FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

I. IDPH License ID Number: 0044552

Facility Name: FAITH CARE CENTER

Address: 100 FAITH DRIVE (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: 3/21/2003

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		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 5/1/2016 to 4/30/2017 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) MARK J. KORTE, CPA — PRINCIPAL
(Firm Name & Address) SCHEFFEL BOYLE — PO BOX 374 HIGHLAND, IL 62249
(Telephone) 618-654-9895 Fax # 618-654-9898

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: 5/1/2016 Ending: 4/30/2017

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	76	Skilled (SNF)	76	27,740	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	27,740	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	3,221	20,582	2,077	25,880	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,221	20,582	2,077	25,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.29%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 3/30/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 76 and days of care provided 1,873

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: 4/30/2017 Fiscal Year: 4/30/2017

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

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	231,174	10,846	31,750	273,770		273,770		273,770			1
2	Food Purchase		186,450		186,450		186,450	(30,066)	156,384			2
3	Housekeeping	88,134	20,186	1,510	109,830		109,830		109,830			3
4	Laundry	88,134		2,684	90,818		90,818		90,818			4
5	Heat and Other Utilities			232,845	232,845		232,845		232,845			5
6	Maintenance	19,177	14,745	41,323	75,245		75,245		75,245			6
7	Other (specify):*			14,587	14,587		14,587		14,587			7
8	TOTAL General Services	426,619	232,227	324,699	983,545		983,545	(30,066)	953,479			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,664,457	59,863	14,525	1,738,845		1,738,845		1,738,845			10
10a	Therapy			178,898	178,898		178,898		178,898			10a
11	Activities	56,227	1,851	4,190	62,268		62,268		62,268			11
12	Social Services	61,116		730	61,846		61,846		61,846			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,781,800	61,714	210,343	2,053,857		2,053,857		2,053,857			16
	C. General Administration											
17	Administrative	53,451			53,451		53,451		53,451			17
18	Directors Fees											18
19	Professional Services			42,685	42,685		42,685		42,685			19
20	Dues, Fees, Subscriptions & Promotions			21,401	21,401		21,401	(10,968)	10,433			20
21	Clerical & General Office Expenses	91,658	35,185	359,096	485,939		485,939	(267,197)	218,742			21
22	Employee Benefits & Payroll Taxes			397,496	397,496		397,496		397,496			22
23	Inservice Training & Education											23
24	Travel and Seminar			453	453		453		453			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,186	54,186		54,186		54,186			26
27	Other (specify):*											27
28	TOTAL General Administration	145,109	35,185	875,317	1,055,611		1,055,611	(278,165)	777,446			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,353,528	329,126	1,410,359	4,093,013		4,093,013	(308,231)	3,784,782			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: 5/1/2016 Ending: 4/30/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			369,936	369,936		369,936		369,936			30
31	Amortization of Pre-Op. & Org.			5,419	5,419		5,419		5,419			31
32	Interest			206,971	206,971		206,971		206,971			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			582,326	582,326		582,326		582,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			80,680	80,680		80,680		80,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,688	177,688		177,688		177,688			42
43	Other (specify):* RETIREMENT CI	344,567		776,286	1,120,853		1,120,853	(1,120,853)				43
44	**TOTAL Special Cost Centers**	344,567		1,034,654	1,379,221		1,379,221	(1,120,853)	258,368			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,698,095	329,126	3,027,339	6,054,560		6,054,560	(1,429,084)	4,625,476			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: 5/1/2016 Ending: 4/30/2017

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	(30,066)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,269)	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	(728)	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	(167,612)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,634)	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	(261,566)	21		24
25	Fund Raising, Advertising and Promotional	(10,968)	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	(953,241)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,429,084)		$	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))**	$ (1,429,084)		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

