

Facility Name & ID Number FAITH CARE CENTER

0044552 Report Period Beginning: 5/1/2017 Ending: 4/30/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,877	18,170	1,689	23,736	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,877	18,170	1,689	23,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.57%

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

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

Senior community meals

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 3/30/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 76 and days of care provided 1,689

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 4/30/2018 Fiscal Year: 4/30/2018

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

Facility Name & ID Number **FAITH CARE CENTER** # **0044552** Report Period Beginning: **5/1/2017** Ending: **4/30/2018**

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	219,580	7,560	29,521	256,661		256,661		256,661		1
2	Food Purchase		173,886		173,886		173,886	(28,511)	145,375		2
3	Housekeeping	87,352	15,748	1,190	104,290		104,290		104,290		3
4	Laundry	87,352		4,397	91,749		91,749		91,749		4
5	Heat and Other Utilities			256,511	256,511		256,511		256,511		5
6	Maintenance	14,279	13,603	51,189	79,071		79,071		79,071		6
7	Other (specify):*			16,050	16,050		16,050		16,050		7
8	TOTAL General Services	408,563	210,797	358,858	978,218		978,218	(28,511)	949,707		8
	B. Health Care and Programs										
9	Medical Director			11,830	11,830		11,830		11,830		9
10	Nursing and Medical Records	1,660,990	52,034	10,924	1,723,948		1,723,948		1,723,948		10
10a	Therapy			245,085	245,085		245,085		245,085		10a
11	Activities	60,489	2,284	3,452	66,225		66,225		66,225		11
12	Social Services	66,284		1,069	67,353		67,353		67,353		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,787,763	54,318	272,360	2,114,441		2,114,441		2,114,441		16
	C. General Administration										
17	Administrative	81,056			81,056		81,056		81,056		17
18	Directors Fees										18
19	Professional Services			43,377	43,377		43,377		43,377		19
20	Dues, Fees, Subscriptions & Promotions			16,360	16,360		16,360	(8,109)	8,251		20
21	Clerical & General Office Expenses	48,728	31,384	228,391	308,503		308,503	(138,536)	169,967		21
22	Employee Benefits & Payroll Taxes			409,945	409,945		409,945		409,945		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,561	3,561		3,561		3,561		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,358	58,358		58,358		58,358		26
27	Other (specify):*										27
28	TOTAL General Administration	129,784	31,384	759,992	921,160		921,160	(146,645)	774,515		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,326,110	296,499	1,391,210	4,013,819		4,013,819	(175,156)	3,838,663		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:

5/1/2017

Ending:

4/30/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			367,729	367,729		367,729		367,729		30
31	Amortization of Pre-Op. & Org.			5,419	5,419		5,419		5,419		31
32	Interest			214,556	214,556		214,556		214,556		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			587,704	587,704		587,704		587,704		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			57,824	57,824		57,824		57,824		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			173,019	173,019		173,019		173,019		42
43	Other (specify):* RETIREMENT CI	335,835		782,096	1,117,931		1,117,931	(1,113,267)	4,664		43
44	TOTAL Special Cost Centers	335,835		1,012,939	1,348,774		1,348,774	(1,113,267)	235,507		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,661,945	296,499	2,991,853	5,950,297		5,950,297	(1,288,423)	4,661,874		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(28,511)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,982)	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	(1,028)	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	(150,772)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,983)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(131,543)	21		24
25	Fund Raising, Advertising and Promotional	(8,109)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(967,159)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,293,087)		\$	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))	\$ (1,293,087)		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: 5/1/2017

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL - SALARY	\$ (335,835)	43	1
2	AL- EMPLOYEE BENEFITS	(53,655)	43	2
3	AL- DIETARY	(97,641)	43	3
4	AL- HOUSEKEEPING	(10,373)	43	4
5	AL- MAINTENANCE	(25,418)	43	5
6	AL- ADMINSTRATIVE	(35,516)	43	6
7	AL- OPERATING	(173,269)	43	7
8	AL- DEPRECIATION	(206,510)	43	8
9	AL - MIP EXPENSE	(24,278)	43	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	(962,495)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28,511)	0	0	0	0	0	0	0	0	0	0	(28,511)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(28,511)	0	0	0	0	0	0	0	0	0	0	(28,511)	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	(8,109)	0	0	0	0	0	0	0	0	0	0	(8,109)	20
21	Clerical & General Office Expenses	(138,536)	0	0	0	0	0	0	0	0	0	0	(138,536)	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	(146,645)	0	0	0	0	0	0	0	0	0	0	(146,645)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(175,156)	0	0	0	0	0	0	0	0	0	0	(175,156)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,113,267)	0	0	0	0	0	0	0	0	0	0	(1,113,267)	43
44	TOTAL Special Cost Centers	(1,113,267)	0	(1,113,267)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,288,423)	0	(1,288,423)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This workpaper is N/A						

