FOR BHF USE

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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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0044552

Facility Name: Faith Care Center

Address: 100 Faith Dr (Number) Highland (City) 62249 (Zip Code)

County: Madison

Telephone Number: 618-654-4600 **Fax #** 618-654-4604

HFS ID Number:

Date of Initial License for Current Owners: 3/21/03

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lisa Ketrow **Telephone Number:** 618-654-4600
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 5/1/12 to 4/30/13 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Gerald Harman
(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Steve Howell, Director
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave., Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4497 Fax # 314-925-4350

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,254	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	7	Sheltered Care (SC)	7	2,562	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,233	20,155	2,515	25,903	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,233	20,155	2,515	25,903	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.12%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
Senior Community Meals

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 03/30/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 69 and days of care provided 2,581

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 04/30/2013 Fiscal Year: 04/30/2013

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	185,438	12,725	24,342	222,505		222,505		222,505			1
2	Food Purchase		211,988		211,988		211,988	(23,264)	188,724			2
3	Housekeeping	141,144	19,219	2,821	163,184		163,184		163,184			3
4	Laundry											4
5	Heat and Other Utilities			219,810	219,810		219,810		219,810			5
6	Maintenance	28,327	20,807	47,702	96,836		96,836		96,836			6
7	Other (specify):*			13,149	13,149		13,149		13,149			7
8	**TOTAL General Services**	354,909	264,739	307,824	927,472		927,472	(23,264)	904,208			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	1,401,575	49,750	20,646	1,471,971		1,471,971		1,471,971			10
10a	Therapy		1,373	380,316	381,689		381,689		381,689			10a
11	Activities	47,922	968	1,413	50,303		50,303		50,303			11
12	Social Services	23,145		424	23,569		23,569		23,569			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,472,642	52,091	409,399	1,934,132		1,934,132		1,934,132			16
	C. General Administration											
17	Administrative	132,149		16,325	148,474		148,474		148,474			17
18	Directors Fees											18
19	Professional Services			21,275	21,275		21,275		21,275			19
20	Dues, Fees, Subscriptions & Promotions			19,276	19,276		19,276	(12,769)	6,507			20
21	Clerical & General Office Expenses	73,657	24,814	783,142	881,613		881,613	(335,442)	546,171			21
22	Employee Benefits & Payroll Taxes			263,235	263,235		263,235		263,235			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,806	3,806		3,806		3,806			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,005	48,005		48,005		48,005			26
27	Other (specify):*											27
28	**TOTAL General Administration**	205,806	24,814	1,155,064	1,385,684		1,385,684	(348,211)	1,037,473			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,033,357	341,644	1,872,287	4,247,288		4,247,288	(371,475)	3,875,813			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 Faith Care Center #0044552 **Report Period Beginning:** 5/1/12 **Ending:** 4/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			378,246	378,246		378,246		378,246			30
31	Amortization of Pre-Op. & Org.			7,355	7,355		7,355		7,355			31
32	Interest			311,271	311,271		311,271		311,271			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			696,872	696,872		696,872		696,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			71,802	71,802		71,802		71,802			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,916	164,916		164,916		164,916			42
43	Other (specify):*	316,846		926,196	1,243,042		1,243,042	(1,243,042)				43
44	**TOTAL Special Cost Centers**	316,846		1,162,914	1,479,760		1,479,760	(1,243,042)	236,718			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,350,203	341,644	3,732,073	6,423,920		6,423,920	(1,614,517)	4,809,403			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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(23,264)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,839)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(62,307)	21		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	(35,608)	21		24
25	Fund Raising, Advertising and Promotional	(12,769)	20.		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,473,730)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,614,517)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,614,517)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Faith Care Center

