

		FOR BHF USE				

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**2015**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2015)

**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><b>I. IDPH License ID Number:</b> <u>0012328</u></p> <p><b>Facility Name:</b> <u>Apostolic Chr Home of Eureka</u></p> <p><b>Address:</b> <u>610 Cruger</u> <u>Eureka</u> <u>61530</u>          Number City Zip Code</p> <p><b>County:</b> <u>Woodford</u></p> <p><b>Telephone Number:</b> <u>(309) 467-2311</u> Fax # <u>(309) 467-2584</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1966</u></p> <p><b>Type of Ownership:</b></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:  <b>Name:</b> <u>Thomas A. Hoffman</u> <b>Telephone Number:</b> <u>(309) 467-2311</u>  <b>Email Address:</b> _____</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2015</u> to <u>12/31/2015</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Type or Print Name) <u>Thomas A. Hoffman</u>            (Title) <u>Administrator</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Date) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Thomas A. Hoffman</u> (Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<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 _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Thomas A. Hoffman</u> (Title) <u>Administrator</u>							
<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	9	Sheltered Care (SC)	9	3,285	5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	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	4 Private Pay	Other	Total	
8	SNF	4,607	28,395	1,102	34,104	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		2,632		2,632	12
13	DD 16 OR LESS					13
14	TOTALS	4,607	31,027	1,102	36,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

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

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

Apartment, Duplex, Condominium

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1966 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 100 and days of care provided 1,102

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: 12/31/2015 Fiscal Year: 12/31/2015

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

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015  
 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	420,216	22,657	26,805	469,678		469,678	469,678			1
2	Food Purchase		309,816		309,816		309,816	(17,931)	291,885		2
3	Housekeeping	130,708	33,708	4,125	168,541		168,541	(5,564)	162,977		3
4	Laundry	132,361	11,158	1,709	145,228		145,228		145,228		4
5	Heat and Other Utilities			216,076	216,076		216,076	(43,136)	172,940		5
6	Maintenance	172,936	11,326	89,421	273,683		273,683	(41,787)	231,896		6
7	Other (specify):*										7
8	TOTAL General Services	856,221	388,665	338,136	1,583,022		1,583,022	(108,418)	1,474,604		8
<b>B. Health Care and Programs</b>											
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	3,423,143	53,293	50,241	3,526,677	37,044	3,563,721		3,563,721		10
10a	Therapy	72,612	1,470	160,487	234,569		234,569	287	234,856		10a
11	Activities	234,319	5,299	7,257	246,875		246,875	(1,640)	245,235		11
12	Social Services	74,702	103	663	75,468		75,468		75,468		12
13	CNA Training					13,755	13,755		13,755		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,804,776	60,165	223,448	4,088,389	50,799	4,139,188	(1,353)	4,137,835		16
<b>C. General Administration</b>											
17	Administrative	220,630			220,630		220,630	(26,171)	194,459		17
18	Directors Fees										18
19	Professional Services			41,270	41,270		41,270		41,270		19
20	Dues, Fees, Subscriptions & Promotions			25,576	25,576	1,328	26,904	(5,457)	21,447		20
21	Clerical & General Office Expenses	142,236	8,367	63,273	213,876	794	214,670	(17,723)	196,947		21
22	Employee Benefits & Payroll Taxes			1,106,237	1,106,237	(1,651)	1,104,586	(12,211)	1,092,375		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,528	14,528	(471)	14,057		14,057		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			101,037	101,037		101,037	(16,264)	84,773		26
27	Other (specify):*										27
28	TOTAL General Administration	362,866	8,367	1,351,921	1,723,154		1,723,154	(77,826)	1,645,328		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,023,863	457,197	1,913,505	7,394,565	50,799	7,445,364	(187,597)	7,257,767		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 Eureka #0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## 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	
30	D. Ownership											
	Depreciation			513,113	513,113		513,113	(69,411)	443,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			27,829	27,829		27,829	(27,829)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			540,942	540,942		540,942	(97,240)	443,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,801	4,599	128,400	(50,799)	77,601		77,601			39
40	Barber and Beauty Shops			30,469	30,469		30,469		30,469			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,498	259,498		259,498		259,498			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		123,801	294,566	418,367	(50,799)	367,568		367,568			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,023,863	580,998	2,749,013	8,353,874		8,353,874	(284,837)	8,069,037			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 Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(17,931)	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	12,256	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	(279,162)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (284,837)		\$	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) )	\$ (284,837)		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



SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
 IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number \_\_\_\_\_ # \_\_\_\_\_ Report Period Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A.	General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
 IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number \_\_\_\_\_ # \_\_\_\_\_ Report Period Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0 45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V		\$				\$	\$	15	
16	V								16	
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$				\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V		\$				\$	\$	15	
16	V								16	
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$				\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES

A. (Continued)      Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2015

Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328 Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$ 0	25

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka

# 0012328 Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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				\$	\$		\$ 0	25

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				\$	\$		\$	0

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2					-							2
3					-							3
4					-							4
5					-							5
	<b>Working Capital</b>											
6					-							6
7					-						-	7
8					-							8
9	TOTAL Facility Related						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.		<b>Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.</b>		\$	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 2015 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	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. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>				\$	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:	2010 _____	8	<b>FOR BHF USE ONLY</b>			
	2011 _____	9			13 FROM R. E. TAX STATEMENT FOR 2014 \$	13
	2012 _____	10			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2013 _____	11			15 LESS REFUND FROM LINE 6 \$	15
	2014 _____	12			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates  
 RE: 2014 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 2014 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2014.

Please complete the Real Estate Tax Statement below and include it in the 2015 cost report along with a copy of your 2014 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.

**2014 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0012328

CONTACT PERSON REGARDING THIS REPORT Thomas A. Hoffman

TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

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

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 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 2000 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. 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.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME \_\_\_\_\_ COUNTY \_\_\_\_\_

FACILITY IDPH LICENSE NUMBER \_\_\_\_\_

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (    ) \_\_\_\_\_ FAX #: (    ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>0.00</u>	\$ <u>0.00</u>

**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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,865 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire Resistance Number of Stories Two

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

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

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

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

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>63,500</u>	<u>1963</u>	<u>\$ 58,945</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>63,500</b>		<b>\$ 58,945</b>	<b>3</b>

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	62		1966	1966	\$ 488,404	\$	40	\$	\$	\$ 488,404	4
5	38		1975	1975	605,234		40	15,131	15,131	598,772	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	833,296	6
7	4		1994	1994	226,582	3,957	39	5,810	1,853	122,100	7
8				1989	3,512		20			3,512	8
	Improvement Type**										
9	1967 - 1990			1967	222,229		40			222,229	9
10	Trees & Shrubs			1992	403		20			403	10
11	Radiator Covers			1992	5,500		20			5,500	11
12	Plumbing Upgrade			1992	2,348		20			2,348	12
13	Shed			1992	2,000		20			2,000	13
14	Alarm System			1992	4,520		20			4,520	14
15	Lock Sets			1992	1,207		20			1,207	15
16	Fireplace Glass			1992	587		10			587	16
17	Fountain Lights			1993	1,179		10			1,179	17
18	Exterior Lighting			1993	850	5	20		(5)	850	18
19	Kitchen Flooring			1993	2,441		20			2,441	19
20	Office Addition			1994	57,234	1,431	39	1,468	37	31,809	20
21	Roof			1994	17,577		20			17,577	21
22	Interior Hallway			1994	7,134		10			7,134	22
23	Improvements			1995	3,293		10			3,293	23
24	Roof & Insulation			1995	21,002	525	20	523	(2)	21,002	24
25	Building Improvements			1995	7,787		10			7,787	25
26	Life Safety Code			1995	21,125	528	20	1,015	487	21,125	26
27	Water Softner			1996	3,442		10			3,442	27
28	Social Service Office Remodel			1996	2,750	207	20		(207)	2,750	28
29	Life Safety Code			1996	8,113	336	20	406	70	7,729	29
30	Life Safety Door			1996	5,061	253	20	253		5,009	30
31	Ventilation & A/C System			1996	5,990		10			5,990	31
32	Front Room Carpet			1996	2,432		20	122	122	2,389	32
33	Guttering System			1996	3,355	168	20	168		3,283	33
34	Cabinetry in Tub Room			1996	2,945		10			2,945	34
35	Air Conditioning & Ventilation System			1996	8,942	447	20	447		8,624	35
36	Speaker System			1996	3,798		10			3,798	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 Eureka# 0012328

