephone, Television and Radio	3,560	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,937	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	659	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 659	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,412	28
28a	Non-Care Facility	374,239	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 378,651	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,366,448	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,072,574	31
32	Health Care	2,151,864	32
33	General Administration	1,043,129	33
B. Capital Expense			
34	Ownership	178,127	34
C. Ancillary Expense			
35	Special Cost Centers	391,729	35
36	Provider Participation Fee	225,824	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,063,247	40
41	Income before Income Taxes (line 30 minus line 40)**	(696,799)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (696,799)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ (676,417)	44
45	Private Pay - Net Inpatient Revenue	3,984,313	45
46	Medicare - Net Inpatient Revenue	424,906	46
47	Other-(specify) Rounding		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,732,802	49

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

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

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

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

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

12/31/2012

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	1,864	2,080	\$ 67,697	\$ 32.55	1
2	Assistant Director of Nursing	1,474	1,647	48,010	29.15	2
3	Registered Nurses	11,663	12,941	365,001	28.21	3
4	Licensed Practical Nurses	8,429	9,005	224,584	24.94	4
5	CNAs & Orderlies	63,108	67,594	970,583	14.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,789	5,322	123,004	23.11	8
9	Activity Director	2,065	2,313	37,469	16.20	9
10	Activity Assistants	4,995	5,506	64,094	11.64	10
11	Social Service Workers	2,825	3,082	44,201	14.34	11
12	Dietician					12
13	Food Service Supervisor	1,852	2,080	47,493	22.83	13
14	Head Cook	7,543	8,203	104,566	12.75	14
15	Cook Helpers/Assistants	13,877	14,634	154,093	10.53	15
16	Dishwashers					16
17	Maintenance Workers	1,962	2,222	64,512	29.03	17
18	Housekeepers	20,505	21,956	247,839	11.29	18
19	Laundry					19
20	Administrator	1,810	2,080	80,840	38.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,149	10,004	170,319	17.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,910	170,669	\$ 2,814,305 *	\$ 16.49	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	112	\$ 5,018	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	83	5,390	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	4	260	10a.3	40
41	Occupational Therapy Consultant	6	402	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	428	10a.3	43
44	Activity Consultant	15	752	11.3	44
45	Social Service Consultant	15	760	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	242	\$ 13,010		49

C. CONTRACT NURSES

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

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												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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 2,738
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,498 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. \$ 225,824
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,672
- (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? No
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.