

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 Bx530</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>01/01/2014</u> to <u>12/31/2014</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Richard D. Isaia</u> (Title) <u>Administrator</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # () </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Richard D. Isaia</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Roanoke

0021493 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	21,900	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	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	365	163	1,143	1,671	8
9	SNF/PED					9
10	ICF	8,867	9,425		18,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,232	9,588	1,143	19,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.16%

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 1,143

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRAU MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
 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	Dietary	320,418	26,204	7,904	354,526		354,526	354,526			1
2	Food Purchase		216,147		216,147		216,147	(8,283)	207,864		2
3	Housekeeping	234,195	32,201	9,014	275,410		275,410		275,410		3
4	Laundry		4,831		4,831		4,831		4,831		4
5	Heat and Other Utilities			87,606	87,606		87,606		87,606		5
6	Maintenance	72,071	41,254	61,062	174,387		174,387		174,387		6
7	Other (specify):*										7
8	TOTAL General Services	626,684	320,637	165,586	1,112,907		1,112,907	(8,283)	1,104,624		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,702,677	85,697	13,027	1,801,401		1,801,401		1,801,401		10
10a	Therapy	123,022	3,255	121,907	248,184		248,184		248,184		10a
11	Activities	98,688	14,413	754	113,855		113,855		113,855		11
12	Social Services	58,365	20	698	59,083		59,083		59,083		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,982,752	103,385	136,386	2,222,523		2,222,523		2,222,523		16
	C. General Administration										
17	Administrative	87,149			87,149		87,149		87,149		17
18	Directors Fees										18
19	Professional Services			43,750	43,750	(351)	43,399		43,399		19
20	Dues, Fees, Subscriptions & Promotions			5,954	5,954	5,259	11,213		11,213		20
21	Clerical & General Office Expenses	186,540	22,459	54,941	263,940	(4,908)	259,032	(10,679)	248,353		21
22	Employee Benefits & Payroll Taxes			602,524	602,524		602,524		602,524		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			48,026	48,026		48,026		48,026		26
27	Other (specify):*										27
28	TOTAL General Administration	273,689	22,459	755,195	1,051,343		1,051,343	(10,679)	1,040,664		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,883,125	446,481	1,057,167	4,386,773		4,386,773	(18,962)	4,367,811		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: 01/01/2014 Ending: 12/31/2014

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			167,688	167,688		167,688	(1,781)	165,907			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,914	18,914		18,914		18,914			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			186,602	186,602		186,602	(1,781)	184,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,800		61,800		61,800		61,800			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,632	146,632		146,632		146,632			42
43	Other (specify):*		12,193	305,197	317,390		317,390	(317,390)				43
44	TOTAL Special Cost Centers		73,993	451,829	525,822		525,822	(317,390)	208,432			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,883,125	520,474	1,695,598	5,099,197		5,099,197	(338,133)	4,761,064			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: 01/01/2014 Ending: 12/31/2014

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	(8,283)	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	(1,781)	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
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(328,069)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (338,133)		\$	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))	\$ (338,133)		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/2014 Ending: 12/31/2014

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** YES NO
A. Directly Facility Related											
Long-Term											
1	Apostolic Christian Church	x	Working Capital	none	various	\$ 359,000	\$ 100,000	n/a		\$	1
2	Morton Community Bank		Long-term debt	7,000	2014	500,000	461,729	2019	0.0375		7,792
3				-							3
4				-							4
5				-							5
Working Capital											
6	Morton Community Bank		Working Capital	none	various		219,000	various	various		11,122
7				-							-
8				-							8
9	TOTAL Facility Related			7,000		\$ 859,000	\$ 780,729			\$	18,914
B. Non-Facility Related*											
10	Commerce Bank		Building Loan	7,800.00	2000	875,000		2014	0		-296
11	Morton Community Bank		Working Capital								2,920
12											12
13											13
14	TOTAL Non-Facility Related			7800		\$ 875,000	\$			\$	2,624
15	TOTALS (line 9+line14)					\$ 1,734,000	\$ 780,729			\$	21,538

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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:	2009	8	<table border="1"> <thead> <tr> <th colspan="3">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2013</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> </tbody> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2013	\$	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 2013	\$			13																		
14	PLUS APPEAL COST FROM LINE 5	\$			14																		
15	LESS REFUND FROM LINE 6	\$			15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
	2010	9																					
	2011	10																					
	2012	11																					
	2013	12																					

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
 RE: 2013 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 2013 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2013.

