

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0044552

Facility Name: Faith Care Center

Address: 100 Faith Drive Highland 62249
 Number City Zip Code

County: Madison

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

HFS ID Number: 371057583002

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/05 to 04/30/06 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) _____	<u>11/28/06</u>
	(Type or Print Name) <u>Darlene Genteman</u>	(Date)
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	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: 05/01/05 Ending: 04/30/06

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 03/21/03

	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	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,630</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>14</u>	Sheltered Care (SC)	<u>14</u>	<u>5,110</u>	5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</u>	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				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	<u>12,248</u>	<u>8,755</u>		<u>21,003</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>4,995</u>		<u>4,995</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,248</u>	<u>13,750</u>		<u>25,998</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.72%

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 MealsF. 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 03/30/03

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

YES Date 03/01/79 NO

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

YES NO If YES, enter number of beds certified 8 and days of care provided 0Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 04/30/06 Fiscal Year: 04/30/06

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

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/05 Ending: 04/30/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,089	16,323	5,368	216,780		216,780	216,780			1
2	Food Purchase		153,071		153,071	(17,435)	135,636	124,014			2
3	Housekeeping	108,627	13,390	1,947	123,964	(62,956)	61,008	61,008			3
4	Laundry					61,009	61,009	61,009			4
5	Heat and Other Utilities			271,643	271,643	(147,359)	124,284	124,284			5
6	Maintenance	31,513	28,882	3,465	63,860		63,860	63,860			6
7	Other (specify):*										7
8	TOTAL General Services	335,229	211,666	282,423	829,318	(166,741)	662,577	650,955			8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600	6,600			9
10	Nursing and Medical Records	1,076,291	50,077	4,705	1,131,073	(944)	1,130,129	1,130,129			10
10a	Therapy										10a
11	Activities	38,904	843		39,747		39,747	39,747			11
12	Social Services	21,983	13	451	22,447		22,447	22,447			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,137,178	50,933	11,756	1,199,867	(944)	1,198,923	1,198,923			16
	C. General Administration										
17	Administrative	79,712			79,712		79,712	79,712			17
18	Directors Fees										18
19	Professional Services			17,181	17,181		17,181	17,181			19
20	Dues, Fees, Subscriptions & Promotions					6,097	6,097	6,097			20
21	Clerical & General Office Expenses	42,397	29,397	19,082	90,876	(6,610)	84,266	74,280			21
22	Employee Benefits & Payroll Taxes			215,720	215,720	16,327	232,047	232,047			22
23	Inservice Training & Education										23
24	Travel and Seminar					2,565	2,565	2,565			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice					62,930	62,930	62,930			26
27	Other (specify):*										27
28	TOTAL General Administration	122,109	29,397	251,983	403,489	81,309	484,798	474,812			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,594,516	291,996	546,162	2,432,674	(86,376)	2,346,298	2,324,690			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: 05/01/05 Ending: 04/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			326,514	326,514		326,514		326,514		30
31	Amortization of Pre-Op. & Org.			13,164	13,164		13,164		13,164		31
32	Interest			548,503	548,503		548,503	(1,796)	546,707		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*					44,061	44,061		44,061		36
37	TOTAL Ownership			888,181	888,181	44,061	932,242	(1,796)	930,446		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					42,315	42,315		42,315		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers					42,315	42,315		42,315		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,594,516	291,996	1,434,343	3,320,855		3,320,855	(23,404)	3,297,451		45

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

FAITH COUNTRYSIDE HOMES

PROVIDER #0044552

YEAR: 05/01/05 - 04/30/06

RECLASSIFICATIONS - Column 5 - Page 3 & 4

<u>LINE #</u>	<u>AMOUNT</u>	<u>DESCRIPTION</u>
3	(54,314)	Reclass Laundry Wages
4	54,314	Reclass Laundry Wages
5	(42,315)	Reclass IPA Fees
42	42,315	Reclass IPA Fees
5	(106,991)	Reclass Property & Liability Insurance
26	106,991	Reclass Property & Liability Insurance
2	(17,435)	Reclass employee meals
22	17,435	Reclass employee meals
3	(1,947)	Reclass trash removal
5	1,947	Reclass trash removal
3	(6,695)	Reclass laundry supplies
4	6,695	Reclass laundry supplies
10	(762)	Reclass resident background checks
20	762	Reclass resident background checks
10	(182)	Reclass nursing forms
21	182	Reclass nursing forms
20	1,108	Reclass healthcare worker background checks
22	(1,108)	Reclass healthcare worker background checks
21	(2,565)	Reclass seminar expenses
24	2,565	Reclass seminar expenses
20	3,433	Reclass dues & subscriptions
21	(3,433)	Reclass dues & subscriptions
21	(794)	Reclass staff recruiting advertisement
20	794	Reclass staff recruiting advertisement
26	(44,061)	Reclass PMI insurance
36	44,061	Reclass PMI insurance

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning: 05/01/05

Ending: 04/30/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,622)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(1,796)	V-32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(61)	V-21		17
18	Fines and Penalties	(5,696)	V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,151)	V-21		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 Resident Gifts	(78)	V-21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,404)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (23,404)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Faith Care Center

ID# 0044552
 Report Period Beginning: 05/01/05
 Ending: 04/30/06

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

05/01/05

Ending:

04/30/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

05/01/05

Ending:

04/30/06

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	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: 05/01/05 Ending: 04/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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			
A. Directly Facility Related																				
Long-Term																				
1	Mortgage Interest		Construct Facility	\$76,584.00	10/23/01	\$ 13,445,000	\$ 13,172,674	10/2041	0.0620	\$ 546,707	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related			\$76,584.00		\$ 13,445,000	\$ 13,172,674			\$ 546,707	9									
B. Non-Facility Related*																				
10	Finance chrgs pd to vendors									1,796	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			1,796	14									
15	TOTALS (line 9+line14)					\$ 13,445,000	\$ 13,172,674			\$ 548,503	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,061 Line # 36

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2005 report.		\$ N/A	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>_____</td><td>8</td></tr> <tr><td>2002</td><td>_____</td><td>9</td></tr> <tr><td>2003</td><td>_____</td><td>10</td></tr> <tr><td>2004</td><td>_____</td><td>11</td></tr> <tr><td>2005</td><td>_____</td><td>12</td></tr> </table>	2001	_____	8	2002	_____	9	2003	_____	10	2004	_____	11	2005	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	_____	8																																		
2002	_____	9																																		
2003	_____	10																																		
2004	_____	11																																		
2005	_____	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

05/01/05 Ending:

04/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,963 B. General Construction Type: Exterior Vinyl Siding 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 Village Homes, Independent Living, 34 units

FCH Countryside Center, Independent Senior Citizen Center

FCH Assisted Living, Assisted Living apartments, 36 units

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>372,874</u>	<u>1989</u>	<u>\$ 18,549</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	372,874		\$ 18,549	3

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

05/01/05

Ending:

04/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		2003	2003	\$ 7,334,181	\$ 239,877	31	\$ 239,877		\$ 739,474	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Shelving				1,606	321	5	321	(1)	400	9
10	Parking Lot Improvements				8,753	511	10	511		511	10
11	Grounds Improvements/Excavating & Sidewalks				9,005	299	15	299		299	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

*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:

05/01/05

Ending:

04/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 7,353,545	\$ 241,008		\$ 241,008	\$ (1)	\$ 740,684	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: 05/01/05 Ending: 04/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 856,287	\$ 85,244	\$ 85,244	\$	5-20 yrs	\$ 272,686	71
72	Current Year Purchases	11,140	262	262		10-15 yrs	262	72
73	Fully Depreciated Assets	23,221					23,221	73
74								74
75	TOTALS	\$ 890,648	\$ 85,506	\$ 85,506	\$		\$ 296,169	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Ford E350 Van	1997	\$ 35,436	\$	\$	\$	5	\$ 35,436	76
77	Maintenance	1988 Chevy C1500 PU	1998	2,682				5	2,682	77
78										78
79										79
80	TOTALS			\$ 38,118	\$	\$	\$		\$ 38,118	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,300,860	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 326,514	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 326,514	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,074,971	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: 05/01/05

Ending: 04/30/06

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: 05/01/05 Ending: 04/30/06

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		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	N/A	hrs	\$												1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													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	Exceptional Care Program															12
13	Other (specify):															13
14	TOTAL			\$				\$		\$			\$			14

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning: 05/01/05

Ending:

04/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 04/30/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 30,340	\$	1
2	Cash-Patient Deposits	11,679		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 25,000)	250,350		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,504		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)	\$ 297,873	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	4,497,064		11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	7,353,545		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	928,766		16
17	Accumulated Depreciation (book methods)	(1,074,971)		17
18	Deferred Charges	344,542		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	591,950		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing Costs	467,179		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,126,624	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,424,497	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,816	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,130		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,199		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider Tax	2,790		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 162,935	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,208,264		40
41	Bonds Payable			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)	\$ 13,208,264	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,371,199	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 53,298	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,424,497	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 174,278	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 174,278	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(120,980)	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)	\$ (120,980)	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)	\$ 53,298	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning: 05/01/05

Ending: 04/30/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,134,539	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,134,539	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	3,643	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,643	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	13,952	14
15	Telephone, Television and Radio	5,277	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,229	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	38,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,797	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	3,282	28
28a	Vending Income	385	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,667	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,199,875	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	833,302	31
32	Health Care	1,199,867	32
33	General Administration	399,505	33
B. Capital Expense			
34	Ownership	888,181	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,320,855	40
41	Income before Income Taxes (line 30 minus line 40)**	(120,980)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (120,980)	43

* 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.

Interest on escrow & r

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	1,928	2,080	\$ 45,081	\$ 21.67	1
2	Assistant Director of Nursing	2,110	2,231	41,660	18.67	2
3	Registered Nurses	6,562	7,262	145,807	20.08	3
4	Licensed Practical Nurses	16,905	18,557	315,666	17.01	4
5	CNAs & Orderlies	47,314	51,178	523,674	10.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,881	2,073	20,648	9.96	9
10	Activity Assistants	1,766	1,988	18,256	9.18	10
11	Social Service Workers	1,947	2,109	21,983	10.42	11
12	Dietician					12
13	Food Service Supervisor	1,980	2,430	33,561	13.81	13
14	Head Cook	5,039	5,615	54,583	9.72	14
15	Cook Helpers/Assistants	14,213	15,552	106,945	6.88	15
16	Dishwashers					16
17	Maintenance Workers	3,405	3,615	31,513	8.72	17
18	Housekeepers	6,352	6,874	54,314	7.90	18
19	Laundry	6,351	6,873	54,313	7.90	19
20	Administrator	2,584	2,704	79,712	29.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,845	4,092	42,397	10.36	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	261	493	4,403	8.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,443	135,726	\$ 1,594,516 *	\$ 11.75	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	150	\$ 5,368	1-3	35
36	Medical Director	132	6,600	9-3	36
37	Medical Records Consultant	20	400	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	8	451	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	358	\$ 14,019		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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning: 05/01/05

Ending: 04/30/06

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	Ex. Director		\$ 25,144	Workers' Compensation Insurance	\$ 89,198	IDPH License Fee	\$		
Darlene Genteman	Administrator		54,568	Unemployment Compensation Insurance	1,515	Advertising: Employee Recruitment	794		
				FICA Taxes	119,841	Health Care Worker Background Check	1,108		
				Employee Health Insurance		(Indicate # of checks performed <u>68</u>)			
				Employee Meals	17,435	Patient Background Checks	48 762		
				Illinois Municipal Retirement Fund (IMRF)*		Civic Dues	60		
				Awards & Bonus	4,058	Life Safety Subscription	114		
						LSN Membership Dues	3,169		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 79,712			CLIA Fees	150		
(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		
							Seminar Expense		
							see attached schedule	2,565	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								\$ 6,097	
C. Professional Services									
Vendor/Payee	Type	Amount							
Larson, Allen, Weishair	Accounting	\$ 12,689							
Larson, Allen, Weishair	Financing	508							
Gershman Investment	Trustee Fees	3,984							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 17,181						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

FAITH COUNTRYSIDE HOMES

PROVIDER #0044552

SEMINAR EXPENSES

YEAR: 05/01/05 - 04/30/06

<u>EMPLOYEE</u>	<u>SEMINAR</u>	<u>LOCATION</u>	<u>EXPENSE</u>	<u>AMOUNT</u>
Darlene Genteman	Medicaid Reimbursement	Illinois	registration	375
Chris Gomez			mileage	70
Sherri Powell				
Chris Gomez	Medicare conference	Illinois	registration	297
Darlene Genteman			mileage	53
Lisa Ketrow				
Darlene Genteman	Behaviorial Health & Aging Conf	Illinois	registration	40
			mileage	32
Lisa Ketrow	Criminal Background Symposium	Illinois	registration	20
Nancy Sudbring				
Lisa Ketrow	Medicaid 2006 New Rules	Illinois	seminar	380
Darlene Genteman			mileage	101
Chris Gomez				
Judy Weiss				
Judy Weiss	Moving From Assessment to Care	Illinois	seminar	190
Chris Gomez			mileage	53
Judy Weiss	Basic Rehab/Restorative Training	Illinois	seminar	430
			mileage	344
			lodging	104
			meals	76
	TOTAL			2,565

Facility Name & ID Number Faith Care Center

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Life Services Network-\$3169
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,836 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 42,315
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. \$ 17,435 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Larson, Allen, Weishair & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. pending-will forward when complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

FAITH COUNTRYSIDE HOMES
PROVIDER #0044552
YEAR: 05/01/05 - 04/30/06

BOARD OF DIRECTORS LISTING

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No services are provided to Faith Care Center by a board member, nor does any board member have ownership in a company that conducts business w/Faith Care