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

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

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

5/1/2017

Ending:

4/30/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number FAITH CARE CENTER # 0044552 Report Period Beginning: 5/1/2017 Ending: 4/30/2018

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	This workpaper is N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending: 1/30/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number **FAITH CARE CENTER**

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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	Series 2001 A & B Bonds		X	Construction of facility	\$57,637.00	7/31/2012	\$ 7,338,128	\$ 6,392,037	10/1/2041	0.0320	\$ 214,556	1								
2	secured by HUD mortgage.											2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$57,637.00		\$ 7,338,128	\$ 6,392,037			\$ 214,556	9								
B. Non-Facility Related*																				
10	Series 2001 A & B Bonds		X	Construction of facility	\$57,637.00	7/31/2012	5,765,672	5,022,315	10/1/2041	0.0320	155,435	10								
11	secured by HUD mortgage.											11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$57,637.00		\$ 5,765,672	\$ 5,022,315			\$ 155,435	14								
15	TOTALS (line 9+line14)						\$ 13,103,800	\$ 11,414,352			\$ 369,991	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 57,805 Line # 21-3 & 43-3

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 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 2017 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 2017.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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:

5/1/2017 Ending:

4/30/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,963 B. General Construction Type: Exterior Vinyl Frame Wook/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, Assisted Living Apartments, 36 Units