Report Period Beginning:

01/01/2015 Ending:12/31/2015

## 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 Life Safety Ventilation System	1996	\$ 798	\$ 40	20	\$ 40		\$ 768	37
38 Six Air Conditioners	1997	2,882		10			2,882	38
39 Wall Fountain	1997	653		10			653	39
40 Hall Remodeling	1997	16,641	832	20	832		15,115	40
41 1998 - 1999	1998	22,349		10			22,349	41
42 Seven Air Conditioners	2000	3,626		10			3,626	42
43 Air Conditioner	2000	1,508		10			1,508	43
44 Generator & Building	2000	303,007	7,579	40	7,575	(4)	120,617	44
45 Wall Carpet	2000	3,630		10			3,630	45
46 Courtyard Improvements	2000	5,312		10			5,312	46
47 Courtyard improvements	1999	11,738		10			11,738	47
48 Air conditioner	2001	632		10			632	48
49 Lighting	2001	2,233		5			2,233	49
50 Attached wash stations	2001	849		10			849	50
51 Counter top	2001	550		10			550	51
52 Air conditioner	2001	9,725	486	20	486		7,006	52
53 Installation of sinks	2001	1,050		10			1,050	53
54 New dumpster door	2002	928	46	20	46		633	54
55 Flooring for 2002 addition and remodel	2002	85,333	4,267	20	4,267		55,471	55
56 2002 addition and remodel	2002	2,247,842	56,196	40	56,196		730,548	56
57 Room designation	2002	627		10			627	57
58 Drapes and blinds for dining, activity, therapy	2002	15,437		10			15,437	58
59 Courtyard sprinkler system	2002	8,800		10			8,800	59
60 Gravel driveway	2002	634		5			634	60
61 Landscaping for 2002 addition	2002	198,700	9,935	20	9,935		129,155	61
62 Sprinkler system for 2002 addition	2002	9,600		10			9,600	62
63 Surveillance camera	2003	1,750		5			1,750	63
64 Signage	2003	895		10			895	64
65 Valances	2003	662		10			662	65
66 Electrical work addition	2003	8,185	205	40	205		2,632	66
67 Addition painting	2003	5,289	132	40	132		1,684	67
68 Remodel breakroom	2003	3,085	154	20	154		1,964	68
69 Thermostats in addition	2003	560		10			560	69
70 TOTAL (lines 4 thru 69)		\$ 6,246,612	\$ 125,782		\$ 144,240	\$ 18,458	\$ 3,606,604	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 Eureka# 0012328

Report Period Beginning:

01/01/2015 Ending:12/31/2015

## 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		\$ 6,246,612	\$ 125,782		\$ 144,240	\$ 18,458	\$ 3,606,604	1
2	Steel Doors	2003	1,095	55	20	55		683	2
3	Oxygen room exhaust fan	2003	2,062	52	40	52		641	3
4	Storm sewer work	2003	3,500		10			3,500	4
5	Door alert system	2004	1,342		10			1,342	5
6	Smoke detectors, roller latches, fire window	2004	8,913		13	686	686	8,175	6
7	Life safety, wall repair, carpeting	2004	9,202	288	15	613	325	7,257	7
8	Handrails	2004	1,472		10			1,472	8
9	Roofing	2004	6,500	325	20	325		3,766	9
10	Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		27,437	10
11	Carpeting room 255-257, office renovations	2004	13,647	153	20	682	529	7,560	11
12	Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	240	17	491	251	5,401	12
13	Water softener for kitchen	2005	3,708	185	10	120	(65)	3,708	13
14	Cabinet for dining	2005	719	36	10	35	(1)	719	14
15	ADON office remodel	2005	1,841	92	20	92		997	15
16	Living room remodel	2005	1,615		20	81	81	878	16
17	Door for laundry room	2005	536	27	20	27		290	17
18	Water lines for water softner	2005	780	39	20	39		413	18
19	Central air conditioning unit	2005	4,902	245	20	245		2,574	19
20	Remodel tub rooms	2005	47,940	2,397	20	2,397		24,975	20
21	Kitchen hood and light fixtures	2005	9,076	454	20	454		4,692	21
22	Replace floor in walk-in cooler	2005	2,160	108	20	108		1,107	22
23	Doors for east hall room	2005	1,280	64	20	64		645	23
24	Wall carpet and corner guards	2005	2,278	114	15	152	38	1,533	24
25	Hot water delivery system	2006	2,142	214	10	214		2,106	25
26	Carpeting	2006	969	97	10	97		946	26
27	Storage area	2006	1,228	123	10	123		1,200	27
28	Plumbing & electrical for dishwasher	2006	1,089	109	10	109		1,017	28
29	Soffit work	2006	4,268	427	10	427		3,914	29
30	Floor & wall tiling	2006	13,669	683	20	683		6,261	30
31	West entrance automatic door	2006	1,736	174	10	174		1,595	31
32	Sheltered care and tub room renovations	2006	16,029	801	20	801		7,277	32
33	Automatic door	2007	4,979		10	498	498	4,440	33
34	TOTAL (lines 1 thru 33)		\$ 6,473,339	\$ 135,669		\$ 156,469	\$ 20,800	\$ 3,745,125	34

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

## STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2015Ending: 12/31/2015

## 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		\$ 6,473,339	\$ 135,669		\$ 156,469	\$ 20,800	\$ 3,745,125	1
2	Drywall in stairwell	2007	1,973	99	20	99		875	2
3	Sprinkler system	2007	802	40	20	40		354	3
4	Fireproofing of stairwell	2007	1,951	98	20	98		849	4
5	Carpeting & cabinets rm 200	2007	2,172	217	10	217		1,863	5
6	Fire panel	2007	2,311	231	10	231		1,925	6
7	Flooring rooms 134, 135, 136	2007	5,628	563	10	563		4,646	7
8	Flooring in quad	2007	52,194	2,610	20	2,610		21,316	8
9	Front entrance hallway renovations	2007	2,374	237	10	237		1,936	9
10	Exterior quad soffit replacement	2007	10,400	520	20	520		4,247	10
11	Smoke detectors	2007	569	57	10	57		456	11
12	Flooring	2007	2,910	291	10	291		2,328	12
13	Sprinkler system	2007	10,644	533	20	532	(1)	4,256	13
14	Fire grid ceiling	2008	1,725	86	20	86		681	14
15	Cabinetry in laundry	2008	561	56	10	56		443	15
16	Sprinkler system	2008	19,429	971	20	971		7,689	16
17	Air conditioning system	2008	2,300	115	20	115		834	17
18	Wood flooring install	2008	9,647	965	10	965		6,755	18
19	Doors for stairwell	2008	2,472	247	10	247		1,729	19
20	Phone system install	2008	26,715	2,672	10	2,672		20,944	20
21	Draperies	2008	1,568	157	10	157		1,217	21
22	Tub for upstairs w.s. room	2009		1,524	10		(1,524)		22
23	Sprinklers, fire damper updates w/caulking	2009	13,436	1,232	12	1,120	(112)	7,659	23
24	Flooring rms 109,110,111,112	2009	5,800	580	10	580		3,917	24
25	Auto doors, elevator & phone, walls, floors east rms.	2009	267,524	13,608	20	13,376	(232)	88,098	25
26	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009	15,716	1,572	10	1,572		9,828	26
27	Cabinets kitchen, water line n. hall & wing	2009	4,711	326	16	294	(32)	1,838	27
28	Tub for upstairs east south room	2010		1,795	10		(1,795)		28
29	Overhead & auto doors lawnshop & upeast entrance	2010	5,345	535	10	535		2,944	29
30	Blinds, flooring, walls for 214-220, utility, nurse station	2010	482,556	25,532	20	24,128	(1,404)	132,803	30
31	Flooring & wall tiles for upeast south hall spa rm	2010	7,140	714	10	714		3,930	31
32	Flooring, walls, ceiling upeast library	2010	5,632	563	10	563		3,003	32
33	Flooring, walls, ceiling for 101-108	2010	42,719	4,272	10	4,272		BR162	33
34	TOTAL (lines 1 thru 33)		\$ 7,482,263	\$ 198,687		\$ 214,387	\$ 15,700	\$ 4,084,488	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2015Ending: 12/31/2015

## 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 12C, Carried Forward		\$ 7,482,263	\$ 198,687		\$ 214,387	\$ 15,700	\$ 4,084,488	1
2	A/C for main kitchen	2010	4,250	213	20	213		1,119	2
3	Gutter coverings south & north sides	2010	3,475	231	15	232	1	1,218	3
4	Water heaters	2010	4,343	434	10	434		2,207	4
5	Flooring for downstairs E & W + nurse station	2011	42,244	2,112	20	2,112		10,381	5
6	Repair boiler & zone valves 214 - 220	2011	4,461	446	10	446		2,192	6
7	Vinyl flooring for 245 & 249	2011	4,494	449	10	449		1,946	7
8	Bus garage and mezzanine	2011	112,089	3,963	30	3,736	(227)	15,568	8
9	Water heater for kitchen	2011	5,769	577	10	577		2,308	9
10	Walnut street directional signage	2011		205	5		(205)		10
11	Fire alarm kit/ldr, DW wall, chr rail, window trim, security cam lvg r	2012	13,097	1,539	5	2,619	1,080	8,295	11
12	Flooring:120,125,122,126,239,124,Breakroom,Entrance,Kitchen	2012	46,149	4,616	10	4,615	(1)	15,388	12
13	Front entrance wall, window, door, ceiling, wiring, A/C, signage	2012	872,571	43,689	20	43,629	(60)	145,470	13
14	Laundry A/C, walls	2012	8,510	851	10	851		2,837	14
15	Mixing Valve for kitchen, laundry, resident rooms	2013	5,019	502	10	502		1,425	15
16	HL room - painting, wall board, lights	2013	5,859	586	10	586		1,613	16
17	Main Kitchen dishroom flooring	2013	2,937	294	10	294		785	17
18	Vinyl wood flooring for upstairs family & activity room	2013	13,757	1,376	10	1,376		3,559	18
19	Convert fire alarms to chimes	2013	9,565	957	10	957		2,396	19
20	Vinyl wood flooring for Room #123 & #247	2013	5,247	525	10	525		1,225	20
21	Air conditioning unit for Social Service office	2013	2,550	255	10	255		595	21
22	Tile & carpet flooring for UW hallways & SS Office	2013	32,389	1,702	20	1,619	(83)	3,646	22
23	UW nurses station walls, closet, cabinetry, countertop	2013	10,221	1,022	10	1,022		2,131	23
24	Boiler Replacement	2013	154,265	15,426	10	15,427	1	30,854	24
25	Flooring & bathroom tile work UE rooms 201-209	2013	41,832	4,183	10	4,183		8,366	25
26	Concrete to replace asphalt at entrance	2013	10,680	534	20	534		1,381	26
27	Concrete portion of parking lot	2013	5,940	297	20	297		619	27
28	Vinyl & carpet flooring for Rms 131, 127, 129, 121, 241, 224	2014	12,706	1,376	10	1,271	(105)	2,434	28
29	Controller for boiler	2014	2,796	559	5	559		1,028	29
30	Adjust-a-sink & electrical for beauty shop	2014	4,758	874	5	952	78	1,669	30
31	Air conditioning condensing unit for beauty shop	2014	3,450	345	10	345		577	31
32	Awning for courtyard west door	2014	2,861	572	5	572		763	32
33	Courtyard brick patio and landscaping	2014	47,424	2,949	20	2,371	(578)	3,164	33
34	TOTAL (lines 1 thru 33)		\$ 8,977,971	\$ 292,346		\$ 307,947	\$ 15,601	\$ 4,361,647	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 Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 12D, Carried Forward		\$ 8,977,971	\$ 292,346		\$ 307,947	\$ 15,601	\$ 4,361,647	1
2	Concrete main parking lot	2014	18,200	910	20	910		1,062	2
3	Expansion of rooms 201-212-HVAC, Carpentry, Electrical, Plumbing.	2014	691,032	34,660	20	34,552	(108)	60,584	3
4	Flooring in commons, kitchen, baths, storage, hallways	2014	39,895	1,995	20	1,995		2,164	4
5	Dining & Kitchen cabinetry & counter top, carpentry, electrical	2014	66,432	3,322	20	3,322		3,604	5
6	Palatium Care nurse call system	2015	105,024	5,642	10	8,805	3,163	8,805	6
7	Vinyl wood flooring rm:237,241,256,242,246,254,255,259,128,130,258,dining	2015	34,803	1,741	10	1,754	13	1,754	7
8	Autodoors rm: dining, break, break	2015	12,595	629	10	738	109	738	8
9	Elevator shunt trip	2015	7,460	373	10	125	(248)	125	9
10	UW dry sprinkler system	2015	68,200	1,705	20	570	(1,135)	570	10
11	Gas line main kitchent	2015	3,157	158	10	27	(131)	27	11
12	Energy project: VFD's, Zone dampers, Zone valves - air handlers	2015	50,760	2,538	10		(2,538)		12
13	Electrical outlets in rooms, nurse station, therapy	2015	3,313	166	10		(166)		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)		\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	34

