



Facility Name & ID Number Faith Care Center

# 0044552 Report Period Beginning: 5/1/2015 Ending: 4/30/2016

**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	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,200	19,923	2,115	25,238	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,200	19,923	2,115	25,238	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 90.73%

**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  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 3/30/2003

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 3/1/2003 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified 76 and days of care provided 2,115

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 4/30/2016 Fiscal Year: 4/30/2016

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/2015 Ending: 4/30/2016

**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
	<b>A. General Services</b>										
1	Dietary	227,952	11,953	33,823	273,728		273,728		273,728		1
2	Food Purchase		215,096		215,096		215,096	(26,842)	188,254		2
3	Housekeeping	182,688	23,646	3,498	209,832		209,832		209,832		3
4	Laundry										4
5	Heat and Other Utilities			232,807	232,807		232,807		232,807		5
6	Maintenance	27,959	14,556	47,489	90,004		90,004		90,004		6
7	Other (specify):*			15,112	15,112		15,112		15,112		7
8	<b>TOTAL General Services</b>	<b>438,599</b>	<b>265,251</b>	<b>332,729</b>	<b>1,036,579</b>		<b>1,036,579</b>	<b>(26,842)</b>	<b>1,009,737</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,800	12,800		12,800		12,800		9
10	Nursing and Medical Records	1,601,852	51,396	24,254	1,677,502		1,677,502		1,677,502		10
10a	Therapy		332	200,026	200,358		200,358		200,358		10a
11	Activities	58,510	2,520	1,762	62,792		62,792		62,792		11
12	Social Services	59,178		849	60,027		60,027		60,027		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,719,540</b>	<b>54,248</b>	<b>239,691</b>	<b>2,013,479</b>		<b>2,013,479</b>		<b>2,013,479</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,341			53,341		53,341		53,341		17
18	Directors Fees										18
19	Professional Services			51,958	51,958		51,958		51,958		19
20	Dues, Fees, Subscriptions & Promotions			22,254	22,254		22,254	(8,040)	14,214		20
21	Clerical & General Office Expenses	86,815	30,477	72,044	189,336		189,336	(6,268)	183,068		21
22	Employee Benefits & Payroll Taxes			394,012	394,012		394,012		394,012		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,025	4,025		4,025		4,025		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,237	60,237		60,237		60,237		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>140,156</b>	<b>30,477</b>	<b>604,530</b>	<b>775,163</b>		<b>775,163</b>	<b>(14,308)</b>	<b>760,855</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,298,295</b>	<b>349,976</b>	<b>1,176,950</b>	<b>3,825,221</b>		<b>3,825,221</b>	<b>(41,150)</b>	<b>3,784,071</b>		<b>29</b>

\*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 &amp; ID Number Faith Care Center

#0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

## 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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			381,619	381,619		381,619		381,619		30
31	Amortization of Pre-Op. & Org.			5,419	5,419		5,419		5,419		31
32	Interest			223,957	223,957		223,957		223,957		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			610,995	610,995		610,995		610,995		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			69,650	69,650		69,650		69,650		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			182,080	182,080		182,080		182,080		42
43	Other (specify):* Retirement Center	348,118	786,882		1,135,000		1,135,000	(1,135,000)			43
44	<b>TOTAL Special Cost Centers</b>	348,118	786,882	251,730	1,386,730		1,386,730	(1,135,000)	251,730		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,646,413	1,136,858	2,039,675	5,822,946		5,822,946	(1,176,150)	4,646,796		45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,842)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,227)	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	(637)	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)	(306)	21		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	(1,098)	21		24
25	Fund Raising, Advertising and Promotional	(8,040)	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 See Pg 5A	(1,135,000)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,176,150)		\$	30

**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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,176,150)		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.			\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Faith Care Center

ID# 0044552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL - Salary	\$ (348,118)	43	1
2	AL - Employee Benefits	(49,566)	43	2
3	AL - Dietary	(114,979)	43	3
4	AL - Housekeeping	(11,874)	43	4
5	AL - Maintenance	(25,013)	43	5
6	AL - Administrative	(32,807)	43	6
7	AL - Operating	(158,003)	43	7
8	AL - Depreciation	(203,106)	43	8
9	AL - MIP Expense	(25,585)	43	9
10	AL - Interest Expense	(165,949)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	<b>Total</b>	(1,135,000)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