FAITH CARE CENTER

ID# 0044552

Report Period Beginning: 5/1/2016

Ending: 4/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL - SALARY	$ (344,567)	43	1
2	AL- EMPLOYEE BENEFITS	(46,638)	43	2
3	AL- DIETARY	(105,590)	43	3
4	AL- HOUSEKEEPING	(6,858)	43	4
5	AL- MAINTENANCE	(18,371)	43	5
6	AL- ADMINSTRATIVE	(35,349)	43	6
7	AL- OPERATING	(158,283)	43	7
8	AL- DEPRECIATION	(202,910)	43	8
9	AL - MIP EXPENSE	(24,941)	43	9
10	AL- INTEREST EXPENSE	(5,525)	43	10
11	AL- BAD DEBT EXPENSE	(4,209)	43	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	**Total**	(953,241)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAITH CARE CENTER # 0044552 **Report Period Beginning:** 5/1/2016 **Ending:** 4/30/2017

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	(30,066)	0	0	0	0	0	0	0	0	0	0	(30,066)	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**	(30,066)	0	0	0	0	0	0	0	0	0	0	(30,066)	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	(10,968)	0	0	0	0	0	0	0	0	0	0	(10,968)	20
21	Clerical & General Office Expenses	(267,197)	0	0	0	0	0	0	0	0	0	0	(267,197)	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**	(278,165)	0	0	0	0	0	0	0	0	0	0	(278,165)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(308,231)	0	0	0	0	0	0	0	0	0	0	(308,231)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAITH CARE CENTER # 0044552 **Report Period Beginning:** 5/1/2016 **Ending:** 4/30/2017

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):*	(1,120,853)	0	0	0	0	0	0	0	0	0	0	(1,120,853)	43
44	**TOTAL Special Cost Centers**	(1,120,853)	0	0	0	0	0	0	0	0	0	0	(1,120,853)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,429,084)	0	0	0	0	0	0	0	0	0	0	(1,429,084)	45

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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 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: 5/1/2016 Ending: 4/30/2017

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	This workpaperis 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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								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: 5/1/2016 Ending: 1/30/2017

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 [x]

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		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	TOTALS					$	$		$	25

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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	$57,637.00	7/31/2012	$ 7,338,128	$ 6,571,681	10/1/2041	0.0320	$ 213,325	1
2	secured by HUD mortgage.											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$57,637.00		$ 7,338,128	$ 6,571,681			$ 213,325	9
	B. Non-Facility Related*											
10	Series 2001 A & B Bonds		X	Construction of facility	$57,637.00	7/31/2012	5,765,672	5,163,464	10/1/2041	0.0320	167,612	10
11	secured by HUD mortgage.											11
12												12
13												13
14	TOTAL Non-Facility Related				$57,637.00		$ 5,765,672	$ 5,163,464			$ 167,612	14
15	TOTALS (line 9+line14)						$ 13,103,800	$ 11,735,145			$ 380,937	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 59,386 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: 5/1/2016 Ending: 4/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	This workpaper is N/A		$	$
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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 5/1/2016 Ending: 4/30/2017

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? [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, Assisted 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: 5/1/2016 Ending: 4/30/2017