ID# 0044552

Report Period Beginning: 5/1/12

Ending: 4/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL- Payroll	$ (316,846)	43	1
2	AL-Employee Benefits	(39,515)	43	2
3	AL-Dietary	(111,071)	43	3
4	AL-Housekeeping	(9,519)	43	4
5	AL-Maintenance	(31,813)	43	5
6	AL-Administrative	(32,114)	43	6
7	AL-Operating	(127,692)	43	7
8	AL-Depreciation	(296,128)	43	8
9	AL-Bad Debt	(63)	43	9
10				10
11	AL-MIP Expense	(27,139)	43	11
12	AL-Interest Expense	(225,402)	43	12
13	AL-Insurance Expense	(25,740)	43	13
14	AL- Loss on refinancing	(230,688)	21	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,473,730)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Faith Care Center **#** 0044552 **Report Period Beginning:** 5/1/12 **Ending:** 4/30/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(23,264)	0	0	0	0	0	0	0	0	0	0	(23,264)	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**	(23,264)	0	0	0	0	0	0	0	0	0	0	(23,264)	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	(12,769)	0	0	0	0	0	0	0	0	0	0	(12,769)	20
21	Clerical & General Office Expenses	(335,442)	0	0	0	0	0	0	0	0	0	0	(335,442)	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**	(348,211)	0	0	0	0	0	0	0	0	0	0	(348,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(371,475)	0	0	0	0	0	0	0	0	0	0	(371,475)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/12 **Ending:** 4/30/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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):*	(1,243,042)	0	0	0	0	0	0	0	0	0	0	(1,243,042)	43
44	**TOTAL Special Cost Centers**	(1,243,042)	0	0	0	0	0	0	0	0	0	0	(1,243,042)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,614,517)	0	0	0	0	0	0	0	0	0	0	(1,614,517)	45

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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	See attached board of directors listing.								$		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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Series 2001 A & B Bonds		X	Construction of Facility		10/23/01	$	$	10/2041	0.0620	$ 143,657	1
2	secured by HUD mortgage.											2
3	Series 2001 A & B Bonds		X	Construct Facility	$57,637.00	7/31/2012	7,338,128	7,235,508	10/2041	0.0320	156,880	3
4	secured by HUD mortgage.											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$57,637.00		$ 7,338,128	$ 7,235,508			$ 300,537	9
	B. Non-Facility Related*											
10	Series 2001 A & B Bonds		X	Construction of Facility (AL portion)		10/23/01			10/2041	0.0620	112,874	10
11	secured by HUD mortgage											11
12	Series 2001 A & B Bonds		X	Construction of Facility (AL po	$57,637.00	7/31/2012	5,765,672	5,685,042	10/2041	0.0320	123,262	12
13	secured by HUD mortgage											13
14	TOTAL Non-Facility Related				$57,637.00		$ 5,765,672	$ 5,685,042			$ 236,136	14
15	TOTALS (line 9+line14)						$ 13,103,800	$ 12,920,550			$ 536,673	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 64,617** **Line #** **21-3 & 43-3**

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

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

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 5/1/12 **Ending:** 4/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	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).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2013 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.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011		11
2012		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Faith Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0044552

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 2012 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 2012.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,963 B. General Construction Type: Exterior Vinyl Siding Frame Wood/Steel Number of Stories

C. Does the Operating Entity? [X] (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? [X] (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).

FCH Apartments, Independent Living, 84 Units
FCH Assisted Living, Assisting Living Apartments, 36 Units
FCH Countryside Center, Independent Senior Citizen Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	372,834	1989	$ 18,549	1
2					2
3	TOTALS	372,834		$ 18,549	3

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		2003	2003	$ 7,334,181	$ 239,877	30.5	$ 239,877	$	$ 2,418,616	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2005 Fixed Assets			31-Dec	16,856	1,525	Various	1,525		11,536	9
10	2006 Fixed Assets			12/31/2006	5,473	365	Various	365		3,996	10
11	2007 Fixed Assets			12/31/2007	14,731	1,174	Various	1,174		5,875	11
12	Door Closers			2/1/2008	2,883	576	5	576		2,450	12
13	Door Closers			2/1/2008	681	136	5	136		579	13
14	Parking Lot Resurfacing			10/8/2008	16,048	1,958	3	1,958		17,749	14
15	Parking Lot Resurfacing			11/8/2008	12,122	2,020	3	2,020		12,122	15
16	Parking Lot Resurfacing			10/8/2008	3,793	527	3	527		3,793	16
17	Parking Lot Resurfacing			11/8/2008	2,865	478	3	478		2,865	17
18	Ice Maker			1/8/2010	1,635	545	3	545		1,226	18
19	Bed			2/8/2010	1,858	186	10	186		434	19
20	Covered Patio			3/8/2010	29,311	1,970	30	1,970		4,753	20
21	Ice Maker			2/8/2010	386	129	3	129		290	21
22	Heat Pumps			5/1/2010	9,258	1,852	5	1,852		3,704	22
23	Call Lights			6/1/2010	6,964	1,393	5	1,393		2,670	23
24	Sprinkler Valves			6/1/2010	1,839	368	5	368		705	24
25	Painting			6/1/2010	1,000	200	5	200		383	25
26	Elevator Upgrades			7/1/2010	2,472	247	10	247		453	26
27	Heat Pump			7/1/2010	3,080	616	5	616		1,129	27
28	Painting			7/1/2010	220	44	5	44		81	28
29	Magnum Cooling Tower			8/1/2010	1,324	265	5	265		463	29
30	Surge Supression			10/1/2010	3,295	659	5	659		1,043	30
31	Speed Bumps and Signs			10/1/2010	284	57	5	57		90	31
32	Painting			1/1/2011	4,667	933	5	933		1,245	32
33	Plumbing Work			3/1/2011	6,325	632	10	632		685	33
34	Heat Pumps			5/1/2010	2,188	438	5	438		876	34
35	Call Lights			6/1/2010	1,446	322	5	322		619	35
36	Elevator Upgrades			7/1/2010	584	58	10	58		107	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heat Pump	7/1/2010	$ 728	$ 146	5	$ 146	$	$ 267	37
38	Painting	7/1/2010	52	10	5	10		19	38
39	Cooling Tower	8/1/2010	313	63	5	63		110	39
40	Surge Suppression	10/1/2010	779	156	5	156		247	40
41	Speed Bumps and Signs	10/1/2010	189	38	5	38		60	41
42	Shingle Replacement	5/1/2011	2,150	108	3	108		108	42
43	Door Closers	7/1/2011	1,734	289	5	289		289	43
44	United Carpet - Carpeting	7/1/2011	28,700	4,783	5	4,783		4,783	44
45	Water Cooling Tower	7/1/2011	28,050	4,675	5	4,675		4,675	45
46	Guttering	8/1/2011	7,250	363	5	363		363	46
47	Cooling Tower	8/1/2011	9,946	373	5	373		373	47
48	Heat Pumps	8/1/2011	6,500	488	5	488		488	48
49	Cooling Tower	9/1/2011	9,946	332	5	332		332	49
50	Maedge Trucking	9/1/2011	2,000	67	5	67		67	50
51	Cooling Tower	9/1/2011	561	19	5	19		19	51
52	Cooling Tower	10/1/2011	1,683	49	5	49		49	52
53	Cooling Tower	10/1/2011	9,397	274	5	274		274	53
54	Loading Dock Railing	11/1/2011	2,320	58	5	58		58	54
55	Midwest Machinery	12/1/2011	8,875	370	5	370		370	55
56	Valve & Piping	12/1/2011	3,933	164	5	164		164	56
57	Pump Repairs	12/1/2011	1,050	88	5	88		88	57
58	Pump Repairs	12/1/2011	1,050	88	5	88		88	58
59	Door Panic Bar	1/1/2012	1,652	110	5	110		110	59
60	Valve Replacement	2/1/2012	1,415	35	5	35		35	60
61	4 Heat Pumps	2/1/2012	5,330	267	5	267		267	61
62	1 Heat Pump	2/1/2012	1,750	87	5	87		87	62
63	3 Heat Pumps	2/1/2012	4,653	233	5	233		233	63
64	Patio	4/1/2012	4,740	26	15	26		26	64
65	Patio Awning	7/1/2012	6,400	533	10	533		533	65
66	Kitchen repairs	7/1/2012	1,195	100	10	100		100	66
67	Dry sprinkler repairs	7/1/2012	3,703	617	5	617		617	67
68	Door Controls	7/1/2012	1,764	265	5	265		265	68
69	Heating/Cooling	8/1/2012	4,032	302	10	302		302	69
70	TOTAL (lines 4 thru 69)		$ 7,651,609	$ 275,126		$ 275,126	$	$ 2,516,403	70