FCH Countryside Center, Independent Senior Citizen Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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			2003	2003	\$ 7,127,061	\$ 239,877	30.5	\$ 239,877	\$	\$ 3,470,717	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		2005 Fixed Assets		12/31/2005	16,856		various			16,856	9
10		2006 Fixed Assets		12/31/2006	5,473	167	various	167		4,999	10
11		2007 Fixed Assets		12/31/2007	14,731	791	various	791		12,531	11
12		Door Closers		2/1/2008	2,883		5			2,883	12
13		Door Closers		2/1/2008	681		5			681	13
14		Parking Lot Resurfacing		10/8/2008	16,049		3			16,049	14
15		Parking Lot Resurfacing		11/8/2008	12,122		3			12,122	15
16		Parking Lot Resurfacing		10/8/2008	3,793		3			3,793	16
17		Parking Lot Resurfacing		11/8/2008	2,865		3			2,865	17
18		Covered Patio		3/8/2010	29,111	1,964	30	1,964		16,524	18
19		Heat Pumps		5/1/2010	9,258		5			9,258	19
20		Call Lights		6/1/2010	6,964		5			6,964	20
21		Sprinkler Valves		6/1/2010	1,839		5			1,839	21
22		Painting		6/1/2010	1,000		5			1,000	22
23		Elevator Upgrades		7/1/2010	2,472	247	10	247		1,936	23
24		Heat Pump		7/1/2010	3,080		5			3,080	24
25		Painting		7/1/2010	220		5			220	25
26		Magnum Cooling Tower		8/1/2010	1,324		5			1,324	26
27		Surge Supression		10/1/2010	3,295		5			3,295	27
28		Speed Bumps and Signs		10/1/2010	284		5			284	28
29		Painting		1/1/2011	4,667		5			4,667	29
30		Plumbing Work		3/1/2011	6,325	632	10	632		4,479	30
31		Heat Pumps		5/1/2010	2,188		5			2,188	31
32		Call Lights		6/1/2010	1,646		5			1,646	32
33		Elevator Upgrades		7/1/2010	584	58	10	58		457	33
34		Heat Pump		7/1/2010	728		5			728	34
35		Painting		7/1/2010	52		5			52	35
36		Cooling Tower		8/1/2010	313		5			313	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Surge Supression	10/1/2010	\$ 779	\$	5	\$	\$	\$ 779	37
38	Speed Bumps and Signs	10/1/2010	189		5			189	38
39	Shingle Replacement	5/1/2011	2,150	108	20	108		753	39
40	Door Closers	7/1/2011	1,734		5			1,734	40
41	United Carpet - Carpeting	7/1/2011	28,700		5			28,700	41
42	Water Cooling Tower	7/1/2011	28,050		5			28,050	42
43	Guttering	8/1/2011	7,250	483	5	483		3,262	43
44	Cooling Tower	8/1/2011	9,946	497	5	497		3,356	44
45	Hear Pumps	8/1/2011	6,500	650	5	650		4,388	45
46	Cooling Tower	9/1/2011	9,946	497	5	497		3,315	46
47	Maedge Trucking	9/1/2011	2,000	100	5	100		666	47
48	Cooling Tower	9/1/2011	561	28	5	28		187	48
49	Cooling Tower	10/1/2011	1,683	84	5	84		554	49
50	Cooling Tower	10/1/2011	9,397	470	5	470		3,093	50
51	Loading Dock Railing	11/1/2011	2,320	116	5	116		754	51
52	Midwest Machinery	12/1/2011	8,875	888	5	888		5,695	52
53	Valve & Piping	12/1/2011	3,933	393	5	393		2,523	53
54	Pump Repairs	12/1/2011	1,050		5			1,050	54
55	Pump Repairs	12/1/2011	1,050		5			1,050	55
56	Door Panic Bar	1/1/2012	1,652		5			1,652	56
57	Valve Replacement	2/1/2012	1,415	141	5	141		884	57
58	4 Heat Pumps	2/1/2012	5,330		5			5,330	58
59	1 Heat Pump	2/1/2012	1,750		5			1,750	59
60	3 Heat Pumps	2/1/2012	4,653		5			4,653	60
61	Patio	4/1/2012	4,740	316	15	316		1,922	61
62	Patio Awning	7/1/2012	6,400	640	10	640		3,733	62
63	Kitchen Repairs	7/1/2012	1,195	120	10	120		698	63
64	Dry Sprinkler Repairs	7/1/2012	3,703	123	5	123		3,703	64
65	Door Controls	7/1/2012	1,764	88	5	88		1,764	65
66	Heating/Cooling	8/1/2012	4,032	403	10	403		2,318	66
67	Awning Power	8/1/2012	493	49	10	49		283	67
68	Wet Prinkler Repairs	8/1/2012	4,362	219	5	219		4,362	68
69	Shingle Replacement	9/1/2012	970	97	10	97		550	69
70	TOTAL (lines 4 thru 69)		\$ 7,446,436	\$ 250,246		\$ 250,246	\$	\$ 3,727,450	70

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,446,436	\$ 250,246		\$ 250,246	\$	\$ 3,727,450	1
2	Cooling Tower Pump Motor	9/1/2012	1,728	173	10	173		979	2
3	Door Closers	9/1/2012	1,141	76	5	76		1,141	3
4	Door Alarm	9/1/2012	1,700	114	5	114		1,700	4
5	Parking Lot Paving	10/1/2012	53,461		3			53,461	5
6	Sprinkler Upgrade	10/1/2012	8,619	718	5	718		8,619	6
7	Fire Door - Apt 211	10/1/2012	598	50	5	50		598	7
8	Cooling Tower Pump	11/1/2012	759	76	10	76		417	8
9	Controller for Cooling Tower	11/1/2012	961	96	10	96		528	9
10	Labor for Apt 211 Door Installation	11/1/2012	473	47	5	47		473	10
11	Plumbing Upgrades	12/1/2012	2,468	247	10	247		1,337	11
12	Supply/Return Air Boxes	12/1/2012	337	34	10	34		183	12
13	Control Board for HVAC	1/1/2013	3,688	369	10	369		1,967	13
14	Kone - Elevator Upgrades	3/1/2013	2,396	240	10	240		1,239	14
15	Korte Services - AL Laundry	3/1/2013	4,675	312	15	312		1,611	15
16	Session Freedom Dishwasher	3/1/2013	4,111	411	10	411		2,124	16
17	S Horn - #30 Window/Frame	4/1/2013	772	51	15	51		261	17
18	Crest-Nurse Call Boxes (4)	4/1/2013	787		3			787	18
19	Provst Heating & Cooling - upgrades - Main HVAC System	7/1/2013	3,986	797	5	797		3,853	19
20	B-Line Striping - Parking Lot Striping - Frong Guest Parking	9/1/2013	1,600		2			1,600	20
21	Simplex Grinnell - Dry Sprinkler Repairs - Pipe Repl - Common	9/1/2013	1,974	395	5	395		1,843	21
22	Essenpreis - Mixing Valves - Basement - Main System	10/1/2013	712	142	5	142		652	22
23	Foresight - Roofing - Building Exterior Roofing	10/1/2013	5,702	380	15	380		1,742	23
24	Pro-Alarm - Security Upgrades - Common Area	10/1/2013	8,350	835	10	835		3,827	24
25	Simplex Grinnell - Intercom Upgrades - Hallways	10/1/2013	2,720	272	10	272		1,247	25
26	Water Cooling Equip - Sheaves in Tower - Main Cooling Unit	10/1/2013	2,900	580	5	580		2,658	26
27	Door Controls - Alarms in Freedom Hall	11/1/2013	1,926	385	5	385		1,733	27
28	Essenpreis - Water Line Replacement - Main Water System	11/1/2013	1,694	339	5	339		1,525	28
29	Prost - Water Heater Parts - Main Distribution System	11/1/2013	785	157	5	157		707	29
30	Simplex - Dry Sprinkler System Upgrades - Common Area	11/1/2013	4,609	922	5	922		4,148	30
31	Steinmann - Gaskets/Seals for Freezers - Main Kitchen	11/1/2013	865	173	5	173		779	31
32	Torbis - Carpeting - Room #61	11/1/2013	982	196	5	196		884	32
33	Pro Alarm - Camera System - Freedom Hall	1/1/2014	3,775	378	10	378		1,636	33
34	TOTAL (lines 1 thru 33)		\$ 7,577,690	\$ 259,211		\$ 259,211	\$	\$ 3,833,709	34