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	$ 7,127,061	$ 239,877	30.5	$ 239,877	$	$ 3,230,840	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2005 Fixed Assets			12/31/2005	16,856		various			16,856	9
10	2006 Fixed Assets			12/31/2006	5,473	167	various	167		4,832	10
11	2007 Fixed Assets			12/31/2007	14,731	1,174	various	1,174		11,740	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	16,049		3			16,049	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	1,964	30	1,964		14,560	18
19	Heat Pumps			5/1/2010	9,258		5			9,258	19
20	Call Lights			6/1/2010	6,964		5			6,964	20
21	Sprinkler Valves			6/1/2010	1,839		5			1,839	21
22	Painting			6/1/2010	1,000		5			1,000	22
23	Elevator Upgrades			7/1/2010	2,472	247	10	247		1,689	23
24	Heat Pump			7/1/2010	3,080		5			3,080	24
25	Painting			7/1/2010	220		5			220	25
26	Magnum Cooling Tower			8/1/2010	1,324		5			1,324	26
27	Surge Supression			10/1/2010	3,295		5			3,295	27
28	Speed Bumps and Signs			10/1/2010	284		5			284	28
29	Painting			1/1/2011	4,667		5			4,667	29
30	Plumbing Work			3/1/2011	6,325	632	10	632		3,847	30
31	Heat Pumps			5/1/2010	2,188		5			2,188	31
32	Call Lights			6/1/2010	1,646		5			1,646	32
33	Elevator Upgrades			7/1/2010	584	58	10	58		399	33
34	Heat Pump			7/1/2010	728		5			728	34
35	Painting			7/1/2010	52		5			52	35
36	Cooling Tower			8/1/2010	313		5			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 & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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	Surge Supression	10/1/2010	$ 779	$	5	$	$	$ 779	37
38	Speed Bumps and Signs	10/1/2010	189		5			189	38
39	Shingle Replacement	5/1/2011	2,150	108	20	108		645	39
40	Door Closers	7/1/2011	1,734	58	5	58		1,734	40
41	United Carpet - Carpeting	7/1/2011	28,700	957	5	957		28,700	41
42	Water Cooling Tower	7/1/2011	28,050	935	5	935		28,050	42
43	Guttering	8/1/2011	7,250	483	5	483		2,779	43
44	Cooling Tower	8/1/2011	9,946	497	5	497		2,859	44
45	Hear Pumps	8/1/2011	6,500	650	5	650		3,738	45
46	Cooling Tower	9/1/2011	9,946	497	5	497		2,818	46
47	Maedge Trucking	9/1/2011	2,000	100	5	100		566	47
48	Cooling Tower	9/1/2011	561	28	5	28		159	48
49	Cooling Tower	10/1/2011	1,683	84	5	84		470	49
50	Cooling Tower	10/1/2011	9,397	470	5	470		2,623	50
51	Loading Dock Railing	11/1/2011	2,320	116	5	116		638	51
52	Midwest Machinery	12/1/2011	8,875	888	5	888		4,807	52
53	Valve & Piping	12/1/2011	3,933	393	5	393		2,130	53
54	Pump Repairs	12/1/2011	1,050	123	5	123		1,050	54
55	Pump Repairs	12/1/2011	1,050	123	5	123		1,050	55
56	Door Panic Bar	1/1/2012	1,652	220	5	220		1,652	56
57	Valve Replacement	2/1/2012	1,415	141	5	141		743	57
58	4 Heat Pumps	2/1/2012	5,330	799	5	799		5,330	58
59	1 Heat Pump	2/1/2012	1,750	263	5	263		1,750	59
60	3 Heat Pumps	2/1/2012	4,653	698	5	698		4,653	60
61	Patio	4/1/2012	4,740	316	15	316		1,606	61
62	Patio Awning	7/1/2012	6,400	640	10	640		3,093	62
63	Kitchen Repairs	7/1/2012	1,195	120	10	120		578	63
64	Dry Sprinkler Repairs	7/1/2012	3,703	741	5	741		3,580	64
65	Door Controls	7/1/2012	1,764	353	5	353		1,676	65
66	Heating/Cooling	8/1/2012	4,032	403	10	403		1,915	66
67	Awning Power	8/1/2012	493	49	10	49		234	67
68	Wet Prinkler Repairs	8/1/2012	4,362	872	5	872		4,143	68
69	Shingle Replacement	9/1/2012	970	97	10	97		453	69
70	TOTAL (lines 4 thru 69)		$ 7,446,436	$ 256,341		$ 256,341	$	$ 3,477,204	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: 5/1/2016 Ending: 4/30/2017