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

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	
1	Totals from Page 12E, Carried Forward	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
1	Totals from Page 12F, Carried Forward	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	34

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

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	
1	Totals from Page 12G, Carried Forward	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
1	Totals from Page 12H, Carried Forward	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,078,842	\$ 346,185		\$ 360,745	\$ 14,560	\$ 4,441,080	34

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	\$ 462,900	\$ 71,529	\$ 71,529	\$	5	\$ 446,668	71
72	Current Year Purchases	48,210	2,585	2,585		5	2,585	72
73	Fully Depreciated Assets	1,190,104					1,190,104	73
74								74
75	TOTALS	\$ 1,701,214	\$ 74,114	\$ 74,114	\$		\$ 1,639,357	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 & Maintenance	99 Ford bus & 98 Dodge Pickup	1999	\$ 62,519	\$	\$	\$	10	\$ 62,519	76
77	Patient Transport	14 Dodge Caravan	2015	36,443	1,822	1,822		10	1,822	77
78	Patient Transport	07 Chevy Van	2008	35,100	3,510	3,510		10	28,080	78
79	Patient Transport	05 Chevy bus	2005	46,122	2,306	2	(2,304)	10	46,122	79
80	TOTALS			\$ 180,184	\$ 7,638	\$ 5,334	\$ (2,304)		\$ 138,543	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)	\$ 12,019,185	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 427,937	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 440,193	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,256	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,218,980	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	Apartments Various	\$ 506,726	\$ 14,601	\$ 396,222	86
87	Condos Various	1,559,638	47,818	952,232	87
88	Duplexes Various	1,084,452	20,524	921,253	88
89	Rental Units Various	747,362	1,658	15,149	89
90	Garages Various	36,768	575	32,596	90
91	TOTALS	\$ 3,934,946	\$ 85,176	\$ 2,317,452	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$	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>/2016</u>	\$ _____
13.	<u>/2017</u>	\$ _____
14.	<u>/2018</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.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
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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)		12,325		12,325
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,430		1,430
9	TOTALS	\$	\$ 13,755	\$	\$ 13,755
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,755		

- (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.