## 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(26,842)	0	0	0	0	0	0	0	0	0	0	(26,842)	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	<b>TOTAL General Services</b>	<b>(26,842)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(26,842)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(8,040)	0	0	0	0	0	0	0	0	0	0	(8,040)	20
21	Clerical & General Office Expenses	(6,268)	0	0	0	0	0	0	0	0	0	0	(6,268)	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	<b>TOTAL General Administration</b>	<b>(14,308)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,308)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(41,150)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,150)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(1,135,000)	0	0	0	0	0	0	0	0	0	0	(1,135,000)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,135,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,135,000)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,176,150)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,176,150)</b>	<b>45</b>

**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
This workpaper is N/A						

**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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

## 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	Dr. Robert Hellige	President							\$		1
2	Kathy Harris	Vice President									2
3	Louise Hemann	Secretary									3
4	Susan Bowman	Treasurer									4
5	Pastor Chris Hill	Board Member									5
6	Robert Nagel	Board Member									6
7	Robert Sudhoff	Board Member									7
8	Marietta Miller	Board Member									8
9	Michael Marchal	Board Member									9
10	Chris Cooper	Board Member									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:

5/1/2015

Ending: 1/30/2016

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	This workpaper is N/A				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

**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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Series 2001 A & B Bonds		X	Construction of facility	\$57,637.00	7/31/2012	\$ 7,338,128	\$ 6,745,676	10/2041	0.0320	\$ 218,347	1								
2	secured by HUD mortgage.											2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$57,637.00		\$ 7,338,128	\$ 6,745,676			\$ 218,347	9								
<b>B. Non-Facility Related*</b>																				
10	Series 2001 A & B Bonds		X	Construction of facility (AL Por	\$57,637.00	7/31/2012	5,765,672	5,300,174	10/2041	0.0320	171,559	10								
11	secured by HUD mortgage.											11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				\$57,637.00		\$ 5,765,672	\$ 5,300,174			\$ 171,559	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 13,103,800	\$ 12,045,850			\$ 389,906	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 60,917      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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 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 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	8
	2012	9
	2013	10
	2014	11
	2015	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.**

**2015 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 2015 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 2015.

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

**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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

5/1/2015 Ending:

4/30/2016

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 49,963 B. General Construction Type: Exterior Vinyl Frame Wood/Steel Number of Stories 1

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).

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  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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>372,834</u>	<u>1989</u>	<u>\$ 18,549</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>372,834</b>		<b>\$ 18,549</b>	<b>3</b>