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		$ 7,446,436	$ 256,341		$ 256,341	$	$ 3,477,204	1
2	Cooling Tower Pump Motor	9/1/2012	1,728	173	10	173		806	2
3	Door Closers	9/1/2012	1,141	228	5	228		1,065	3
4	Door Alarm	9/1/2012	1,700	340	5	340		1,586	4
5	Parking Lot Paving	10/1/2012	53,461		3			53,461	5
6	Sprinkler Upgrade	10/1/2012	8,619	1,724	5	1,724		7,901	6
7	Fire Door - Apt 211	10/1/2012	598	120	5	120		548	7
8	Cooling Tower Pump	11/1/2012	759	76	10	76		341	8
9	Controller for Cooling Tower	11/1/2012	961	96	10	96		432	9
10	Labor for Apt 211 Door Installation	11/1/2012	473	95	5	95		426	10
11	Plumbing Upgrades	12/1/2012	2,468	247	10	247		1,090	11
12	Supply/Return Air Boxes	12/1/2012	337	34	10	34		149	12
13	Control Board for HVAC	1/1/2013	3,688	369	10	369		1,598	13
14	Kone - Elevator Upgrades	3/1/2013	2,396	240	10	240		999	14
15	Korte Services - AL Laundry	3/1/2013	4,675	312	15	312		1,299	15
16	Session Freedom Dishwasher	3/1/2013	4,111	411	10	411		1,713	16
17	S Horn - #30 Window/Frame	4/1/2013	772	51	15	51		210	17
18	Crest-Nurse Call Boxes (4)	4/1/2013	787		3			787	18
19	Provst Heating & Cooling - upgrades - Main HVAC System	7/1/2013	3,986	797	5	797		3,056	19
20	B-Line Striping - Parking Lot Striping - Frong Guest Parking	9/1/2013	1,600		2			1,600	20
21	Simplex Grinnell - Dry Sprinkler Repairs - Pipe Repl - Common	9/1/2013	1,974	395	5	395		1,448	21
22	Essenpreis - Mixing Values - Basement - Main System	10/1/2013	712	142	5	142		510	22
23	Foresight - Roofing - Building Exterior Roofing	10/1/2013	5,702	380	15	380		1,362	23
24	Pro-Alarm - Security Upgrades - Common Area	10/1/2013	8,350	835	10	835		2,992	24
25	Simplex Grinnell - Intercom Upgrades - Hallways	10/1/2013	2,720	272	10	272		975	25
26	Water Cooling Equip - Sheaves in Tower - Main Cooling Unit	10/1/2013	2,900	580	5	580		2,078	26
27	Door Controls - Alarms in Freedom Hall	11/1/2013	1,926	385	5	385		1,348	27
28	Essenpreis - Water Line Replacement - Main Water System	11/1/2013	1,694	339	5	339		1,186	28
29	Prost - Water Heater Parts - Main Distribution System	11/1/2013	785	157	5	157		550	29
30	Simplex - Dry Sprinkler System Upgrades - Common Area	11/1/2013	4,609	922	5	922		3,226	30
31	Steinmann - Gaskets/Seals for Freezers - Main Kitchen	11/1/2013	865	173	5	173		606	31
32	Torbits - Carpeting - Room #61	11/1/2013	982	196	5	196		688	32
33	Pro Alarm - Camera System - Freedom Hall	1/1/2014	3,775	378	10	378		1,258	33
34	TOTAL (lines 1 thru 33)		$ 7,577,690	$ 266,808		$ 266,808	$	$ 3,574,498	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: 5/1/2016 Ending: 4/30/2017