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	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

- (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*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 3,806,643	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	266,308		3
4 Supply Inventory (priced at FIFO )	47,547		4
5 Short-Term Investments			5
6 Prepaid Insurance	85,466		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)	\$ 4,205,964	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	1,026,056		13
14 Buildings, at Historical Cost	12,832,552		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	2,381,100		16
17 Accumulated Depreciation (book methods)	(8,483,809)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): <u>Construction in Progress</u>			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,755,899	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,961,863	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 127,913	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	372,864		30
31 Accrued Taxes Payable (excluding real estate taxes)	(250)		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Accrued Expenses</u>	250,956		36
37 <u>Life Lease Deferred Income</u>	132,226		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 883,709	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 <u>Life Lease Equity</u>	1,835,448		43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,835,448	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,719,157	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 9,242,706	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,961,863	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,140,737	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>	2,431	4
5	<u>Rounding</u>		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,143,168	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	99,538	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 99,538	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 9,242,706	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,530,040	1
2	Discounts and Allowances for all Levels	(446,969)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,083,071	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,239	6
7	Oxygen	45,456	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 407,695	8
<b>C. Other Operating Revenue</b>			
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	30,063	13
14	Non-Patient Meals	17,931	14
15	Telephone, Television and Radio	16,205	15
16	Rental of Facility Space		16
17	Sale of Drugs	58,406	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,951	19
20	Radiology and X-Ray		20
21	Other Medical Services	138,871	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 273,427	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	381,538	24
25	Interest and Other Investment Income***	16,754	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 398,292	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	15,586	28
28a	Non-Care Facility	275,341	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 290,927	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,453,412	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,583,022	31
32	Health Care	4,088,389	32
33	General Administration	1,723,154	33
<b>B. Capital Expense</b>			
34	Ownership	540,942	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	158,869	35
36	Provider Participation Fee	259,498	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,353,874	40
41	Income before Income Taxes (line 30 minus line 40)**	99,538	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,538	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 575,706	44
45	Private Pay - Net Inpatient Revenue	6,373,973	45
46	Medicare - Net Inpatient Revenue	133,391	46
47	Other-(specify) <u>Rounding</u>	1	47
48	Other-(specify) <u>Rounding</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,083,071	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 67,681	\$ 32.54	1
2	Assistant Director of Nursing	1,872	1,872	61,224	32.71	2
3	Registered Nurses	35,034	38,111	1,215,249	31.89	3
4	Licensed Practical Nurses	15,502	16,916	385,056	22.76	4
5	CNAs & Orderlies	112,814	122,952	1,681,608	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,611	4,024	72,612	18.04	8
9	Activity Director	1,867	1,907	32,853	17.23	9
10	Activity Assistants	16,429	17,758	201,466	11.35	10
11	Social Service Workers	3,512	3,667	74,702	20.37	11
12	Dietician					12
13	Food Service Supervisor	4,057	4,215	82,566	19.59	13
14	Head Cook	3,910	4,468	64,584	14.45	14
15	Cook Helpers/Assistants	11,681	12,622	145,668	11.54	15
16	Dishwashers	11,077	11,984	127,398	10.63	16
17	Maintenance Workers	7,126	7,746	160,098	20.67	17
18	Housekeepers	9,854	10,605	125,406	11.83	18
19	Laundry	10,219	11,109	132,361	11.91	19
20	Administrator	1,833	1,833	110,515	60.29	20
21	Assistant Administrator					21
22	Other Administrative	7,354	8,263	103,399	12.51	22
23	Office Manager	1,833	1,833	83,944	45.80	23
24	Clerical	1,609	1,809	23,149	12.80	24
25	Vocational Instruction	387	387	12,325	31.85	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)	263,661	286,161	\$ 4,963,864 *	\$ 17.35	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	163	\$ 10,690	1.3	35
36	Medical Director	24	4,800	9.3	36
37	Medical Records Consultant	32	2,367	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	68	6,760	10.3	39
40	Physical Therapy Consultant	64	4,067	10a.3	40
41	Occupational Therapy Consultant	8	476	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	458	10a.3	43
44	Activity Consultant	7	425	11.3	44
45	Social Service Consultant	5	325	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	378	\$ 30,368		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 Eureka# 0012328Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## 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. Leading Age Dues 7,771
- (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. \$ 50,643 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. \$ 259,498  
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. \$ 17,931
- (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. \$ Zero
- (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.