Facility Name &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76	2003	2003	\$ 7,127,061	\$ 239,877	30.5	\$ 239,877	\$	\$ 2,990,962	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	2005 Fixed Assets		12/31/2005	16,854	879	Various	879		16,854	9
10	2006 Fixed Assets		12/31/2006	5,473	167	Various	167		4,664	10
11	2007 Fixed Assets		12/31/2007	14,730	1,174	Various	1,174		10,569	11
12	Door Closers		2/1/2008	2,883		5			2,883	12
13	Door Closers		2/1/2008	681		5			681	13
14	Parking Lot Resurfacing		10/8/2008	16,048		3			16,048	14
15	Parking Lot Resurfacing		11/8/2008	12,122		3			12,122	15
16	Parking Lot Resurfacing		10/8/2008	3,793		3			3,793	16
17	Parking Lot Resurfacing		11/8/2008	2,865		3			2,865	17
18	Covered Patio		3/8/2010	29,111	1,963	30	1,963		12,593	18
19	Heat Pumps		5/1/2010	9,258		5			9,258	19
20	Call Lights		6/1/2010	6,964	116	5	116		6,964	20
21	Sprinkler Valves		6/1/2010	1,839	30	5	30		1,839	21
22	Painting		6/1/2010	1,000	17	5	17		1,000	22
23	Elevator Upgrades		7/1/2010	2,472	247	10	247		1,442	23
24	Heat Pump		7/1/2010	3,080	103	5	103		3,080	24
25	Painting		7/1/2010	220	7	5	7		220	25
26	Magnum Cooling Tower		8/1/2010	1,324	66	5	66		1,324	26
27	Surge Supression		10/1/2010	3,295		5			3,295	27
28	Speed Bumps and Signs		10/1/2010	284	24	5	24		284	28
29	Painting		1/1/2011	4,667	622	5	622		4,667	29
30	Plumbing Work		3/1/2011	6,325	632	10	632		3,214	30
31	Heat Pumps		5/1/2010	2,188		5			2,188	31
32	Call Lights		6/1/2010	1,646	28	5	28		1,646	32
33	Elevator Upgrades		7/1/2010	584	58	10	58		340	33
34	Heat Pump		7/1/2010	728	24	5	24		728	34
35	Painting		7/1/2010	52	2	5	2		52	35
36	Cooling Tower		8/1/2010	313	15	5	15		313	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 &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Surge Suppression	10/1/2010	\$ 779	\$ 65	5	\$ 65		\$ 779	37
38	Speed Bumps and Signs	10/1/2010	189	15	5	15		189	38
39	Shingle Replacement	5/1/2011	2,150	108	20	108		539	39
40	Door Closers	7/1/2011	1,734	347	5	347		1,677	40
41	United Carpet - Carpeting	7/1/2011	28,700	5,740	5	5,740		27,743	41
42	Water Cooling Tower	7/1/2011	28,050	5,610	5	5,610		27,115	42
43	Guttering	8/1/2011	7,250	483	5	483		2,295	43
44	Cooling Tower	8/1/2011	9,946	497	5	497		2,362	44
45	Heat Pumps	8/1/2011	6,500	650	5	650		3,088	45
46	Cooling Tower	9/1/2011	9,946	497	5	497		2,320	46
47	Maedge Trucking	9/1/2011	2,000	100	5	100		467	47
48	Cooling Tower	9/1/2011	561	28	5	28		131	48
49	Cooling Tower	10/1/2011	1,683	84	5	84		385	49
50	Cooling Tower	10/1/2011	9,397	470	5	470		2,154	50
51	Loading Dock Railing	11/1/2011	2,320	116	5	116		522	51
52	Midwest Machinery	12/1/2011	8,875	888	5	888		3,921	52
53	Valve & Piping	12/1/2011	3,933	393	5	393		1,736	53
54	Pump Repairs	12/1/2011	1,050	210	5	210		928	54
55	Pump Repairs	12/1/2011	1,050	210	5	210		928	55
56	Door Panic Bar	1/1/2012	1,652	330	5	330		1,431	56
57	Valve Replacement	2/1/2012	1,415	141	5	141		600	57
58	4 Heat Pumps	2/1/2012	5,330	1,066	5	1,066		4,531	58
59	1 Heat Pump	2/1/2012	1,750	350	5	350		1,487	59
60	3 Heat Pumps	2/1/2012	4,653	931	5	931		3,956	60
61	Patio	4/1/2012	4,740	316	15	316		1,290	61
62	Patio Awning	7/1/2012	6,400	640	10	640		2,453	62
63	Kitchen repairs	7/1/2012	1,195	120	10	120		459	63
64	Dry sprinkler repairs	7/1/2012	3,703	741	5	741		2,840	64
65	Door Controls	7/1/2012	1,764	353	5	353		1,323	65
66	Heating/Cooling	8/1/2012	4,032	403	10	403		1,512	66
67	Awning power	8/1/2012	493	49	10	49		184	67
68	Wet sprinkler repairs	8/1/2012	4,362	872	5	872		3,270	68
69	Shingle replacement	9/1/2012	970	97	10	97		356	69
70	TOTAL (lines 4 thru 69)		\$ 7,446,432	\$ 268,971		\$ 268,971		\$ 3,220,859	70