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 12B, Carried Forward		$ 7,577,690	$ 266,808		$ 266,808	$	$ 3,574,498	1
2	Lakeside Roofing - Building Exterior Roof	12/1/2013	258,911	17,261	15	17,261		58,974	2
3	Pro Alarm - DVR for Security System - Common Area	12/1/2013	1,455	291	5	291		994	3
4	Probst Heating & Cooling - 2 Actuators - Main System	12/1/2013	1,603	321	5	321		1,096	4
5	BBC Lighting - 8 Dining Room Lights - Main Dining Rooms	2/1/2014	1,090	109	10	109		354	5
6	Connor Co - 3 Heat Pumps - #21,61 & 45	2/1/2014	4,041	808	5	808		2,627	6
7	Direct Supply - 5 Bedside Tables - Resident Rooms	2/1/2014	1,435	144	10	144		466	7
8	Omni Refrig - Ice Machine Upgrades - Main Kitchen	2/1/2004	3,089	618	5	618		2,008	8
9	Essenpreis - Mixing Valves & Lines - Main Hot Water System	3/1/2004	4,172	834	5	834		2,643	9
10	Highland Auto Glass - NC Windows - Main Sprinkler system	3/1/2014	1,391	139	10	139		440	10
11	Prost - Motor for Fail Coil - Alpine Hall HVAC	3/1/2014	906	181	5	181		574	11
12	Ron Wiegmann - Nightstands - Resident Rooms	4/1/2014	720	144	5	144		444	12
13	Simples - Sprinkler Upgrades - Main Sprinkler System	4/1/2014	1,422	284	5	284		877	13
14	Luitjohan Flooring - Flooring Room 50	8/1/2013	1,281	128	10	128		480	14
15	S Horn Const. - Drywall Room 50	8/1/2013	754	75	10	75		283	15
16	Connor Co - 1 Heat Pump	5/1/2014	1,891	378	5	378		1,134	16
17	Foresight - Roof	5/1/2014	5,702	570	10	570		1,710	17
18	Simplex - Fire Board Replacement	5/1/2014	1,564	313	5	313		939	18
19	Ehret, Inc - Replaced Switches in Water System	6/1/2014	1,133	227	5	227		661	19
20	Prost Heating - Upgraded McQuay System	6/1/2014	1,798	360	5	360		1,049	20
21	Simplex - 6 Dry Heats on Sprinkler System	6/1/2014	3,060	612	5	612		1,785	21
22	Simplex - 2 Sprinkler Fittings	6/1/2014	3,364	673	5	673		1,962	22
23	Murphy Company - Water Heater	8/1/2014	12,883	1,288	10	1,288		3,543	23
24	Rakers Electric - Kitchen on Generator	8/1/2014	6,123	1,225	5	1,225		3,368	24
25	Finley Flooring - Cove Base	9/1/2014	435	87	5	87		232	25
26	Prost Heating - Upgraded McQuay System - Monitor	9/1/2014	1,596	319	5	319		851	26
27	Rakers Electric - Emergency B/U Additions	9/1/2014	1,236	247	5	247		659	27
28	Simplex Grinnell - New Sprinkler Piping	9/1/2014	9,749	1,950	5	1,950		5,199	28
29	Rakers Electric - Generator Upgrades	10/1/2014	2,447	489	5	489		1,264	29
30	Simplex Grinnell - Wet Sprinkler Piping	10/1/2014	2,512	502	5	502		1,298	30
31	Simplex Grinnell - Dry Sprinkler Piping	11/1/2014	1,647	329	5	329		823	31
32	Essenpreis - New Water Lines	12/1/2014	1,776	178	10	178		429	32
33	Meyer Contracting - Doors	1/1/2015	1,444	144	10	144		337	33
34	TOTAL (lines 1 thru 33)		$ 7,920,320	$ 298,036		$ 298,036	$	$ 3,674,001	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: 5/1/2016 Ending: 4/30/2017