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,577,690	\$ 259,211		\$ 259,211	\$	\$ 3,833,709	1
2	Lakeside Roofing - Building Exterior Roof	12/1/2013	258,911	17,261	15	17,261		76,235	2
3	Pro Alarm - DVR for Security System - Common Area	12/1/2013	1,455	291	5	291		1,285	3
4	Probst Heating & Cooling - 2 Actuators - Main System	12/1/2013	1,603	321	5	321		1,417	4
5	BBC Lighting - 8 Dining Room Lights - Main Dining Rooms	2/1/2014	1,090	109	10	109		463	5
6	Connor Co - 3 Heat Pumps - #21,61 & 45	2/1/2014	4,041	808	5	808		3,435	6
7	Direct Supply - 5 Bedside Tables - Resident Rooms	2/1/2014	1,435	144	10	144		610	7
8	Omni Refrig - Ice Machine Upgrades - Main Kitchen	2/1/2004	3,089	618	5	618		2,626	8
9	Essenpreis - Mixing Valves & Lines - Main Hot Water System	3/1/2004	4,172	834	5	834		3,477	9
10	Highland Auto Glass - NC Windows - Main Sprinkler system	3/1/2014	1,391	139	10	139		579	10
11	Prost - Motor for Fail Coil - Alpine Hall HVAC	3/1/2014	906	181	5	181		755	11
12	Ron Wiegmann - Nightstands - Resident Rooms	4/1/2014	720	144	5	144		588	12
13	Simplex - Sprinkler Upgrades - Main Sprinkler System	4/1/2014	1,422	284	5	284		1,161	13
14	Luitjohan Flooring - Flooring Room 50	8/1/2013	1,281	128	10	128		608	14
15	S Horn Const. - Drywall Room 50	8/1/2013	754	75	10	75		358	15
16	Connor Co - 1 Heat Pump	5/1/2014	1,891	378	5	378		1,512	16
17	Foresight - Roof	5/1/2014	5,702	570	10	570		2,280	17
18	Simplex - Fire Board Replacement	5/1/2014	1,564	313	5	313		1,252	18
19	Ehret, Inc - Replaced Switches in Water System	6/1/2014	1,133	227	5	227		888	19
20	Prost Heating - Upgraded McQuay System	6/1/2014	1,798	360	5	360		1,409	20
21	Simplex - 6 Dry Heats on Sprinkler System	6/1/2014	3,060	612	5	612		2,397	21
22	Simplex - 2 Sprinkler Fittings	6/1/2014	3,364	673	5	673		2,635	22
23	Murphy Company - Water Heater	8/1/2014	12,883	1,288	10	1,288		4,831	23
24	Rakers Electric - Kitchen on Generator	8/1/2014	6,123	1,225	5	1,225		4,593	24
25	Finley Flooring - Cove Base	9/1/2014	435	87	5	87		319	25
26	Prost Heating - Upgraded McQuay System - Monitor	9/1/2014	1,596	319	5	319		1,170	26
27	Rakers Electric - Emergency B/U Additions	9/1/2014	1,236	247	5	247		906	27
28	Simplex Grinnell - New Sprinkler Piping	9/1/2014	9,749	1,950	5	1,950		7,149	28
29	Rakers Electric - Generator Upgrades	10/1/2014	2,447	489	5	489		1,753	29
30	Simplex Grinnell - Wet Sprinkler Piping	10/1/2014	2,512	502	5	502		1,800	30
31	Simplex Grinnell - Dry Sprinkler Piping	11/1/2014	1,647	329	5	329		1,152	31
32	Essenpreis - New Water Lines	12/1/2014	1,776	178	10	178		607	32
33	Meyer Contracting - Doors	1/1/2015	1,444	144	10	144		481	33
34	TOTAL (lines 1 thru 33)		\$ 7,920,320	\$ 290,439		\$ 290,439	\$	\$ 3,964,440	34