Please complete the Real Estate Tax Statement below and include it in the 2014 cost report along with a copy of your 2013 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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Roanoke COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT Richard D. Isaia

TELEPHONE (309) 923-2071 FAX #: (309) 923-7919

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

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	<u>100,000</u>		<u>\$ 35,875</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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		516,513	6
7			1992	1992	129,607	4,469	30	4,320	(149)	99,211	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			36,135	26
27		Building & land improvements - '94		1994	14,661		20			14,661	27
28		Building & land improvements - '95		1995	30,372		20	1,518	1,518	30,372	28
29		Building & land improvements - '96		1996	5,114		20	256	256	4,859	29
30		Building & land improvements - '97		1997	28,536		20	1,427	1,427	25,683	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.

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493

Report Period Beginning:

01/01/2014Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Building & land improvements - '04	2004	\$ 111,862	\$	7	\$	\$	\$ 111,862	37
38 New Flooring (18W)	2005	1,750		7			1,750	38
39 Drywall State Survey	2005	8,016		7			8,016	39
40 Air Conditioner Relocation	2005	448		7			448	40
41 West Side Plumbing	2005	4,108		7			4,108	41
42 Dining Remodel	2005	67,687		7			67,687	42
43 Water Piping	2006	728		7			728	43
44 Dining Room Insulation	2006	850		7			850	44
45 Floor Joist	2006	1,010		7			1,010	45
46 Furnace and Ductwork	2006	1,305		7			1,305	46
47 Generator	2006	2,496		7			2,496	47
48 Sprinkler Update	2006	960		7			960	48
49 Tub	2006	14,095		7			14,095	49
50 Activity Window Coverings	2006	558		7			558	50
51 Electrical Wiring	2006	389		7			389	51
52 Canopy Sprinkler Repair	2006	4,866		7			4,866	52
53 Retaining wall, Rm12 plaster, door latches, draperies	2006			7				53
54 Sprinkler system & plumbing upgrade	2006			7				54
55 South elevator improvement & wallguards	2006			5				55
56 Basement doors	2007	2,605	186	7	32	(154)	2,605	56
57 Water lines and sidewalks	2007	3,300	236	7	316	80	3,300	57
58 North end fire dampers	2007	11,784	842	7	1,405	563	11,784	58
59 Kitchen plumbing, electrical, carpentry, flooring, insulation	2007	93,241	6,581	7	11,095	4,514	93,241	59
60 Kitchen sinks	2007	4,179		5			4,179	60
61 Dining room cabinetry	2007	4,375		5			4,375	61
62 Kitchen air conditioning	2007	2,500		5			2,500	62
63 Elevator wiring	2007	4,720		5			4,720	63
64 Wallguards	2007	6,578		5			6,578	64
65 Kitchen lighting fixtures and ramps	2007			5				65
66 Exit light upgrade	2008		156	7		(156)		66
67 Kitchen hot water heater piping	2008		237	7		(237)		67
68 Kitchen doors	2008	12,848	1,835	7	1,835		12,393	68
69 Room 9 west flooring	2008		327	7		(327)		69
70 TOTAL (lines 4 thru 69)		\$ 2,707,270	\$ 37,245		\$ 44,580	\$ 7,335	\$ 2,518,538	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493

Report Period Beginning:

01/01/2014 Ending:12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	10
1	Totals from Page 12A, Carried Forward		\$ 2,707,270	\$ 37,245		\$ 44,580	\$ 7,335	\$ 2,518,538	1
2	South basement wall, lighting, sink & vanity	2008	3,404	486	7	486		3,242	2
3	Sprinkler system upgrade	2008		380	7		(380)		3
4	Basement sewer & plumbing system repair	2008	10,354	1,479	7	1,479		9,867	4
5	Maintenance garage sewer hook-up	2008		154	7		(154)		5
6	Water heater upgrade	2008	10,898		5			10,898	6
7	Elevator and pole light	2008	4,153		5			4,153	7
8	Kitchen grease trap replacement	2008	3,972		5	2	2	3,972	8
9	East & West end flooring	2008	12,916		5			12,916	9
10	Door replacements	2008			5				10
11	Northeast exit sidewalk replacement	2008	18,726	1,622	10	1,873	251	11,551	11
12	Front sewer line installation and repair	2008	4,216	422	10	422		2,602	12
13	Sprinkler system upgrade	2009	3,288	503	5	656	153	3,288	13
14	Water heaters, fresh air hook-up, door upgrade w/ramps	2009	12,302	1,521	5	810	(711)	12,302	14
15	Wiring/installation of digital cable system	2009		2,172	5		(2,172)		15
16	Roofing project	2009	72,252	2,297	30	2,408	111	12,647	16
17	Kitchen cabinets, countertop, plumbing	2009	2,798	280	5	89	(191)	2,798	17
18	Nurse station & med rm counter top, insulation	2010	9,407	2,264	5	1,881	(383)	8,627	18
19	Sprinkler system upgrade	2010	13,072	2,614	5	2,614		10,893	19
20	Doors, openers, exit lighting	2010	3,783	756	5	757	1	3,345	20
21	Furnace, air conditioners, disposal	2010	6,475	1,295	5	1,295		5,723	21
22	Asphalt parking lot	2010	20,152	2,015	10	2,015		8,397	22
23	Basement ceiling drywall & rm 11 carpeting	2011	4,912	591	10	491	(100)	1,761	23
24	Basement ceiling drywall & rewiring	2011		846	5		(846)		24
25	Resident rm wall mounted box holders	2011	3,422	684	5	684		2,052	25
26	Water heater	2011	6,999	1,400	5	1,400		5,374	26
27	West flooring, furnace, electrical, ceiling	2011	18,658	2,512	5	3,732	1,220	11,820	27
28	West Doors	2011	61,657	6,166	10	6,166		18,498	28
29	Wall mounted nursing stations	2011		1,297	5		(1,297)		29
30	West air conditioner	2012	3,914	783	5	783		1,828	30
31	West room signage, plumbing, electrical, sprinklers, curtains, wall mou	2012	5,880	3,604	5	1,176	(2,428)	3,041	31
32	West & basement floors, walls, ceiling, electrical, plumbing	2012	133,422	13,474	10	13,342	(132)	30,047	32
33	West & east floors, walls, ceiling, electrical, plumbing	2012	17,854	1,786	10	1,785	(1)	3,868	33
34	TOTAL (lines 1 thru 33)		\$ 3,176,156	\$ 90,648		\$ 90,926	\$ 278	\$ 2,724,048	34

**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: 01/01/2014 Ending: 12/31/2014

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		\$ 3,176,156	\$ 90,648		\$ 90,926	\$ 278	\$ 2,724,048	1
2	South floors, walls, ceiling, electrical, plumbing	2013	9,750	975	10	975		1,867	2
3	Water line replacement west side	2013	13,456	1,346	10	1,346		1,685	3
4	Dining Room a/c unit and pad	2013	4,274	855	5	855		1,356	4
5	Door locks	2013	4,809	962	5	962		1,123	5
6	Concrete N.E. loading area	2014	36,506	913	20	305	(608)	305	6
7	Elevator door restrictor, heat detector, call box	2014	5,121	512	5	772	260	772	7
8	Sprinkler piping and spray heads	2014	14,177	1,418	5	1,189	(229)	1,189	8
9	Security system wiring & affixed hardware	2014	13,751	1,375	5		(1,375)		9
10	Rms 21 & 15, conference rm flooring	2014	6,634	663	5	556	(107)	556	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,284,634	\$ 99,667		\$ 97,886	\$ (1,781)	\$ 2,732,901	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: 01/01/2014 Ending: 12/31/2014

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	\$ 499,754	\$ 57,930	\$ 57,930	\$	5	\$ 206,936	71
72	Current Year Purchases	50,305	5,032	5,032		5	5,032	72
73	Fully Depreciated Assets	1,191,855					1,191,855	73
74								74
75	TOTALS	\$ 1,741,914	\$ 62,962	\$ 62,962	\$		\$ 1,403,823	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	196	196		5	1,964	78
79	Patient Transport	2011 Dodge Caravan	2011	48,628	4,863	4,863		10	17,020	79
80	TOTALS			\$ 112,331	\$ 5,059	\$ 5,059	\$		\$ 80,723	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)	\$ 5,174,754	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,688	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 165,907	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,781)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,217,447	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	\$ 3,039,092	\$ 109,691	\$ 1,353,591	86
87	Country View Apartments Various	1,099,505	23,650	361,443	87
88	Duplex Furniture & Fixtures Various	234,237	29,872	149,980	88
89	Country View Furniture & Fixt Various	249,200	26,762	202,729	89
90	Duplex Land & Improvements Various	466,751	24,262	276,608	90
91	TOTALS	\$ 5,088,785	\$ 214,237	\$ 2,344,351	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.	<u>/2015</u>	\$ _____
13.	<u>/2016</u>	\$ _____
14.	<u>/2017</u>	\$ _____