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 12C, Carried Forward		$ 7,920,320	$ 298,036		$ 298,036	$	$ 3,674,001	1
2	Firestoppers - Fire Caulking for Sprinklers System Piping	3/1/2015	6,823	682	10	682		1,478	2
3	Finley Flooring	6/1/2014	1,799	180	10	180		525	3
4	Flooring	9/1/2013	1,761	176	10	176		645	4
5	Flooring	4/1/2014	951	190	5	190		586	5
6	Connor Co - Heat Pumps	5/1/2015	9,061	1,812	5	1,812		3,624	6
7	Simplex - Relay for Fire System	5/1/2015	600	120	5	120		240	7
8	Prost - McQuay Drier and Keypad Display	6/1/2015	2,329	466	5	466		893	8
9	City of Highland - Exterior Sign	8/1/2015	100	33	3	33		58	9
10	Digital Artz - Exterior Sign	8/1/2015	2,917	972	3	972		1,701	10
11	Essempreis Plumbing - Hot Water Boiler Parts	8/1/2015	728	182	1	182		728	11
12	Finley Flooring - 3 Bathroom Floors	8/1/2015	660	165	3	165		660	12
13	Foppe Visual - Office Signs	8/1/2015	1,594		3				13
14	Gateway Industrial - Generator Board	8/1/2015	1,836	612	2	612		1,071	14
15	Kunz Caprentry - Kitchenette Cabinets	8/1/2015	1,350	675	1	675		1,181	15
16	Simplex - Hood System for Deep Fryer	9/1/2015	2,525	505	5	505		842	16
17	Prost - McQuay Compressor	9/1/2015	4,181	836	5	836		1,394	17
18	Crest - Nurse Call Boxes	10/1/2015	711	237	5	237		375	18
19	Essenpreis Plumbing - Backflow Preventor	10/1/2015	1,008	202	5	202		319	19
20	Prost Heating - Ignition Moduel on Water Heater	10/1/2015	758	152	5	152		240	20
21	Roger Echeimeier - Chemical Pump on Cooling Tower	10/1/2015	3,975	795	5	795		1,259	21
22	Simplex - Relay for Fire System	10/1/2015	909	182	5	182		288	22
23	Simplex - Relay for Fire System	10/1/2015	1,092	218	3	218		346	23
24	Simplex - Power Interface on Fire Alarm	10/1/2015	2,627	525	5	525		832	24
25	Weeke Sales - Garbage Disposal Main Kitchen	11/1/2015	2,171	217	10	217		326	25
26	Capital One - Room Signs	11/1/2015	1,157	231	5	231		347	26
27	Magnum Rotating - Motor For Water Pump	11/1/2015	881	441	2	441		661	27
28	Simplex - Nurse Call System	12/1/2015	2,973	595	5	595		843	28
29	Simplex - Extinguisher Nozzle - Kitchen	1/1/2016	2,725	545	5	545		727	29
30	Simplex - Fire Alarm Batteries	1/1/2016	1,322	881	1	881		1,322	30
31	Torbits - Flooring Room 61	2/1/2016	2,145	429	5	429		536	31
32	Door Controls	3/1/2016	620	124	5	124		145	32
33	Essenpries Plumbing - 2 Shower Valves	3/1/2016	1,376	275	5	275		321	33
34	TOTAL (lines 1 thru 33)		$ 7,985,985	$ 311,691		$ 311,691	$	$ 3,698,514	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: 5/1/2016 Ending: 4/30/2017

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 12D, Carried Forward		$ 7,985,985	$ 311,691		$ 311,691	$	$ 3,698,514	1
2	Ideal Home Solutions - Kitchen Wash Bay	3/1/2016	5,621	375	15	375		437	2
3	Rakers Electric - Cooling Tower Motor	3/1/2016	9,442	944	10	944		1,146	3
4	S. Horn Const - Kitchen Wash Bay	3/1/2016	842	56	15	56		66	4
5	Weeke Sales - Parts for Kitchen Slicer	3/1/2016	978	326	3	326		380	5
6	Essenpreis Plumbing - Mixing Vavles in Kitchen	4/1/2016	963	193	5	193		209	6
7	Simplex Grinnell - Valve in Wet Sprinkler System	4/1/2016	934	467	2	467		506	7
8	Simplex Grinnell - Line Replacement in Dry Sprinkler	4/1/2016	945	477	2	477		517	8
9	Simplex Grinnell - Line Replacement in Beauty Shop	4/1/2016	760	380	2	380		411	9
10	Weeke Sales - Booster	4/1/2016	5,366	671	8	671		727	10
11	Kunz Carpentry - Kitchenette Cabinets	8/1/2016	675	338	2	338		507	11
12	Gerstner Plumbing - Sink Mixing Vavles	8/1/2016	709	266	2	266		266	12
13	Rakers Electric - Cooling Tower Improvements	8/1/2016	1,240	310	3	310		310	13
14	Simplex - Wet Sprinkler Piping - Beauty Shop	8/1/2016	8,049	595	10	595		595	14
15	Torbits - Flooring Room 30	9/1/2016	1,961	262	5	262		262	15
16	Coonor Co - Heat Pumps	9/1/2016	6,153	678	5	678		678	16
17	Dorma USA Door - Front Door Lock	2/1/2017	1,151	96	3	96		76	17
18	Essenpries - Boiler Pipe Replacement	2/1/2017	3,145	157	5	157		157	18
19	Weeke - NC Dishwasher	2/1/2017	3,800	317	3	317		317	19
20	Weeke - Pilot Assembly on Stove	2/1/2017	561	70	2	70		70	20
21	Prost - Flow Switches on Cooling Tower	2/1/2017	786	98	2	98		98	21
22	Pro-Alarm - 2 Color Cameras	3/1/2017	518	43	2	43		43	22
23	Climate Company - Linden DR Heat Pump Condensor	3/1/2017	859	29	5	29		29	23
24	Ellis & Associates - #62 Flooring	4/1/2017	2,044	34	5	34		34	24
25	Ellis & Associates - #76	4/1/2017	1,234	21	5	21		21	25
26	Climate Company - Condenser for ADON Office	4/1/2017	859	14	5	14		14	26
27	Simplex - Sprinkler Pipe	7/1/2016	22,719	3,161	5	3,161		3,161	27
28	Simplex - Dry Sprinkler Pipe	12/1/2016	60,700	1,447	10	1,447		1,447	28
29	Climate Company - Living Room AC Condenser	4/1/2017	859	14	5	14		14	29
30	Tie Out to Support		(10)	(2)		(2)		103	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,129,848	$ 323,528		$ 323,528	$	$ 3,711,115	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: 5/1/2016 Ending: 4/30/2017