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,651,609	$ 275,126		$ 275,126	$	$ 2,516,403	1
2	Awning power	8/1/2012	493	37	10	37		37	2
3	Wet sprinkler repairs	8/1/2012	4,362	654	5	654		654	3
4	Shingle replacement	9/1/2012	970	65	10	65		65	4
5	Cooling tower pump motor	9/1/2012	1,728	115	10	115		115	5
6	Door Closers	9/1/2012	1,141	152	5	152		152	6
7	Door Alarm	9/1/2012	1,700	227	5	227		227	7
8	Parking lot paving	10/1/2012	53,461	10,395	3	10,395		10,395	8
9	Sprinkler upgrade	10/1/2012	8,619	1,006	5	1,006		1,006	9
10	Fire Door - apt 211	10/1/2012	598	70	5	70		70	10
11	Cooling tower pump	11/1/2012	759	38	10	38		38	11
12	Controller for cooling tower	11/1/2012	961	48	10	48		48	12
13	Labor for apt 211 door installation	11/1/2012	473	47	5	47		47	13
14	Plumbing Upgrades	12/1/2012	2,468	103	10	103		103	14
15	Supply/return air boxes	12/1/2012	337	14	10	14		14	15
16	Control board for HVAC	1/1/2013	3,688	123	10	123		123	16
17	Kone- elevator upgrades	3/1/2013	2,396	40	10	40		40	17
18	Korte Services - AL Laundry	3/1/2013	4,675	52	15	52		52	18
19	Session Freedom Dishwasher	3/1/2013	4,111	69	10	69		69	19
20	S Horn - #30 window/frame	4/1/2013	772	4	15	4		4	20
21	Crest-nurse call boxes - 4	4/1/2013	787	22	3	22		22	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)		$ 7,746,107	$ 288,407		$ 288,407	$	$ 2,529,684	34

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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	$ 931,430	$ 87,615	$ 87,615	$	various	$ 870,427	71
72	Current Year Purchases	17,734	1,533	1,533		various	1,533	72
73	Fully Depreciated Assets	43,718				various	41,356	73
74								74
75	TOTALS	$ 992,882	$ 89,148	$ 89,148	$		$ 913,316	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 Care	1997 Ford E350 van	1997	$ 35,436	$	$	$	5	$ 35,436	76
77	Maintenance	1998 Chevy C1500 PU	1998	2,682				5	2,682	77
78	Patient Care, Maintenance	Golf Cart	2011	5,600	1,120	1,120		5	1,773	78
79										79
80	TOTALS			$ 43,718	$ 1,120	$ 1,120	$		$ 39,891	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)	$ 8,801,256	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,675	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 378,675	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,482,891	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	AL - Building & Improvements	$ 5,787,463	$ 190,026	$ 1,874,323	86
87	AL - Equipment	14,602	1,775	11,934	87
88					88
89					89
90					90
91	TOTALS	$ 5,802,065	$ 191,801	$ 1,886,257	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

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.	/2014	$
13.	/2015	$
14.	/2016	$

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 Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Faith Care Center only hires CNAs that are already certified

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	2,340	$ 67,463	$	2,340	$ 67,463	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,142	32,942		1,142	32,942	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		3,842	110,775		3,842	110,775	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,324	$ 211,180	$	7,324	$ 211,180	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.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 4/30/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 158,812	$	1
2	Cash-Patient Deposits	25,828		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	989,804		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,026		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)**	$ 1,209,470	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	13,529,688		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,047,320		16
17	Accumulated Depreciation (book methods)	(5,399,792)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,375,218		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing Costs	153,994		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,724,977	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,934,447	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,183	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,568		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,583		30
31	Accrued Taxes Payable (excluding real estate taxes)	75,647		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	34,455		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Related Party	123,275		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 553,711	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	12,638,251		40
41	Bonds Payable	282,299		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related Party Note Payable - Surplus Cas	274,936		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 13,195,486	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,749,197	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,814,750)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,934,447	$	48

***(See instructions.)**

Facility Name & ID Number Faith Care Center **#** 0044552 **Report Period Beginning:** 5/1/12 **Ending:** 4/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,201,984)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,201,984)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(612,766)	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)**	$ (612,766)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,814,750)	24 *