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,920,320	\$ 290,439		\$ 290,439	\$	\$ 3,964,440	1
2	Firestoppers - Fire Caulking for Sprinklers System Piping	3/1/2015	6,823	682	10	682		2,160	2
3	Finley Flooring	6/1/2014	1,799	180	10	180		705	3
4	Flooring	9/1/2013	1,761	176	10	176		821	4
5	Flooring	4/1/2014	951	190	5	190		776	5
6	Connor Co - Heat Pumps	5/1/2015	9,061	1,812	5	1,812		5,436	6
7	Simplex - Relay for Fire System	5/1/2015	600	120	5	120		360	7
8	Prost - McQuay Drier and Keypad Display	6/1/2015	2,329	466	5	466		1,359	8
9	City of Highland - Exterior Sign	8/1/2015	100	33	3	33		91	9
10	Digital Artz - Exterior Sign	8/1/2015	2,917	972	3	972		2,673	10
11	Essempreis Plumbing - Hot Water Boiler Parts	8/1/2015	728		1			728	11
12	Finley Flooring - 3 Bathroom Floors	8/1/2015	660		3			660	12
13	Foppe Visual - Office Signs	8/1/2015	1,594		3				13
14	Gateway Industrial - Generator Board	8/1/2015	1,836	612	2	612		1,683	14
15	Kunz Caprentry - Kitchenette Cabinets	8/1/2015	1,350	169	1	169		1,350	15
16	Simplex - Hood System for Deep Fryer	9/1/2015	2,525	505	5	505		1,347	16
17	Prost - McQuay Compressor	9/1/2015	4,181	836	5	836		2,230	17
18	Crest - Nurse Call Boxes	10/1/2015	711	237	5	237		612	18
19	Essempreis Plumbing - Backflow Preventor	10/1/2015	1,008	202	5	202		521	19
20	Prost Heating - Ignition Moduel on Water Heater	10/1/2015	758	152	5	152		392	20
21	Roger Echeimeier - Chemical Pump on Cooling Tower	10/1/2015	3,975	795	5	795		2,054	21
22	Simplex - Relay for Fire System	10/1/2015	909	182	5	182		470	22
23	Simplex - Relay for Fire System	10/1/2015	1,092	218	3	218		564	23
24	Simplex - Power Interface on Fire Alarm	10/1/2015	2,627	525	5	525		1,357	24
25	Weeke Sales - Garbage Disposal Main Kitchen	11/1/2015	2,171	217	10	217		543	25
26	Capital One - Room Signs	11/1/2015	1,157	231	5	231		578	26
27	Magnum Rotating - Motor For Water Pump	11/1/2015	881	220	2	220		881	27
28	Simplex - Nurse Call System	12/1/2015	2,973	595	5	595		1,438	28
29	Simplex - Extinguisher Nozzle - Kitchen	1/1/2016	2,725	545	5	545		1,272	29
30	Simplex - Fire Alarm Batteries	1/1/2016	1,322		1			1,322	30
31	Torbis - Flooring Room 61	2/1/2016	2,145	429	5	429		965	31
32	Door Controls	3/1/2016	620	124	5	124		269	32
33	Essenpries Plumbing - 2 Shower Valves	3/1/2016	1,376	275	5	275		596	33
34	TOTAL (lines 1 thru 33)		\$ 7,985,985	\$ 302,139		\$ 302,139	\$	\$ 4,000,653	34

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,985,985	\$ 302,139		\$ 302,139	\$	\$ 4,000,653	1
2	Ideal Home Solutions - Kitchen Wash Bay	3/1/2016	5,621	375	15	375		812	2
3	Rakers Electric - Cooling Tower Motor	3/1/2016	9,442	944	10	944		2,090	3
4	S. Horn Const - Kitchen Wash Bay	3/1/2016	842	56	15	56		122	4
5	Weeke Sales - Parts for Kitchen Slicer	3/1/2016	978	326	3	326		706	5
6	Essenpreis Plumbing - Mixing Vavles in Kitchen	4/1/2016	963	193	5	193		402	6
7	Simplex Grinnell - Valve in Wet Sprinkler System	4/1/2016	934	428	2	428		934	7
8	Simplex Grinnell - Line Replacement in Dry Sprinkler	4/1/2016	945	428	2	428		945	8
9	Simplex Grinnell - Line Replacement in Beauty Shop	4/1/2016	760	349	2	349		760	9
10	Weeke Sales - Booster	4/1/2016	5,366	671	8	671		1,398	10
11	Kunz Carpentry - Kitchenette Cabinets	8/1/2016	675	84	2	84		675	11
12	Gerstner Plumbing - Sink Mixing Vavles	8/1/2016	709	355	2	355		621	12
13	Rakers Electric - Cooling Tower Improvements	8/1/2016	1,240	413	3	413		723	13
14	Simplex - Wet Sprinkler Piping - Beauty Shop	8/1/2016	8,049	805	10	805		1,400	14
15	Torbitts - Flooring Room 30	9/1/2016	1,961	392	5	392		654	15
16	Coonor Co - Heat Pumps	9/1/2016	6,153	1,236	5	1,236		1,914	16
17	Dorma USA Door - Front Door Lock	2/1/2017	1,151	384	3	384		480	17
18	Essenpries - Boiler Pipe Replacement	2/1/2017	3,145	629	5	629		786	18
19	Weeke - NC Dishwasher	2/1/2017	3,800	1,267	3	1,267		1,583	19
20	Weeke - Pilot Assembly on Stove	2/1/2017	561	281	2	281		351	20
21	Prost - Flow Switches on Cooling Tower	2/1/2017	786	393	2	393		491	21
22	Pro-Alarm - 2 Color Cameras	3/1/2017	518	259	2	259		302	22
23	Climate Company - Linden DR Heat Pump Condensor	3/1/2017	859	172	5	172		200	23
24	Ellis & Associates - #62 Flooring	4/1/2017	2,044	409	5	409		443	24
25	Ellis & Associates - #76	4/1/2017	1,234	247	5	247		267	25
26	Climate Company - Condenser for ADON Office	4/1/2017	859	172	5	172		186	26
27	Simplex - Sprinkler Pipe	7/1/2016	22,719	5,386	5	5,386		8,547	27
28	Simplex - Dry Sprinkler Pipe	12/1/2016	60,700	6,070	10	6,070		7,516	28
29	Climate Company - Living Room AC Condenser	4/1/2017	859	172	5	172		186	29
30	Connor Co - Heat Pump	9/1/2017	4,366	582	5	582		582	30
31	Connor Co - Heat Pump	10/1/2017	4,171	487	5	487		487	31
32	Crest - Single Station Call System	10/1/2017	645	188	2	188		188	32
33	Door Controls - NC Side Entrance Door Closure	11/1/2017	2,599	22	10	22		22	33
34	TOTAL (lines 1 thru 33)		\$ 8,141,639	\$ 326,314		\$ 326,314	\$	\$ 4,037,426	34

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,141,639	\$ 326,314		\$ 326,314	\$	\$ 4,037,426	1
2	Ellis & Assoc	9/1/2017	241	32	5	32		32	2
3	Ellis & Assoc - Nurses Station Flooring	8/1/2017	2,011	302	5	302		302	3
4	Essenpreis Plumbing	9/1/2017	905	201	3	201		201	4
5	Essenpreis Plumbing - Boiler Piping	10/1/2017	1,786	208	5	208		208	5
6	Essenpreis - Boiler Valve	4/1/2018	646	11	5	11		11	6
7	Kelley Daniels - Phone Card	6/1/2017	1,185	362	3	362		362	7
8	Kelley Daniels - Phone System Batteries & Power Supply	4/1/2018	764	13	5	13		13	8
9	Parking Lot Striping	11/1/2017	2,900	725	2	725		725	9
10	Prost Heating - Boiler Room Piping	11/1/2017	2,167	36	5	36		36	10
11	Prost Heating - McQuay Upgrades	11/1/2017	615	26	2	26		26	11
12	Prost Heating - McQuay Upgrades	11/1/2017	1,302	54	2	54		54	12
13	Rakers Electric - Parking Lot Light & Pole	9/1/2017	2,400	160	10	160		160	13
14	Rakers Electric - Add Elevator & Kitchen to Generator	7/1/2017	2,773	462	5	462		462	14
15	S Horn Construction - Kitchen Dishwasher Wall Redesign	7/1/2017	904	251	3	251		251	15
16	Simplex - Accelerator for Wet System	4/1/2018	1,491	25	5	25		25	16
17	Simplex - New Pipe for Dry System	4/1/2018	3,770	63	5	63		63	17
18	Simplex - Nurse Call System Upgrade	10/1/2017	832	243	2	243		243	18
19	The Korte Company - Roof Hatch	12/1/2017	4,637	193	10	193		193	19
20	Torbit's - Flooring	8/1/2017	717	107	5	107		107	20
21	Water Cooling Equip - Drift Eliminators	6/1/2017	4,975	456	10	456		456	21
22	Weeke Sales - Cooler Fan Motor	6/1/2017	1,035	190	5	190		190	22
23	Weeke Sales - Garbage Disposal	6/1/2017	2,948	541	5	541		541	23
24	Weeke Sales - NC Freezer Compressor	4/1/2018	819	14	5	14		14	24
25	Weeke Sales - Walk-In Freezer Valves	10/1/2017	1,068	208	3	208		208	25
26	Tie Out to Support		(12)	(3)		(3)			26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,184,518	\$ 331,194		\$ 331,194	\$	\$ 4,042,309	34

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

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning:

5/1/2017

Ending:

4/30/2018

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	\$ 138,968	\$ 25,892	\$ 25,892	\$		\$ 89,735	71
72	Current Year Purchases	32,735	3,797	3,797			3,797	72
73	Fully Depreciated Assets	970,079	1,121	1,121			970,079	73
74								74
75	TOTALS	\$ 1,141,782	\$ 30,810	\$ 30,810	\$		\$ 1,063,611	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care, Maintenance	Golf Cart	2011	\$ 6,701	\$ 513	\$ 513	\$	5	\$ 6,159	76
77	Patient Care	Southern IL Bus	2013	52,922	5,212	5,212		10	23,889	77
78										78
79										79
80	TOTALS			\$ 59,623	\$ 5,725	\$ 5,725	\$		\$ 30,048	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,404,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 367,729	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 367,729	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)	\$ 5,135,968	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	\$ 5,896,622	\$ 202,279	\$ 2,864,134	86
87	AL - Equipment	35,079	4,173	30,144	87
88					88
89					89
90					90
91	TOTALS	\$ 5,931,701	\$ 206,452	\$ 2,894,278	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: **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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,166	\$ 71,635	\$	2,166	\$ 71,635	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		674	38,827		674	38,827	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,359	134,623		3,359	134,623	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			\$	6,199	\$ 245,085	\$	6,199	\$ 245,085	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **4/30/2018**

(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	\$ 139,960	\$	1
2	Cash-Patient Deposits	23,534		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>188,531</u>)	634,445		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,013		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)	\$ 859,952	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	14,081,141		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,236,446		16
17	Accumulated Depreciation (book methods)	(8,030,245)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	599,359		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing</u>	126,898		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,032,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,892,100	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 359,920	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,088		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,148		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,288		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	30,438		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Related Party</u>	620,780		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,289,662	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	274,936		39
40	Mortgage Payable	11,414,352		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)	\$ 11,689,288	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,978,950	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,086,850)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,892,100	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,521,586)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,521,586)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(565,264)	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)	\$ (565,264)	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)	\$ (4,086,850)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning: 5/1/2017

Ending: 4/30/2018

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	\$ 4,234,297	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,234,297	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	308,118	6
7	Oxygen	3,051	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 311,169	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	28,511	14
15	Telephone, Television and Radio	2,982	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	30,752	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,991	21
22	Laundry	5,871	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,107	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,028	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,028	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apt/Garden Home Revenue</u>	758,452	28
28a	<u>Misc. Income</u>	2,980	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 761,432	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,385,033	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	978,218	31
32	Health Care	2,114,441	32
33	General Administration	921,160	33
B. Capital Expense			
34	Ownership	587,704	34
C. Ancillary Expense			
35	Special Cost Centers	1,175,755	35
36	Provider Participation Fee	173,019	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,950,297	40
41	Income before Income Taxes (line 30 minus line 40)**	(565,264)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (565,264)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 595,149	44
45	Private Pay - Net Inpatient Revenue	3,227,168	45
46	Medicare - Net Inpatient Revenue	411,980	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,234,297	49

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

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

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

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

Facility Name & ID Number **FAITH CARE CENTER**

0044552

Report Period Beginning: **5/1/2017**

Ending:

4/30/2018

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	1,896	2,160	\$ 68,553	\$ 31.74	1
2	Assistant Director of Nursing	1,916	2,203	65,055	29.53	2
3	Registered Nurses	7,311	8,277	215,384	26.02	3
4	Licensed Practical Nurses	23,483	25,911	554,355	21.39	4
5	CNAs & Orderlies	51,786	56,894	703,403	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,248	3,530	46,851	13.27	8
9	Activity Director	1,981	2,148	26,934	12.54	9
10	Activity Assistants	2,812	3,157	33,554	10.63	10
11	Social Service Workers	3,233	3,699	66,284	17.92	11
12	Dietician					12
13	Food Service Supervisor	2,534	2,752	43,053	15.64	13
14	Head Cook	9,252	9,690	98,658	10.18	14
15	Cook Helpers/Assistants	5,248	6,105	51,897	8.50	15
16	Dishwashers	2,990	3,136	25,972	8.28	16
17	Maintenance Workers	1,048	1,144	14,279	12.48	17
18	Housekeepers	8,462	9,178	87,352	9.52	18
19	Laundry	8,462	9,178	87,352	9.52	19
20	Administrator	1,712	1,941	81,806	42.15	20
21	Assistant Administrator					21
22	Other Administrative	655	750	18,348	24.46	22
23	Office Manager					23
24	Clerical	2,272	2,492	29,630	11.89	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	596	675	7,390	10.95	31
32	Other Health Care(specify)	26,755	29,203	335,835	11.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	167,652	184,223	\$ 2,661,945 *	\$ 14.45	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	159	\$ 7,974	1-3	35
36	Medical Director	120	11,830	9-3	36
37	Medical Records Consultant	16	1,076	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,855	10a-3	39
40	Physical Therapy Consultant	144	10,000	10a-3	40
41	Occupational Therapy Consultant	144	10,000	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	144	10,000	10a-3	43
44	Activity Consultant	17	1,069	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	792	\$ 55,804		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Gerald Harman	Executive Director		\$ 34,289	Workers' Compensation Insurance	\$ 89,009	IDPH License Fee	\$		
Lisa Ketrow	Director of Finance		46,767	Unemployment Compensation Insurance	5,059	Advertising: Employee Recruitment	3,244		
				FICA Taxes	176,013	Health Care Worker Background Check (Indicate # of checks performed 20)	645		
				Employee Health Insurance	128,023	Patient Background Checks	580		
				Employee Meals		Advertising/Marketing/Promo	8,109		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,782		
				Misc. Employee Benefits Expenses	11,841				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,056						
B. Administrative - Other									
Description			Amount						
			\$			Less: Public Relations Expense	()		
						Non-allowable advertising	(8,109)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 409,945	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,251		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Donovan Rose Nester	Legal		\$ 15,138			\$	Out-of-State Travel	\$	
Donald Johannes	Legal		200						
Scheffel Boyle	Audit		25,526				In-State Travel	1,835	
Clifton Larson Allen	Audit		916						
Benefit Plans Plus	401K		1,358				Seminar Expense	1,726	
ADP	401K		239						
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 43,377	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,561	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Healthcare Association - \$3,250
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 2-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,736 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. \$ 173,019
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. \$ 28,511
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Scheffel Boyle
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees