

Facility Name & ID Number Faith Care Center

0044552 Report Period Beginning: 5/1/11 Ending: 4/30/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,066	16,557	2,547	23,170	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		2,184		2,184	12
13	DD 16 OR LESS					13
14	TOTALS	4,066	18,741	2,547	25,354	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.15%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Senior Community Meals

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 03/30/2003

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

YES Date 03/01/1979 NO

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

YES NO If YES, enter number of beds certified 69 and days of care provided 2,322

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 04/30/2012 Fiscal Year: 04/30/2012

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

Facility Name & ID Number

Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	184,337	9,213	28,130	221,680		221,680	221,680			1
2	Food Purchase		228,572		228,572		228,572	(22,111)	206,461		2
3	Housekeeping	139,714	21,050	5,799	166,563		166,563		166,563		3
4	Laundry										4
5	Heat and Other Utilities			204,208	204,208		204,208		204,208		5
6	Maintenance	28,963	15,661	72,091	116,715		116,715		116,715		6
7	Other (specify):* Cable TV			12,451	12,451		12,451	(7,440)	5,011		7
8	TOTAL General Services	353,014	274,496	322,679	950,189		950,189	(29,551)	920,638		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,382,657	48,203	24,165	1,455,025		1,455,025		1,455,025		10
10a	Therapy		1,678	300,473	302,151		302,151		302,151		10a
11	Activities	47,781	3,257	780	51,818		51,818		51,818		11
12	Social Services	28,639		524	29,163		29,163		29,163		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,459,077	53,138	333,142	1,845,357		1,845,357		1,845,357		16
	C. General Administration										
17	Administrative	111,617		15,020	126,637		126,637		126,637		17
18	Directors Fees										18
19	Professional Services			22,771	22,771		22,771		22,771		19
20	Dues, Fees, Subscriptions & Promotions			21,229	21,229		21,229	(7,311)	13,918		20
21	Clerical & General Office Expenses	113,884	29,606	94,210	237,700		237,700	(36,992)	200,708		21
22	Employee Benefits & Payroll Taxes			246,625	246,625		246,625		246,625		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,088	2,088		2,088		2,088		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,965	51,965		51,965		51,965		26
27	Other (specify):*										27
28	TOTAL General Administration	225,501	29,606	453,908	709,015		709,015	(44,303)	664,712		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,037,592	357,240	1,109,729	3,504,561		3,504,561	(73,854)	3,430,707		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:

5/1/11

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			366,288	366,288		366,288		366,288			30
31	Amortization of Pre-Op. & Org.			13,164	13,164		13,164		13,164			31
32	Interest			416,440	416,440		416,440		416,440			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			795,892	795,892		795,892		795,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			301,770	301,770		301,770		301,770			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,697	172,697		172,697		172,697			42
43	Other (specify):*	338,280		934,313	1,272,593		1,272,593	(1,272,593)				43
44	TOTAL Special Cost Centers	338,280		1,408,780	1,747,060		1,747,060	(1,272,593)	474,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,375,872	357,240	3,314,401	6,047,513		6,047,513	(1,346,447)	4,701,066			45

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

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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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(22,111)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,760)	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	(29,576)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(656)	21		24
25	Fund Raising, Advertising and Promotional	(7,311)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,414)		\$	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))	\$ (66,414)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Faith Care Center

ID# 0044552

Report Period Beginning: 5/1/11

Ending: 4/30/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	AL- Payroll	\$ (338,280)	43	1
2	AL-Employee Benefits	(38,657)	43	2
3	AL-Dietary	(116,860)	43	3
4	AL-Housekeeping	(9,183)	43	4
5	AL-Maintenance	(38,056)	43	5
6	AL-Administrative	(39,909)	43	6
7	AL-Operating	(115,751)	43	7
8	AL-Depreciation	(194,463)	43	8
9	AL-Bad Debt	(12)	43	9
10	Cable TV Expense	(7,440)	7	10
11	AL-MIP Expense	(26,245)	43	11
12	AL-Interest Expense	(325,755)	43	12
13	AL-Insurance Expense	(29,422)	43	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	(1,280,033)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(22,111)	0	0	0	0	0	0	0	0	0	0	(22,111)	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):*	(7,440)	0	0	0	0	0	0	0	0	0	0	(7,440)	7
8	TOTAL General Services	(29,551)	0	(29,551)	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	(7,311)	0	0	0	0	0	0	0	0	0	0	(7,311)	20
21	Clerical & General Office Expenses	(36,992)	0	0	0	0	0	0	0	0	0	0	(36,992)	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	(44,303)	0	(44,303)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,854)	0	(73,854)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Faith Care Center# 0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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):*	(1,272,593)	0	0	0	0	0	0	0	0	0	0	(1,272,593)	43
44	TOTAL Special Cost Centers	(1,272,593)	0	0	0	0	0	0	0	0	0	0	(1,272,593)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,346,447)	0	0	0	0	0	0	0	0	0	0	(1,346,447)	45

Facility Name & ID Number Faith Care Center

0044552

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Ending:

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VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	N/A	\$			\$	\$	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:

5/1/11

Ending:

4/30/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 5/1/11 Ending: 4/30/12

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	See attached board of directors listing.								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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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

Facility Name & ID Number

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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	Series 2001 A & B Bonds		X	Construction of Facility	\$76,854.00	10/23/01	\$ 7,563,181	\$ 7,009,092	10/2041	0.0620	\$ 416,440	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				\$76,854.00		\$ 7,563,181	\$ 7,009,092			\$ 416,440	9					
	B. Non-Facility Related*																
10	Series 2001 A & B Bonds		X	Construction of Facility (AL po	\$76,584.00	10/23/01	5,881,819	5,450,908	10/2041	0.0620	325,755	10					
11	secured by HUD mortgage.											11					
12												12					
13												13					
14	TOTAL Non-Facility Related				\$76,584.00		\$ 5,881,819	\$ 5,450,908			\$ 325,755	14					
15	TOTALS (line 9+line14)						\$ 13,445,000	\$ 12,460,000			\$ 742,195	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 62,488 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.)

2011 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 2011 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 2011.

	(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	\$ <u>_____</u>	\$ <u>_____</u>

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:

5/1/11 Ending:

4/30/12

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 Assisted Living, Assisting Living Apartments, 36 Units

FCH Countryside Center, Independent Senior Citizen Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76	2003	2003	\$ 7,334,181	\$ 239,877	30.5	\$ 239,877	\$	\$ 2,178,738	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	2005 Fixed Assets		31-Dec	16,856	1,525	Various	1,525		11,536	9
10	2006 Fixed Assets		12/31/2006	5,473	365	Various	365		3,996	10
11	2007 Fixed Assets		12/31/2007	14,731	1,174	Various	1,174		5,875	11
12	Door Closers		2/1/2008	2,883	576	5	576		2,450	12
13	Door Closers		2/1/2008	681	136	5	136		579	13
14	Parking Lot Resurfacing		10/8/2008	16,048	2,229	3	2,229		16,048	14
15	Parking Lot Resurfacing		11/8/2008	12,122	2,020	3	2,020		12,122	15
16	Parking Lot Resurfacing		10/8/2008	3,793	527	3	527		3,793	16
17	Parking Lot Resurfacing		11/8/2008	2,865	478	3	478		2,865	17
18	Ice Maker		1/8/2010	1,635	545	3	545		1,226	18
19	Bed		2/8/2010	1,858	186	10	186		434	19
20	Covered Patio		3/8/2010	29,311	1,970	30	1,970		4,753	20
21	Ice Maker		2/8/2010	386	129	3	129		290	21
22	Heat Pumps		5/1/2010	9,258	1,852	5	1,852		3,704	22
23	Call Lights		6/1/2010	6,964	1,393	5	1,393		2,670	23
24	Sprinkler Valves		6/1/2010	1,839	368	5	368		705	24
25	Painting		6/1/2010	1,000	200	5	200		383	25
26	Elevator Upgrades		7/1/2010	2,472	247	10	247		453	26
27	Heat Pump		7/1/2010	3,080	616	5	616		1,129	27
28	Painting		7/1/2010	220	44	5	44		81	28
29	Magnum Cooling Tower		8/1/2010	1,324	265	5	265		463	29
30	Surge Supression		10/1/2010	3,295	659	5	659		1,043	30
31	Speed Bumps and Signs		10/1/2010	284	57	5	57		90	31
32	Painting		1/1/2011	4,667	933	5	933		1,245	32
33	Plumbing Work		3/1/2011	6,325	632	10	632		685	33
34	Heat Pumps		5/1/2010	2,188	438	5	438		876	34
35	Call Lights		6/1/2010	1,446	322	5	322		619	35
36	Elevator Upgrades		7/1/2010	584	58	10	58		107	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Heat Pump	7/1/2010	\$ 728	\$ 146	5	\$ 146	\$	\$ 267	37
38	Painting	7/1/2010	52	10	5	10		19	38
39	Cooling Tower	8/1/2010	313	63	5	63		110	39
40	Surge Suppression	10/1/2010	779	156	5	156		247	40
41	Speed Bumps and Signs	10/1/2010	189	38	5	38		60	41
42	Shingle Replacement	5/1/2011	2,150	108	3	108		108	42
43	Door Closers	7/1/2011	1,734	289	5	289		289	43
44	United Carpet - Carpeting	7/1/2011	28,700	4,783	5	4,783		4,783	44
45	Water Cooling Tower	7/1/2011	28,050	4,675	5	4,675		4,675	45
46	Guttering	8/1/2011	7,250	363	5	363		363	46
47	Cooling Tower	8/1/2011	9,946	373	5	373		373	47
48	Heat Pumps	8/1/2011	6,500	488	5	488		488	48
49	Cooling Tower	9/1/2011	9,946	332	5	332		332	49
50	Maedge Trucking	9/1/2011	2,000	67	5	67		67	50
51	Cooling Tower	9/1/2011	561	19	5	19		19	51
52	Cooling Tower	10/1/2011	1,683	49	5	49		49	52
53	Cooling Tower	10/1/2011	9,397	274	5	274		274	53
54	Loading Dock Railing	11/1/2011	2,320	58	5	58		58	54
55	Midwest Machinery	12/1/2011	8,875	370	5	370		370	55
56	Valve & Piping	12/1/2011	3,933	164	5	164		164	56
57	Pump Repairs	12/1/2011	1,050	88	5	88		88	57
58	Pump Repairs	12/1/2011	1,050	88	5	88		88	58
59	Door Panic Bar	1/1/2012	1,652	110	5	110		110	59
60	Valve Replacement	2/1/2012	1,415	35	5	35		35	60
61	4 Heat Pumps	2/1/2012	5,330	267	5	267		267	61
62	1 Heat Pump	2/1/2012	1,750	87	5	87		87	62
63	3 Heat Pumps	2/1/2012	4,653	233	5	233		233	63
64	Patio	4/1/2012	4,740	26	15	26		26	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,634,515	\$ 273,580		\$ 273,580	\$	\$ 2,273,007	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 904,346	\$ 89,093	\$ 89,093	\$	various	\$ 779,335	71
72	Current Year Purchases	21,563	2,895	2,895		various	2,701	72
73	Fully Depreciated Assets	41,356	68	68		various	41,356	73
74								74
75	TOTALS	\$ 967,265	\$ 92,056	\$ 92,056	\$		\$ 823,392	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Ford E350 Van	1997	\$ 35,436	\$	\$	\$	5	\$ 35,436	76
77	Maintenance	1998 Chevy C1500 PU	1998	2,682				5	2,682	77
78	Patient Care, Maintenance	Golf Cart	2011	5,600	652	652		5	653	78
79										79
80	TOTALS			\$ 43,718	\$ 652	\$ 652	\$		\$ 38,771	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)	\$ 8,664,047	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 366,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 366,288	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,135,170	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	\$ 5,781,689	\$ 192,272	\$ 1,684,297	86
87	AL-Equipment	14,131	2,045	10,281	87
88					88
89					89
90					90
91	TOTALS	\$ 5,795,820	\$ 194,317	\$ 1,694,578	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: 5/1/11 Ending: 4/30/12
 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><u>Faith Care Center</u> hires only CNAs that are already certified.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a.3	hrs	\$	2,603	\$	96,643	\$	2,603	\$	96,643	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,099		40,803		1,099		40,803	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		4,391		163,027		4,391		163,027	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$	8,093	\$	300,473	\$	8,093	\$	300,473	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# 0044552Report Period Beginning: 5/1/11

Ending:

4/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 4/30/12

(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	\$ 38,256	\$	1
2	Cash-Patient Deposits	9,402		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>25,000</u>)	1,144,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,526		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)	\$ 1,197,792	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	13,412,323		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,028,993		16
17	Accumulated Depreciation (book methods)	(4,829,745)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,181,244		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	431,428		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,242,792	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,440,584	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 337,885	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,522		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,732		30
31	Accrued Taxes Payable (excluding real estate taxes)	79,843		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	<u>Due To Related Party</u>	291,650		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 907,632	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	12,281,379		40
41	Bonds Payable	178,621		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Related Party Note Payable - Surplus Cas</u>	274,936		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,734,936	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,642,568	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,201,984)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,440,584	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (847,049)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (847,049)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(354,935)	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)	\$ (354,935)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,201,984)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,960,411	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,960,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,837	6
7	Oxygen	1,356	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,193	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	22,111	14
15	Telephone, Television and Radio	6,760	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	12,022	21
22	Laundry	9,219	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 50,112	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29,576	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,576	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assisted Living Revenue	620,801	28
28a	Miscellaneous Income	25,485	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 646,286	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,692,578	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	950,189	31
32	Health Care	1,845,357	32
33	General Administration	709,015	33
B. Capital Expense			
34	Ownership	795,892	34
C. Ancillary Expense			
35	Special Cost Centers	1,574,363	35
36	Provider Participation Fee	172,697	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,047,513	40
41	Income before Income Taxes (line 30 minus line 40)**	(354,935)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (354,935)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 480,737	44
45	Private Pay - Net Inpatient Revenue	2,980,003	45
46	Medicare - Net Inpatient Revenue	1,499,671	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,960,411	49

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

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

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

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending:

4/30/12

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	1873.75	2155	\$ 58111	\$ 26.97	1
2	Assistant Director of Nursing	1876.75	2153	46344	21.53	2
3	Registered Nurses	9603.25	10537	217498	20.64	3
4	Licensed Practical Nurses	21936.25	24801	441046	17.78	4
5	CNAs & Orderlies	51424	55306	594228	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1976	2150	21395	9.95	8
9	Activity Director	1970.5	2120	25035	11.81	9
10	Activity Assistants	2239.5	2478	22746	9.18	10
11	Social Service Workers	1576	1748	28639	16.38	11
12	Dietician					12
13	Food Service Supervisor	2200.5	2494	38861	15.58	13
14	Head Cook	5812.5	6333	61365	9.69	14
15	Cook Helpers/Assistants	5619	6008	49829	8.29	15
16	Dishwashers	3710.5	4062	34281	8.44	16
17	Maintenance Workers	2318	2622	28963	11.05	17
18	Housekeepers	6606	7168	69857	9.75	18
19	Laundry	6606	7168	69857	9.75	19
20	Administrator	2861.5	3104	111617	35.96	20
21	Assistant Administrator					21
22	Other Administrative	4365	4751	85832	18.07	22
23	Office Manager					23
24	Clerical	2397	2654	28052	10.57	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	328.95	365	4035	11.05	31
32	Other Health Care(specify)	19817	23138	338280	14.62	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,118	173,315	\$ 2,375,871 *	\$ 13.71	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	167	\$ 6928.94	1-3	35
36	Medical Director	96	7200	9-3	36
37	Medical Records Consultant	15	807	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	69.5	4506.91	10a-3	39
40	Physical Therapy Consultant	7	413	10a-3	40
41	Occupational Therapy Consultant	1	55	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9.75	536.25	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	9.3	523.65	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	375	\$ 20,971		49

C. CONTRACT NURSES

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable.	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/11

Ending: 4/30/12

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$2,614/Leading Ages \$1634
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? ?No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-20 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,291 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. \$ 172,697
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. \$ 22,111
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.