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.

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		Contract	Total
		1 Drop-outs	2 Completed		
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	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 7,014	\$	1
2 Cash-Patient Deposits	315		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	736,191		3
4 Supply Inventory (priced at FIFO)	20,000		4
5 Short-Term Investments			5
6 Prepaid Insurance	31,240		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 794,760	\$	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	7,855,472		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	2,090,162		16
17 Accumulated Depreciation (book methods)	(6,575,624)		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)	\$ 3,434,636	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,229,396	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 279,173	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	315		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	78,915		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	4,425		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Accrued Expenses	200,054		36
37 Life Lease Deferred Income			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 562,882	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	959,027		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 Life Lease Equity	2,271,506		43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,230,533	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,793,415	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 435,981	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,229,396	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 609,882	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>		4
5	<u>Rounding</u>		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 609,882	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(617,955)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	444,054	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)	\$ (173,901)	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)	\$ 435,981	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Roanoke # 0021493 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,715,524	1
2	Discounts and Allowances for all Levels	(953,906)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,761,618	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,633	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 262,633	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	18,528	13
14	Non-Patient Meals	8,283	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,811	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,691	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,691	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,945	28
28a	Non-Care Facility	424,544	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 428,489	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,481,242	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,112,907	31
32	Health Care	2,222,523	32
33	General Administration	1,051,343	33
B. Capital Expense			
34	Ownership	186,602	34
C. Ancillary Expense			
35	Special Cost Centers	379,190	35
36	Provider Participation Fee	146,632	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,099,197	40
41	Income before Income Taxes (line 30 minus line 40)**	(617,955)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (617,955)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ (786,260)	44
45	Private Pay - Net Inpatient Revenue	4,333,187	45
46	Medicare - Net Inpatient Revenue	214,692	46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,761,618	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: 01/01/2014

Ending: 12/31/2014

12/31/2014

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	1,780	2,192	\$ 69,068	\$ 31.51	1
2	Assistant Director of Nursing	1,882	2,120	65,201	30.76	2
3	Registered Nurses	12,232	13,000	376,539	28.96	3
4	Licensed Practical Nurses	7,689	8,328	214,869	25.80	4
5	CNAs & Orderlies	61,214	65,479	977,000	14.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,396	5,028	123,022	24.47	8
9	Activity Director	1,900	2,114	35,288	16.69	9
10	Activity Assistants	4,509	5,069	63,400	12.51	10
11	Social Service Workers	3,096	3,340	58,365	17.47	11
12	Dietician					12
13	Food Service Supervisor	1,892	2,088	50,995	24.42	13
14	Head Cook	7,916	8,827	115,616	13.10	14
15	Cook Helpers/Assistants	13,644	14,482	153,807	10.62	15
16	Dishwashers					16
17	Maintenance Workers	2,089	2,310	72,071	31.20	17
18	Housekeepers	17,477	18,855	234,195	12.42	18
19	Laundry					19
20	Administrator	1,915	2,147	87,149	40.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,456	10,522	186,540	17.73	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)	153,087	165,901	\$ 2,883,125 *	\$ 17.38	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	125	\$ 6,809	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	110	7,488	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10.3	39
40	Physical Therapy Consultant	159	5,741	10a.3	40
41	Occupational Therapy Consultant	57	1,494	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	428	10a.3	43
44	Activity Consultant	12	754	11.3	44
45	Social Service Consultant	15	590	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	485	\$ 23,304		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												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Home of Roanoke# 0021493Report Period Beginning: 01/01/2014Ending: 12/31/2014

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 2,940
- (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. \$ 47,855 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. \$ 146,632
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. \$ 8,283
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.