

		FOR BHF USE				

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2018
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2018)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0012328</u></p> <p>Facility Name: <u>Apostolic Christian Home of Eureka</u></p> <p>Address: <u>610 West Cruger</u> <u>Eureka</u> <u>61530</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 467-2311</u> Fax # <u>(309) 467-2584</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1966</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kimberly S. Joos</u> Telephone Number: <u>(309) 467-2311</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Type or Print Name) <u>Kimberly S. Joos</u></td> <td style="padding: 5px;">(Title) <u>Administrator</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Print Name and Title)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Firm Name & Address)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Telephone)</td> <td style="padding: 5px;"><u>()</u> Fax # ()</td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Kimberly S. Joos</u>	(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title)	_____	(Firm Name & Address)	_____	(Telephone)	<u>()</u> Fax # ()
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(Type or Print Name) <u>Kimberly S. Joos</u>	(Title) <u>Administrator</u>															
Paid Preparer	(Signed) _____ (Date) _____															
(Print Name and Title)	_____															
(Firm Name & Address)	_____															
(Telephone)	<u>()</u> Fax # ()															

Facility Name & ID Number Apostolic Christian Home of Eureka

0012328 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	5,595	26,481	760	32,836	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		2,252		2,252	12
13	DD 16 OR LESS					13
14	TOTALS	5,595	28,733	760	35,088	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.19%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve 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 760

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

* 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: 01/01/2018 Ending: 12/31/2018
 V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	454,626	17,300	25,786	497,712		497,712		497,712		1
2	Food Purchase		316,097		316,097		316,097	(31,391)	284,706		2
3	Housekeeping	158,032	33,346	2,465	193,843		193,843	(5,837)	188,006		3
4	Laundry	143,664	11,772	1,753	157,189		157,189		157,189		4
5	Heat and Other Utilities			253,549	253,549		253,549	(57,032)	196,517		5
6	Maintenance	186,486	15,369	98,893	300,748		300,748	(53,895)	246,853		6
7	Other (specify):*										7
8	TOTAL General Services	942,808	393,884	382,446	1,719,138		1,719,138	(148,155)	1,570,983		8
9	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	3,185,177	43,847	119,578	3,348,602	32,946	3,381,548		3,381,548		10
10a	Therapy	80,374	1,358	210,069	291,801		291,801	(369)	291,432		10a
11	Activities	239,433	3,888	5,860	249,181		249,181	(642)	248,539		11
12	Social Services	84,967		1,731	86,698		86,698		86,698		12
13	CNA Training					10,314	10,314		10,314		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,589,951	49,093	342,038	3,981,082	43,260	4,024,342	(1,011)	4,023,331		16
17	C. General Administration										
17	Administrative	255,852			255,852		255,852	(27,610)	228,242		17
18	Directors Fees										18
19	Professional Services			29,474	29,474		29,474		29,474		19
20	Dues, Fees, Subscriptions & Promotions			53,555	53,555	999	54,554	(17,763)	36,791		20
21	Clerical & General Office Expenses	168,651	8,908	84,950	262,509	230	262,739	(17,405)	245,334		21
22	Employee Benefits & Payroll Taxes			1,062,522	1,062,522	(434)	1,062,088	(16,431)	1,045,657		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,635	3,635	(795)	2,840		2,840		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			106,403	106,403		106,403	(17,554)	88,849		26
27	Other (specify):*										27
28	TOTAL General Administration	424,503	8,908	1,340,539	1,773,950		1,773,950	(96,763)	1,677,187		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,957,262	451,885	2,065,023	7,474,170	43,260	7,517,430	(245,929)	7,271,501		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: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			574,114	574,114		574,114	(127,135)	446,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			37,992	37,992		37,992	(37,992)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			612,106	612,106		612,106	(165,127)	446,979			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,386	8,084	123,470	(43,260)	80,210		80,210			39
40	Barber and Beauty Shops			26,768	26,768		26,768		26,768			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,073	248,073		248,073		248,073			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		115,386	282,925	398,311	(43,260)	355,051		355,051			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,957,262	567,271	2,960,054	8,484,587		8,484,587	(411,056)	8,073,531			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: 01/01/2018 Ending: 12/31/2018

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	Reference	BHF USE ONLY
1 Day Care	\$		\$
2 Other Care for Outpatients			
3 Governmental Sponsored Special Programs			
4 Non-Patient Meals	(31,391)	2.2	
5 Telephone, TV & Radio in Resident Rooms			
6 Rented Facility Space			
7 Sale of Supplies to Non-Patients			
8 Laundry for Non-Patients			
9 Non-Straightline Depreciation	(5,343)	30.3	
10 Interest and Other Investment Income		32.3	
11 Discounts, Allowances, Rebates & Refunds			
12 Non-Working Officer's or Owner's Salary			
13 Sales Tax			
14 Non-Care Related Interest			
15 Non-Care Related Owner's Transactions			
16 Personal Expenses (Including Transportation)			
17 Non-Care Related Fees			
18 Fines and Penalties			
19 Entertainment			
20 Contributions			
21 Owner or Key-Man Insurance			
22 Special Legal Fees & Legal Retainers			
23 Malpractice Insurance for Individuals			
24 Bad Debt			
25 Fund Raising, Advertising and Promotional			
Income Taxes and Illinois Personal			
26 Property Replacement Tax			
27 CNA Training for Non-Employees		13	
28 Yellow Page Advertising		20.3	
29 Other-Attach Schedule	(374,322)		
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (411,056)		\$

BHF USE ONLY						
48		49		50		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))	\$ (411,056)	37

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

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

	1	2	3	4
	Yes	No	Amount	Reference
38 Medically Necessary Transport.		x	\$	38
39 Physician Care		x		39
40 Gift and Coffee Shops		x		40
41 Barber and Beauty Shops		x		41
42 Laboratory and Radiology		x		42
43 Prescription Drugs		x		43
44		x		44
45 Other-Attach Schedule		x		45
46 Other-Attach Schedule		x		46
47 TOTAL (C): (sum of lines 38-46)			\$	47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2					-							2
3					-							3
4					-							4
5					-							5
	Working Capital											
6					-							6
7					-							7
8					-							8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
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 2017 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.		\$	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	3																			
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2013	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2017</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATIONS</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2017	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2017	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16																					
	2014	9																						
	2015	10																						
	2016	11																						
	2017	12																						

NOTES:

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

2017 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 Kimberly S. Joos
 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 2017 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 2017.

(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	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	TOTALS	<u>63,500</u>		<u>\$ 58,945</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Bed*	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			605,234	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	950,383	6
7	4		1994	1994	226,582	3,954	39	5,810	1,856	139,530	7
8				1989	3,512		20			3,512	8
	Improvement Type**										
9	Building & land improvements - '67 - '90			1967	222,229		40			222,229	9
10	Building & land improvements - '92			1992	16,565		20			16,565	10
11	Building & land improvements - '93			1993	4,470		20			4,470	11
12	Office Addition			1994	57,234	1,431	39	1,468	37	36,213	12
13	Building & land improvements - '94			1994	24,711		20			24,711	13
14	Building & land improvements - '95			1995	53,207		20			53,207	14
15	Building & land improvements - '96			1996	47,626		20			47,626	15
16	Building & land improvements - '97			1997	3,535		10			3,535	16
17	Hall Remodeling			1997	16,641	416	20		(416)	16,641	17
18	Building & land improvements - '98			1998	22,349		10			22,349	18
19	Building & land improvements - '99			1999	11,738		10			11,738	19
20	Generator & Building			2000	303,007	7,579	40	7,575	(4)	143,342	20
21	Building & land improvements - '00			2000	14,076		10			14,076	21
22	Air conditioner			2001	9,725	486	20	486		8,464	22
23	Building & land improvements - '01			2001	5,314		10			5,314	23
24	New dumpster door			2002	928	46	20	46		771	24
25	Flooring for 2002 addition and remodel			2002	85,333	4,267	20	4,267		68,272	25
26	2002 addition and remodel			2002	2,247,842	56,196	40	56,196		899,136	26
27	Landscaping for 2002 addition			2002	198,700	9,935	20	9,935		158,960	27
28	Building & land improvements - '02			2002	35,098		10			35,098	28
29	Electrical work addition			2003	8,185	205	40	205		3,247	29
30	Addition painting			2003	5,289	132	40	132		2,080	30
31	Remodel breakroom			2003	3,085	154	20	154		2,426	31
32	Steel Doors			2003	1,095	55	20	55		848	32
33	Oxygen room exhaust fan			2003	2,062	52	40	52		797	33
34	Building & land improvements - '03			2003	7,367		10			7,367	34
35	Door alert system			2004	1,342		10			1,342	35
36	Smoke detectors, roller latches, fire window			2004	8,913		13			8,913	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:

01/01/2018Ending: 12/31/2018

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, wall repair, carpeting	2004	\$ 9,202	\$ 288	15	\$ 613	\$ 325	\$ 9,096	37
38 Handrails	2004	1,472		10			1,472	38
39 Roofing	2004	6,500	325	20	325		4,741	39
40 Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		34,592	40
41 Carpeting room 255-257, office renovations	2004	13,647		20	682	682	9,606	41
42 Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	240	17	491	251	6,874	42
43 Water softner for kitchen	2005	3,708		10			3,708	43
44 Cabinet for dining	2005	719		10			719	44
45 ADON office remodel	2005	1,841	92	20	92		1,273	45
46 Living room remodel	2005	1,615		20	81	81	1,121	46
47 Door for laundry room	2005	536	27	20	27		371	47
48 Water lines for water softner	2005	780	39	20	39		530	48
49 Central air conditioning unit	2005	4,902	245	20	245		3,309	49
50 Remodel tub rooms	2005	47,940	2,397	20	2,397		32,166	50
51 Kitchen hood and light fixtures	2005	9,076	454	20	454		6,054	51
52 Replace floor in walk-in cooler	2005	2,160	108	20	108		1,431	52
53 Doors for east hall room	2005	1,280	64	20	64		837	53
54 Wall carpet and corner guards	2005	2,278	52	15	152	100	1,989	54
55 Hot water delivery system	2006	2,142		10			2,142	55
56 Carpeting	2006	969		10			969	56
57 Storage area	2006	1,228		10			1,228	57
58 Plumbing & electrical for dishwasher	2006	1,089		10			1,089	58
59 Soffit work	2006	4,268		10			4,268	59
60 Floor & wall tiling	2006	13,669	683	20	683		8,310	60
61 West entrance automatic door	2006	1,736		10			1,736	61
62 Sheltered care and tub room renovations	2006	16,029	801	20	801		9,680	62
63 Automatic door	2007	4,979		10			4,979	63
64 Drywall in stairwell	2007	1,973	99	20	99		1,172	64
65 Sprinkler system	2007	802	40	20	40		474	65
66 Fireproofing of stairwell	2007	1,951	98	20	98		1,143	66
67 Carpeting & cabinets rm 200	2007	2,172		10			2,172	67
68 Fire panel	2007	2,311		10			2,311	68
69 Flooring rooms 134, 135, 136	2007	5,628		10			5,628	69
70 TOTAL (lines 4 thru 69)		\$ 6,488,176	\$ 131,398		\$ 135,286	\$ 3,888	\$ 4,173,990	70