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,446,432	\$ 268,971		\$ 268,971	\$	\$ 3,220,859	1
2	Cooling tower pump motor	9/1/2012	1,728	173	10	173		634	2
3	Door Closers	9/1/2012	1,141	228	5	228		836	3
4	Door Alarm	9/1/2012	1,700	340	5	340		1,247	4
5	Parking lot paving	10/1/2012	53,461	7,426	3	7,426		53,461	5
6	Sprinkler upgrade	10/1/2012	8,619	1,724	5	1,724		6,177	6
7	Fire Door - apt 211	10/1/2012	598	120	5	120		429	7
8	Cooling tower pump	11/1/2012	759	76	10	76		266	8
9	Controller for cooling tower	11/1/2012	961	96	10	96		336	9
10	Labor for apt 211 door installation	11/1/2012	473	95	5	95		332	10
11	Plumbing Upgrades	12/1/2012	2,468	247	10	247		844	11
12	Supply/return air boxes	12/1/2012	337	34	10	34		116	12
13	Control board for HVAC	1/1/2013	3,688	369	10	369		1,230	13
14	Kone- elevator upgrades	3/1/2013	2,396	240	10	240		760	14
15	Korte Services - AL Laundry	3/1/2013	4,675	312	15	312		988	15
16	Session Freedom Dishwasher	3/1/2013	4,111	411	10	411		1,302	16
17	S Horn - #30 window/frame	4/1/2013	772	51	15	51		158	17
18	Crest-nurse call boxes - 4	4/1/2013	787	262	3	262		808	18
19	Probst Heating & Cooling - upgrades - MAIN HVAC SYSTEM	7/1/2013	3,986	797	5	797		2,258	19
20	B-Line Striping - parking lot striping - FRONT GUEST PARKING	9/1/2013	1,600	800	2	800		2,133	20
21	Simplex Grinnell-dry sprinkler repairs-pipe repl - COMMON AREA	9/1/2013	1,974	395	5	395		1,053	21
22	Essenpreis - mixing valves - BASEMENT - MAIN SYSTEM	10/1/2013	712	142	5	142		367	22
23	Foresight - roofing - BUILDING EXTERIOR ROOF	10/1/2013	5,702	380	15	380		982	23
24	Pro-Alarm - security upgrades - COMMON AREA	10/1/2013	8,350	835	10	835		2,157	24
25	Simplex Grinnell - intercom upgrades - HALLWAYS	10/1/2013	2,720	272	10	272		703	25
26	Water Cooling Equip-sheaves in tower - MAIN COOLING UNIT	10/1/2013	2,900	580	5	580		1,498	26
27	Door Controls - ALARMS IN FREEDOM HALL	11/1/2013	1,926	385	5	385		963	27
28	Essenpreis - Water line replacement - MAIN WATER SYSTEM	11/1/2013	1,694	339	5	339		847	28
29	Prost - water heater parts - MAIN DISTRIBUTION SYSTEM	11/1/2013	785	157	5	157		393	29
30	Simplex - Dry Sprinkler System Upgrades - COMMON AREAS	11/1/2013	4,609	922	5	922		2,305	30
31	Steinmann - Gaskets/Seals for Freezers - MAIN KITCHEN	11/1/2013	865	173	5	173		433	31
32	Torbitts - Carpeting - ROOM #61	11/1/2013	982	196	5	196		490	32
33	Pro Alarm - Camera System - FREEDOM HALL	1/1/2014	3,775	378	10	378		882	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,577,686	\$ 287,926		\$ 287,926	\$	\$ 3,308,247	34