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	$ 136,244	$ 25,259	$ 25,259	$		$ 75,520	71
72	Current Year Purchases	19,100	3,616	3,616			3,616	72
73	Fully Depreciated Assets	953,664	11,808	11,808			953,664	73
74								74
75	TOTALS	$ 1,109,008	$ 40,683	$ 40,683	$		$ 1,032,800	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	$ 6,701	$ 513	$ 513	$	5	$ 5,646	76
77	Patient Care	Southern IL Bus	2013	52,922	5,212	5,212		10	18,677	77
78										78
79										79
80	TOTALS			$ 59,623	$ 5,725	$ 5,725	$		$ 24,323	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)	$ 9,317,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 369,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 369,936	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)	$ 4,768,238	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	$ 5,887,791	$ 198,842	$ 2,661,855	86
87	AL - Equipment	35,079	4,051	25,970	87
88					88
89					89
90					90
91	TOTALS	$ 5,922,870	$ 202,893	$ 2,687,825	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: 5/1/2016 Ending: 4/30/2017

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	TOTAL				$ **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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.

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

STATE OF ILLINOIS
0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,683	$ 53,085	$	1,683	$ 53,085	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		262	14,235		262	14,235	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,999	111,578		2,999	111,578	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			$	4,944	$ 178,898	$	4,944	$ 178,898	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.

STATE OF ILLINOIS

Facility Name & ID Number FAITH CARE CENTER **#** 0044552 **Report Period Beginning:** 5/1/2016 **Ending:** 4/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 4/30/2017 **(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	$ 134,612	$	1
2	Cash-Patient Deposits	31,747		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 353,093)	780,610		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,158		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)**	$ 1,008,127	$	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	14,017,640		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,203,711		16
17	Accumulated Depreciation (book methods)	(7,456,064)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	697,481		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing	132,317		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,613,634	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,621,761	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 298,367	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,656		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,906		30
31	Accrued Taxes Payable (excluding real estate taxes)	60,979		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	31,294		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Related Party	506,063		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,133,265	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	274,936		39
40	Mortgage Payable	11,414,352		40
41	Bonds Payable	320,794		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,010,082	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,143,347	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,521,586)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,621,761	$	48

***(See instructions.)**

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,739,843)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(192,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,931,843)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(589,743)	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)**	$ (589,743)	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)**	$ (3,521,586)	24 *