**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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,488,176	\$ 131,398		\$ 135,286	\$ 3,888	\$ 4,173,990	1
2	Flooring in quad	2007	52,194	2,610	20	2,610		29,146	2
3	Front entrance hallway renovations	2007	2,374		10			2,374	3
4	Exterior quad soffit replacement	2007	10,400	520	20	520		5,807	4
5	Smoke detectors	2007	569		10			569	5
6	Flooring	2007	2,910		10			2,910	6
7	Sprinkler system	2007	10,644	533	20	532	(1)	5,852	7
8	Fire grid ceiling	2008	1,725	86	20	86		939	8
9	Cabinetry in laundry	2008	561	28	10	6	(22)	561	9
10	Sprinkler system	2008	19,429	971	20	971		10,602	10
11	Air conditioning system	2008	2,300	115	20	115		1,179	11
12	Wood flooring install	2008	9,647	482	10	962	480	9,647	12
13	Doors for stairwell	2008	2,472	124	10	247	123	2,470	13
14	Phone system install	2008	26,715	1,336	10	427	(909)	26,715	14
15	Draperies	2008	1,568	78	10	37	(41)	1,568	15
16	Tub for upstairs w.s. room	2009		1,524	10		(1,524)		16
17	Sprinklers, fire damper updates w/caulking	2009	13,436	1,232	12	1,120	(112)	11,019	17
18	Flooring rms 109,110,111,112	2009	5,800	580	10	580		5,657	18
19	Auto doors, elevator & phone, walls, floors east rms.	2009	267,524	13,608	20	13,376	(232)	128,226	19
20	Tile & plumbing for tub rm, flooring rms. 257, 102, 101,224.	2009	15,716	1,572	10	1,572		14,544	20
21	Cabinets kitchen, water line n. hall & wing	2009	4,711	326	16	294	(32)	2,720	21
22	Tub for upstairs east south room	2010		1,795	10		(1,795)		22
23	Overhead & auto doors lawnshop & upeast entrance	2010	5,345	535	10	535		4,549	23
24	Blinds, flooring, walls for 214-220, utility, nurse station	2010	482,556	25,532	20	24,128	(1,404)	205,187	24
25	Flooring & wall tiles for upeastsouth hall spa rm	2010	7,140	714	10	714		6,072	25
26	Flooring, walls, ceiling upeast library	2010	5,632	563	10	563		4,692	26
27	Flooring, walls, ceiling for 101-108	2010	42,719	4,272	10	4,272		35,604	27
28	A/C for main kitchen	2010	4,250	213	20	213		1,758	28
29	Gutter coverings south & north sides	2010	3,475	231	15	232	1	1,914	29
30	Water heaters	2010	4,343		10	434	434	3,509	30
31	Flooring for downstairs E & W + nurse station	2011	42,244	2,112	20	2,112		16,717	31
32	Repair boiler & zone valves 214 - 220	2011	4,461	446	10	446		3,530	32
33	Vinyl flooring for 245 & 249	2011	4,494	449	10	449		3,293	33
34	TOTAL (lines 1 thru 33)		\$ 7,545,530	\$ 193,985		\$ 192,839	\$ (1,146)	\$ 4,723,320	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: 01/01/2018 Ending: 12/31/2018

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		\$ 7,545,530	\$ 193,985		\$ 192,839	\$ (1,146)	\$ 4,723,320	1
2	Bus garage and mezzanine	2011	112,089	3,963	30	3,736	(227)	26,776	2
3	Water heater for kitchen	2011	5,769		10	577	577	4,039	3
4	Fire alarm kit/lndr, DW wall, chr rail, window trim, security cam lvg r	2012	13,097	1,081	5		(1,081)	13,097	4
5	Flooring:120,125,122,126,239,124,Breakroom,Entrance,Kitchen	2012	46,149	4,616	10	4,615	(1)	29,233	5
6	Front entrance wall, window, door, ceiling, wiring, A/C, signage	2012	872,571	43,569	20	43,629	60	276,357	6
7	Laundry A/C, walls	2012	8,510	851	10	851		5,390	7
8	Mixing Valve for kitchen, laundry, resident rooms	2013	5,019	502	10	502		2,931	8
9	HL room - painting, wall board, lights	2013	5,859	586	10	586		3,371	9
10	Main Kitchen dishroom flooring	2013	2,937	294	10	294		1,667	10
11	Vinyl wood flooring for upstairs family & activity room	2013	13,757	1,376	10	1,376		7,687	11
12	Convert fire alarms to chimes	2013	9,565	957	10	957		5,267	12
13	Vinyl wood flooring for Room #123 & #247	2013	5,247	525	10	525		2,800	13
14	Air conditioning unit for Social Service office	2013	2,550	255	10	255		1,360	14
15	Tile & carpet flooring for UW hallways & SS Office	2013	32,389	1,702	20	1,619	(83)	8,503	15
16	UW nurses station walls, closet, cabinetry, countertop	2013	10,221	1,022	10	1,022		5,197	16
17	Boiler Replacement	2013	154,265	15,426	10	15,427	1	77,135	17
18	Flooring & bathroom tile work UE rooms 201-209	2013	41,832	4,183	10	4,183		20,915	18
19	Concrete to replace asphalt at entrance	2013	10,680	534	20	534		2,983	19
20	Concrete portion of parking lot	2013	5,940	297	20	297		1,510	20
21	Vinyl & carpet flooring for Rms 131, 127, 129, 121, 241, 224	2014	12,706	1,376	10	1,271	(105)	6,247	21
22	Controller for boiler	2014	2,796	559	5	559		2,705	22
23	Adjust-a-sink & electrical for beauty shop	2014	4,758	874	5	952	78	4,525	23
24	Air conditioning condensing unit for beauty shop	2014	3,450	345	10	345		1,612	24
25	Awning for courtyard west door	2014	2,861	572	5	572		2,479	25
26	Courtyard brick patio and landscaping	2014	47,424	2,949	20	2,371	(578)	10,277	26
27	Concrete main parking lot	2014	18,200	910	20	910		3,792	27
28	Expansion of rooms 201-212-HVAC, Carpentry, Electrical, Plumbing,	2014	691,032	34,660	20	34,552	(108)	164,240	28
29	Flooring in commons, kitchen, baths, storage, hallways	2014	39,895	1,995	20	1,995		8,149	29
30	Dining & Kitchen cabinetry & counter top, carpentry, electrical	2014	66,432	3,322	20	3,322		13,570	30
31	Palatium Care nurse call system	2015	105,024	11,284	10	10,502	(782)	40,311	31
32	Vinyl wood flooring rm:237,241,256,242,246,254,255,259,128,130,25	2015	34,803	3,480	10	3,480		12,194	32
33	Autodoors rm: dining, break, break	2015	12,595	1,259	10	1,260	1	4,518	33
34	TOTAL (lines 1 thru 33)		\$ 9,945,952	\$ 339,309		\$ 335,915	\$ (3,394)	\$ 5,494,157	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: 01/01/2018 Ending: 12/31/2018

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	\$ 9,945,952	\$ 339,309		\$ 335,915	\$ (3,394)	\$ 5,494,157		1
2	Elevator shunt trip	2015 7,460	746	10	746		2,363		2
3	UW dry sprinkler system	2015 68,200	3,410	20	3,410		10,800		3
4	Gas line main kitchent	2015 3,157	316	10	316		975		4
5	Energy project: VFD's, Zone dampers, Zone valves - air handlers	2015 50,760	5,076	10	5,076		15,228		5
6	Electrical outlets in rooms, nurse station, therapy	2015 3,313	391	10	331	(60)	993		6
7	Vinyl wood flooring rm:251,260,244,248,238	2016 12,853	1,285	10	1,285		3,109		7
8	Sound system & wiring - activity & dining	2016 7,827	782	10	783	1	2,284		8
9	A/C nursing admin	2016 8,754	875	10	875		2,191		9
10	Smoke detectors & circuit panels	2016 8,048	805	10	805		1,610		10
11	Concrete drive, leveling, repairs	2016 33,386	1,842	20	1,669	(173)	4,317		11
12	DE lighting & door - rm 109-112 & supply	2016 4,199	420	10	420		980		12
13	Water heater for kitchens	2017 8,063	806	10	806		806		13
14	Vinyl floor Rm #250, Therapy Rm, West entry	2017 13,465	2,433	5	2,693	260	4,272		14
15	16 H/C units Rms: 120-131; 245-250; dining; tub	2017 50,313	3,354	15	3,354		3,639		15
16	Water heater - old boiler room	2018 8,953	448	10		(448)			16
17	Security system main doors; wiring, wall/ceiling domes.	2018 6,170	617	5	206	(411)	206		17
18	Water heater - new mechanical room	2018 3,900	390	5	261	(129)	261		18
19	Upstairs west resident room lighting Room 236-259	2018 10,800	540	10	814	274	814		19
20	Wood floor: Up dining, sm dining, office, sm sitting rm.	2018 19,771	1,066	10	1,327	261	1,327		20
21	Vinyl floor: Upstairs and downstairs hallways	2018 18,350	918	10	1,232	314	1,232		21
22	Dining & kitchen:carpentry,plumbing,elec,paint,cabinetry	2018 64,590	2,153	15	2,890	737	2,890		22
23	5 PTAC units: Upstairs sitting rm; rms 236,238,240,242	2018 29,650	988	15	168	(820)	168		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)	\$ 10,387,934	\$ 368,970		\$ 365,382	\$ (3,588)	\$ 5,554,622		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: 01/01/2018 Ending: 12/31/2018

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	\$ 1,253,158	\$ 55,984	\$ 55,984	\$	5	\$ 1,336,477	71
72	Current Year Purchases	64,996	5,790	5,790		5	5,790	72
73	Fully Depreciated Assets	482,467					482,467	73
74								74
75	TOTALS	\$ 1,800,621	\$ 61,774	\$ 61,774	\$		\$ 1,824,734	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	05 Chevy bus/17 E350 bus	2005/2018	\$ 111,744	\$ 6,562	\$ 6,562	\$	10	\$ 101,923	76
77	Patient Transport	14 Dodge Caravan	2015	36,443	3,644	3,644		10	12,754	77
78	Patient Transport	07 Chevy Van	2008	35,100	1,755		(1,755)	10	35,100	78
79	Maintenance	13 Nissan Pickup	2016	14,509	2,902	2,902		5	7,020	79
80	TOTALS			\$ 197,796	\$ 14,863	\$ 13,108	\$ (1,755)		\$ 156,797	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)	\$ 12,445,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 445,607	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 440,264	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,343)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,536,153	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	\$ 506,045	\$ 11,616	\$ 432,064	86
87	Condos Various	1,639,335	55,153	1,108,501	87
88	Duplexes Various	1,803,190	58,678	1,053,218	88
89	Rental Units Various	762,323	2,367	20,468	89
90	Garages Various	36,768	693	34,676	90
91	TOTALS	\$ 4,747,661	\$ 128,507	\$ 2,648,927	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 85,805	92
93			93
94			94
95		\$ 85,805	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>/2019</u>	\$ _____
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
1	Community College Tuition	\$	\$ 1,406	\$	\$ 1,406
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		8,238		8,238
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		670		670
9	TOTALS	\$	\$ 10,314	\$	\$ 10,314
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,314		

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	399	\$ 37,774	\$	399	\$ 37,774	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		220	15,384		220	15,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		557	52,659		557	52,659	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				52,055		52,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2					20,071		20,071	13
14	TOTAL			\$	1,176	\$ 105,818	\$ 72,126	1,176	\$ 177,944	14

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

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 5,231,440	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	330,667		3
4 Supply Inventory (priced at FIFO)	42,476		4
5 Short-Term Investments			5
6 Prepaid Insurance	104,510		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)	\$ 5,709,093	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	1,026,056		13
14 Buildings, at Historical Cost	13,894,205		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	2,490,182		16
17 Accumulated Depreciation (book methods)	(9,876,400)		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>	85,805		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,619,848	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,328,941	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 114,864	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	444,592		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	359		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>	256,214		36
37 <u>Life Lease Deferred Income</u>	331,218		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,147,247	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 <u>Life Lease Equity</u>	2,584,210		43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,584,210	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,731,457	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 9,597,484	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,328,941	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,585,170	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>		4
5	<u>Rounding</u>		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,585,170	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,314	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)	\$ 12,314	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,597,484	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2018Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,538,480	1
2	Discounts and Allowances for all Levels	(664,365)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,874,115	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	376,399	6
7	Oxygen	25,890	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 402,289	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,704	13
14	Non-Patient Meals	31,391	14
15	Telephone, Television and Radio	13,475	15
16	Rental of Facility Space		16
17	Sale of Drugs	70,263	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,928	19
20	Radiology and X-Ray		20
21	Other Medical Services	117,821	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 305,582	23
D. Non-Operating Revenue			
24	Contributions	479,704	24
25	Interest and Other Investment Income***	46,508	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 526,212	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,828	28
28a	Non-Care Facility	378,875	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 388,703	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,496,901	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,719,138	31
32	Health Care	3,981,082	32
33	General Administration	1,773,950	33
B. Capital Expense			
34	Ownership	612,106	34
C. Ancillary Expense			
35	Special Cost Centers	150,238	35
36	Provider Participation Fee	248,073	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,484,587	40
41	Income before Income Taxes (line 30 minus line 40)**	12,314	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 12,314	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 750,640	44
45	Private Pay - Net Inpatient Revenue	6,111,837	45
46	Medicare - Net Inpatient Revenue	11,638	46
47	Other-(specify) <u>Rounding</u>		47
48	Other-(specify) <u>Rounding</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,874,115	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	\$ 80,556	\$ 38.73	1
2	Assistant Director of Nursing	1,872	1,872	65,203	34.83	2
3	Registered Nurses	27,183	29,705	1,092,618	36.78	3
4	Licensed Practical Nurses	13,294	14,417	358,632	24.88	4
5	CNAs & Orderlies	99,896	108,688	1,579,930	14.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,674	4,173	80,374	19.26	8
9	Activity Director	1,920	1,920	37,446	19.50	9
10	Activity Assistants	14,961	16,363	201,987	12.34	10
11	Social Service Workers	3,735	3,961	84,967	21.45	11
12	Dietician					12
13	Food Service Supervisor	3,933	4,132	79,739	19.30	13
14	Head Cook	3,752	4,202	67,899	16.16	14
15	Cook Helpers/Assistants	12,817	14,071	163,715	11.63	15
16	Dishwashers	11,318	12,396	143,273	11.56	16
17	Maintenance Workers	6,986	7,598	172,382	22.69	17
18	Housekeepers	11,096	12,247	152,506	12.45	18
19	Laundry	9,712	10,645	143,664	13.50	19
20	Administrator	1,856	1,856	128,536	69.25	20
21	Assistant Administrator	2,020	2,020	99,707	49.36	21
22	Other Administrative	8,840	9,669	114,631	11.86	22
23	Office Manager					23
24	Clerical	3,046	3,430	37,814	11.02	24
25	Vocational Instruction	249	249	8,238	33.08	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)	244,240	265,694	\$ 4,893,817 *	\$ 18.42	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	204	\$ 11,807	1.3	35
36	Medical Director	24	4,800	9.3	36
37	Medical Records Consultant	33	2,442	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	62	6,166	10.3	39
40	Physical Therapy Consultant	61	5,709	10a.3	40
41	Occupational Therapy Consultant	5	522	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	663	10a.3	43
44	Activity Consultant	9	550	11.3	44
45	Social Service Consultant	7	450	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	415	\$ 33,109		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	253	11,848	10.3	51
52	Certified Nurse Assistants/Aides	1,696	41,785	10.3	52
53	TOTAL (lines 50 - 52)	1,949	\$ 53,633		53

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2018Ending: 12/31/2018

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 8,136
- (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. \$ 43,260 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. \$ 248,073
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. \$ 31,391
- (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.