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,355,745	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,355,745	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	567,887	6
7	Oxygen	565	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 568,452	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		13
14	Non-Patient Meals	23,264	14
15	Telephone, Television and Radio	6,839	15
16	Rental of Facility Space		16
17	Sale of Drugs	59,988	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,966	19
20	Radiology and X-Ray		20
21	Other Medical Services	17,519	21
22	Laundry	8,164	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 117,740	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,307	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,307	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenue	706,498	28
28a	Miscellaneous Income	412	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 706,910	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,811,154	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	927,472	31
32	Health Care	1,934,132	32
33	General Administration	1,385,684	33
	B. Capital Expense		
34	Ownership	696,872	34
	C. Ancillary Expense		
35	Special Cost Centers	1,314,844	35
36	Provider Participation Fee	164,916	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,423,920	40
41	**Income before Income Taxes (line 30 minus line 40)****	(612,766)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (612,766)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 363,615	44
45	Private Pay - Net Inpatient Revenue	3,258,667	45
46	Medicare - Net Inpatient Revenue	733,463	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,355,745	49

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

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

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

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,885	2,133	$ 57,733	$ 27.07	1
2	Assistant Director of Nursing	1,942	2,176	46,786	21.50	2
3	Registered Nurses	8,439	8,641	194,566	22.52	3
4	Licensed Practical Nurses	22,625	25,397	476,674	18.77	4
5	CNAs & Orderlies	56,675	57,568	599,688	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,974	2,223	22,107	9.94	8
9	Activity Director	1,953	2,210	26,586	12.03	9
10	Activity Assistants	2,243	2,403	21,336	8.88	10
11	Social Service Workers	1,599	1,772	23,145	13.06	11
12	Dietician					12
13	Food Service Supervisor	1,400	1,465	24,905	17.00	13
14	Head Cook	3,820	4,088	39,776	9.73	14
15	Cook Helpers/Assistants	7,675	8,440	74,342	8.81	15
16	Dishwashers	4,700	5,626	46,415	8.25	16
17	Maintenance Workers	2,050	2,347	28,327	12.07	17
18	Housekeepers	7,223	7,864	70,572	8.97	18
19	Laundry	7,224	7,864	70,572	8.97	19
20	Administrator	2,983	3,183	132,149	41.52	20
21	Assistant Administrator					21
22	Other Administrative	4,600	4,821	73,657	15.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	366	380	4,021	10.58	31
32	Other Health Care(specify)			316,846		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,376	150,601	$ 2,350,203 *	$ 15.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	133	$ 5,526	1-3	35
36	Medical Director	88	6,600	9-3	36
37	Medical Records Consultant	20	1,076	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	65	4,240	10a-3	39
40	Physical Therapy Consultant	26	1,507	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	180	11-3	44
45	Social Service Consultant	8	424	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	342	$ 19,553		49

C. CONTRACT NURSES

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerald Harman	Executive Director		$ 49,431
Darlene Genteman	Administrator		82,718
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,149

B. Administrative - Other

Description	Amount
Non-Audit Accounting Fees	$ 16,325
TOTAL (agree to Schedule V, line 17, col. 3)	$ 16,325
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen LLP	Audit/Accounting	$ 14,897
Donovan Rose Nester	Legal Fees	2,158
CliftonLarsonAllen LLP	Professional Fees	4,220
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,275

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,859
Unemployment Compensation Insurance	21
FICA Taxes	155,226
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Physicals	3,699
Years of Services	1,100
CPR Training	600
Employment Legal Settlement	5,250
See Attachment	16,480
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,235

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	799
Health Care Worker Background Check	
(Indicate # of checks performed 34)	1,020
Patient Background Checks 78	780
Advertising-Marketing/ Promo	11,520
Dues and Subscriptions	4,707
Less: Public Relations Expense	( )
Non-allowable advertising	(12,769)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,057

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	1,606
Seminar Expense	2,200
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,806

**See instructions.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/12 Ending: 4/30/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $2,618**

(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? **N/A**

(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? **N/A**

(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? **5-15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,977** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **164,916**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **23,264**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.