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

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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	$ 4,258,786	1
2	Discounts and Allowances for all Levels	(26,515)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,232,271	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	313,831	6
7	Oxygen	8,362	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 322,193	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	30,066	14
15	Telephone, Television and Radio	3,269	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	56,143	18
19	Laboratory	423	19
20	Radiology and X-Ray	965	20
21	Other Medical Services	7,398	21
22	Laundry	23,318	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 121,582	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	728	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 728	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Apt/Garden Home Revenue**	786,409	28
28a	**Misc. Income**	1,634	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 788,043	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,464,817	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	983,545	31
32	Health Care	2,053,857	32
33	General Administration	1,055,611	33
	B. Capital Expense		
34	Ownership	582,326	34
	C. Ancillary Expense		
35	Special Cost Centers	1,201,533	35
36	Provider Participation Fee	177,688	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,054,560	40
41	**Income before Income Taxes (line 30 minus line 40)****	(589,743)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (589,743)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 612,867	44
45	Private Pay - Net Inpatient Revenue	3,211,350	45
46	Medicare - Net Inpatient Revenue	434,569	46
47	Other-(specify) **Discounts and Allowances for all Levels**	(26,515)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,232,271	49

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

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

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

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

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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	1,952	2,184	$ 65,192	$ 29.85	1
2	Assistant Director of Nursing	1,944	2,130	55,624	26.11	2
3	Registered Nurses	8,256	8,989	238,590	26.54	3
4	Licensed Practical Nurses	22,971	25,557	545,977	21.36	4
5	CNAs & Orderlies	54,186	59,572	727,313	12.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,751	1,885	24,383	12.94	8
9	Activity Director	1,858	2,125	25,928	12.20	9
10	Activity Assistants	2,753	3,031	30,299	10.00	10
11	Social Service Workers	3,223	3,688	61,116	16.57	11
12	Dietician					12
13	Food Service Supervisor	1,215	1,337	25,027	18.72	13
14	Head Cook	6,581	7,103	80,940	11.40	14
15	Cook Helpers/Assistants	10,004	11,083	99,905	9.01	15
16	Dishwashers	2,679	2,988	25,301	8.47	16
17	Maintenance Workers	1,564	1,757	19,177	10.91	17
18	Housekeepers	8,630	9,394	88,134	9.38	18
19	Laundry	8,631	9,395	88,135	9.38	19
20	Administrator	959	1,103	53,451	48.46	20
21	Assistant Administrator					21
22	Other Administrative	1,823	2,043	58,705	28.73	22
23	Office Manager					23
24	Clerical	2,378	2,657	32,953	12.40	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	597	676	7,378	10.91	31
32	Other Health Care(specify)	27,867	30,564	344,567	11.27	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,822	189,261	$ 2,698,095 *	$ 14.26	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	155	$ 7,249	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	16	1,076	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	78	3,053	10a-3	39
40	Physical Therapy Consultant	144	10,000	10a-3	40
41	Occupational Therapy Consultant	144	10,000	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	144	10,000	10a-3	43
44	Activity Consultant	10	730	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	811	$ 54,108		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: 5/1/2016 Ending: 4/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerald Harman	Executive Director		$ 53,451
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,451

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Donovan Rose Nester	Legal	$ 969
CliftonLarsonAllen, LLP	Audit	39,758
Benefit Plans Plus	401K	1,958
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 42,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,628
Unemployment Compensation Insurance	6,697
FICA Taxes	177,881
Employee Health Insurance	108,431
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits Expenses	9,859
TOTAL (agree to Schedule V, line 22, col.8)	$ 397,496

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,193
Health Care Worker Background Check	1,158
(Indicate # of checks performed 26)	
Patient Background Checks 52	527
Advertising/Marketing/Promo	10,968
Dues & Subscriptions	5,555
Less: Public Relations Expense	( )
Non-allowable advertising	(10,968)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,433

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	110
Seminar Expense	343
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 453

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2016 Ending: 4/30/2017

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. $ **10,958** 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. $ **177,688**
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. $ **30,066**

(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: **Scheffel Boyle**

(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