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

## XI. OWNERSHIP COSTS (continued)

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

1	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 7,577,686	\$ 287,926		\$ 287,926		\$ 3,308,247	1
2	Lakeside Roofing - BUILDING EXTERIOR ROOF	12/1/2013	258,911	17,261	15	17,261		41,714	2
3	Pro Alarm - DVR for Security System - COMMON AREA	12/1/2013	1,455	291	5	291		703	3
4	Probst Heating & Cooling - 2 Actuators - MAIN SYSTEM	12/1/2013	1,603	321	5	321		776	4
5	BBC Lighting - 8 Dining Room Lights - MAIN DINING ROOMS	2/1/2014	1,090	109	10	109		245	5
6	Connor Co - 3 Heat Pumps - #21, #61, #45	2/1/2014	4,041	808	5	808		1,818	6
7	Direct Supply -5 Bedside Tables - RESIDENT ROOMS	2/1/2014	1,435	144	10	144		324	7
8	Omni Refrig - Ice machine Upgrades - MAIN KITCHEN	2/1/2014	3,089	618	5	618		1,390	8
9	Essenpreis - Mixing Valves & Lines - MAIN HOT WATER SYST	3/1/2014	4,172	834	5	834		1,807	9
10	Highland Auto Glass - NC Windows - MAIN LIVING AREA WI	3/1/2014	1,391	139	10	139		301	10
11	Prost - Motor for fan Coil - ALPINE HALL HVAC	3/1/2014	906	181	5	181		392	11
12	Ron Wiegmann - Nightstands - RESIDENT ROOMS	4/1/2014	720	144	5	144		300	12
13	Simplex - Sprinkler Upgrades - MAIN SPRINKLER SYSTEM	4/1/2014	1,422	284	5	284		592	13
14	Luitjohan Flooring - Flooring ROOM #50	8/1/2013	1,282	128	10	128		352	14
15	S Horn Const. - Drywall ROOM #50	8/1/2013	754	75	10	75		206	15
16	Connor Co - 1 heat pump	5/1/2014	1,891	378	5	378		756	16
17	Foresight - roof	5/1/2014	5,702	570	10	570		1,140	17
18	Simplex - Fire board replacement	5/1/2014	1,564	313	5	313		626	18
19	Ehret, Inc. - Replaced switches in water system	6/1/2014	1,133	227	5	227		416	19
20	Prost Heating - upgraded McQuay system	6/1/2014	1,798	360	5	360		690	20
21	Simplex - 6 dry heats on sprinkler system	6/1/2014	3,060	612	5	612		1,173	21
22	Simplex - 2 sprinkler fittings	6/1/2014	3,364	673	5	673		1,290	22
23	Murphy Company - water heater	8/1/2014	12,883	1,288	10	1,288		2,254	23
24	Rakers Electric - kitchen on generator	8/1/2014	6,123	1,225	5	1,225		2,144	24
25	Finley Flooring - cove base	9/1/2014	435	87	5	87		145	25
26	Prost Heating - upgraded McQuay system-monitor	9/1/2014	1,596	319	5	319		532	26
27	Rakers Electric - emergency b/u additions	9/1/2014	1,236	247	5	247		412	27
28	Simplex Grinnell - new sprinkler piping	9/1/2014	9,749	1,950	5	1,950		3,250	28
29	Rakers Electric - generator upgrades	10/1/2014	2,447	489	5	489		774	29
30	Simplex Grinnell - wet sprinkler piping	10/1/2014	2,512	502	5	502		795	30
31	Simplex Grinnell - dry sprinkler piping	11/1/2014	1,647	329	5	329		494	31
32	Essenpreis - new water lines	12/1/2014	1,776	178	10	178		252	32
33	Meyer Contracting - doors	1/1/2015	1,444	144	10	144		192	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,920,317	\$ 319,155		\$ 319,155		\$ 3,376,503	34

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

Facility Name &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,920,317	\$ 319,155		\$ 319,155	\$	\$ 3,376,503	1
2	Firestoppers - fire caulking for sprinkler system piping	3/1/2015	6,823	682	10	682		796	2
3	Finley Flooring	6/1/2014	1,799	180	10	180		345	3
4	Flooring	9/1/2013	1,761	176	10	176		469	4
5	Flooring	4/1/2014	951	95	10	95		301	5
6	Connor Co - heat pumps	5/1/2015	9,061	1,812	5	1,812		1,880	6
7	Simplex - relay for fire system	5/1/2015	600	120	5	120		120	7
8	Prost - McQuay drier and keypad display	6/1/2015	2,329	427	5	427		427	8
9	City of Highland - exterior sign	8/1/2015	100	25	3	25		25	9
10	Digital Artz - exterior sign	8/1/2015	2,917	729	3	729		729	10
11	Essenpreis Plumbing - hot water boiler parts	8/1/2015	728	546	1	546		546	11
12	Finley Flooring - 3 bathroom floors	8/1/2015	660	495	3	495		495	12
13	Foppe Visual - office signs	8/1/2015	1,594	44	3	44		44	13
14	Gateway Industrial - generator board	8/1/2015	1,836	459	2	459		459	14
15	Kunz Carpentry - kitchenette cabinets	8/1/2015	1,350	506	1	506		506	15
16	Simplex - hood system for deep fryer	9/1/2015	2,525	337	5	337		337	16
17	Prost - McQuay compressor	9/1/2015	4,181	557	5	557		557	17
18	Crest-nurse call boxes	10/1/2015	711	138	5	138		138	18
19	Essenpreis Plumbing - backflow preventor	10/1/2015	1,008	118	5	118		118	19
20	Prost Heating - Ignition moduel on water heater	10/1/2015	758	88	5	88		88	20
21	Roger Echeimeier - chemical pump on cooling tower	10/1/2015	3,975	464	5	464		464	21
22	Simplex - relay for fire system	10/1/2015	909	106	5	106		106	22
23	Simplex - relay for fire system	10/1/2015	1,092	127	3	127		127	23
24	Simplex - power interface on fire alarm	10/1/2015	2,627	307	5	307		307	24
25	Weeke Sales - garbage disposal main kitchen	11/1/2015	2,171	109	10	109		109	25
26	Capital One - room signs	11/1/2015	1,157	116	5	116		116	26
27	Magnum Rotating - motor for water pump	11/1/2015	881	220	2	220		220	27
28	Simplex - nurse call system	12/1/2015	2,973	248	5	248		248	28
29	Simplex - extinguisher nozzle - kitchen	1/1/2016	2,725	182	5	182		182	29
30	Simplex - fire alarm batteries	1/1/2016	1,322	441	1	441		441	30
31	Torbis - flooring room 61	2/1/2016	2,145	107	5	107		107	31
32	Door controls	3/1/2016	620	21	5	21		21	32
33	Essenpreis Plumbing - 2 shower valves	3/1/2016	1,376	46	5	46		46	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,985,979	\$ 329,183		\$ 329,183	\$	\$ 3,387,377	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 7,985,979	\$ 329,183		\$ 329,183	\$	\$ 3,387,377	1
2	Ideal Home Solutions - kitchen wash bay	3/1/2016	5,621	62	15	62		62	2
3	Rakers Electric - cooling tower motor	3/1/2016	9,442	157	10	157		157	3
4	S. Horn Const - kitchen wash bay	3/1/2016	842	9	15	9		9	4
5	Weeke Sales - parts for kitchen slicer	3/1/2016	978	54	3	54		54	5
6	Essenpreis Plumbing - mixing valves in kitchen	4/1/2016	963	16	5	16		16	6
7	Simplex Grinnell - valve in wet sprinkler system	4/1/2016	934	39	2	39		39	7
8	Simplex Grinnell - line replacement in dry spinkler	4/1/2016	945	40	2	40		40	8
9	Simplex Grinnell - line replacement in beauty shop	4/1/2016	760	32	2	32		32	9
10	Weeke Sales - booster	4/1/2016	5,366	56	8	56		56	10
11	Tie Out to Support		(6)					(354)	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,011,824	\$ 329,648		\$ 329,648	\$	\$ 3,387,488	34

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

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	\$ 151,296	\$ 39,760	\$ 39,760	\$	Various	\$ 80,406	71
72	Current Year Purchases	30,653	3,851	3,851		Various	3,851	72
73	Fully Depreciated Assets	907,960	2,028	2,028		Various	907,960	73
74								74
75	TOTALS	\$ 1,089,909	\$ 45,639	\$ 45,639	\$		\$ 992,217	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, Maintenance	Golf Cart	2011	\$ 5,600	\$ 1,120	\$ 1,120	\$	5	\$ 5,133	76
77	Patient Care	Southern IL Bus	2013	52,922	5,212	5,212		10	13,464	77
78										78
79										79
80	TOTALS			\$ 58,522	\$ 6,332	\$ 6,332	\$		\$ 18,597	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)	\$ 9,178,804	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 381,619	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 381,619	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)	\$ 4,398,302	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	\$ 5,867,658	\$ 198,700	\$ 2,463,013	86
87	AL - Equipment	34,509	4,388	21,919	87
88					88
89					89
90					90
91	TOTALS	\$ 5,902,167	\$ 203,088	\$ 2,484,932	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: 5/1/2015

Ending: 4/30/2016

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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	<b>TOTAL</b>				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	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	\$	2,467	\$ 111,973	\$	2,467	\$ 111,973	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		252	11,438		252	11,438	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,688	76,615		1,688	76,615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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	<b>TOTAL</b>			\$	4,407	\$ 200,026	\$	4,407	\$ 200,026	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 4/30/2016

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 75,196	\$	1
2	Cash-Patient Deposits	31,685		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 151,026 )	1,049,006		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,570		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,215,457	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	13,879,482		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,182,940		16
17	Accumulated Depreciation (book methods)	(6,883,234)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	800,132		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing</u>	137,736		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 9,135,605	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 10,351,062	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 196,282	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,536		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,708		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,931		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	32,122		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Related Party</u>	261,540		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 770,119	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	274,936		39
40	Mortgage Payable	11,735,145		40
41	Bonds Payable	310,705		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 12,320,786	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 13,090,905	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (2,739,843)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 10,351,062	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,544,348)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,544,348)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(195,495)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(195,495)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,739,843)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,437,914	1
2	Discounts and Allowances for all Levels	(55,002)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,382,912	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	338,305	6
7	Oxygen	6,780	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 345,085	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	26,842	14
15	Telephone, Television and Radio	4,227	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	55,104	18
19	Laboratory	1,174	19
20	Radiology and X-Ray		20
21	Other Medical Services	7,797	21
22	Laundry	14,010	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 109,154	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	637	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 637	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Apt/Garden Home Revenue</b>	789,357	28
28a	<b>Misc. Income</b>	306	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 789,663	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,627,451	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,036,579	31
32	Health Care	2,013,479	32
33	General Administration	775,163	33
<b>B. Capital Expense</b>			
34	Ownership	610,995	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,204,650	35
36	Provider Participation Fee	182,080	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,822,946	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(195,495)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (195,495)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 507,349	44
45	Private Pay - Net Inpatient Revenue	3,375,437	45
46	Medicare - Net Inpatient Revenue	500,126	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,382,912	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:

5/1/2015

Ending:

4/30/2016

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,623	1,839	\$ 54,768	\$ 29.78	1
2	Assistant Director of Nursing	800	948	24,666	26.02	2
3	Registered Nurses	8,032	9,131	201,158	22.03	3
4	Licensed Practical Nurses	27,478	30,339	608,225	20.05	4
5	CNAs & Orderlies	57,222	62,980	685,857	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,711	1,890	19,351	10.24	8
9	Activity Director	1,945	2,129	25,929	12.18	9
10	Activity Assistants	2,852	3,190	32,581	10.21	10
11	Social Service Workers	1,640	1,799	31,829	17.69	11
12	Dietician					12
13	Food Service Supervisor	1,351	1,536	29,870	19.45	13
14	Head Cook	5,052	5,678	66,010	11.63	14
15	Cook Helpers/Assistants	11,030	11,863	105,763	8.92	15
16	Dishwashers	2,825	3,071	26,309	8.57	16
17	Maintenance Workers	2,096	2,329	27,959	12.00	17
18	Housekeepers	8,889	9,756	91,344	9.36	18
19	Laundry	8,888	9,756	91,344	9.36	19
20	Administrator	972	1,103	53,341	48.36	20
21	Assistant Administrator					21
22	Other Administrative	3,651	4,044	82,611	20.43	22
23	Office Manager					23
24	Clerical	2,351	2,628	31,553	12.01	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	627	730	7,827	10.72	31
32	Other Health Care(specify)	28,176	30,808	348,118	11.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,211	197,547	\$ 2,646,413 *	\$ 13.40	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	170	\$ 8,176	1-3	35
36	Medical Director	128	12,800	9-3	36
37	Medical Records Consultant	16	1,076	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,735	10a-3	39
40	Physical Therapy Consultant	144	10,000	10a-3	40
41	Occupational Therapy Consultant	144	10,000		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	144	10,000		43
44	Activity Consultant	6	425	11-3	44
45	Social Service Consultant	6	424	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	854	\$ 56,636		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gerald Harman	Executive Director		\$ 53,341	Workers' Compensation Insurance	\$ 101,742	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,855	Advertising: Employee Recruitment	5,378	
				FICA Taxes	174,315	Health Care Worker Background Check	892	
				Employee Health Insurance	104,101	(Indicate # of checks performed 27 )		
				Employee Meals		Patient Background Checks	137	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising/Marketing/Promo	8,040	
				Misc. Employee Benefits Expenses	10,999	Dues & Subscriptions	6,574	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 53,341					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	2,142
							Seminar Expense	1,883
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Entertainment Expense	( )
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
Donovan Rose Nester	Legal		\$ 16,233					
CliftonLarsonAllen, LLP	Audit		33,223					
Benefit Plans Plus	401K		2,327					
Donald Johannes	Legal		175					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 51,958					
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Faith Care Center

# 0044552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

**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. IL Healthcare Association - \$4,765
- (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? 2-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,599 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. \$ 182,080  
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. \$ 26,842
- (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? 0  
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 LLP
- (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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees