

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0044552</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Faith Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>5/1/2015</u> to <u>4/30/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>100 Faith Drive</u> <u>Highland</u> <u>62249</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Madison</u>																																																			
Telephone Number: <u>618-654-4600</u> Fax # <u>618-654-4604</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>3/21/2003</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____			
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		☐	Limited Liability Co.	_____																																															
		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>Lisa Ketrow</u>																																																			
Telephone Number: <u>618-654-4600</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) _____																																																	
		(Title) _____																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>Kevin E. Wellen, CPA</u> <u>Director</u>																																																	
		(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave. Suite 1800 St. Louis, MO 63101</u>																																																	
		(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>																																																	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

Facility Name & ID Number Faith Care Center

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

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

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

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

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 76 and days of care provided 2,115

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

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

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

V. COST CENTER EXPENSES (continued)

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

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,842)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,227)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(637)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(306)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,098)	21		24
25	Fund Raising, Advertising and Promotional	(8,040)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(1,135,000)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,176,150)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,176,150)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL - Salary	\$ (348,118)	43	1
2	AL - Employee Benefits	(49,566)	43	2
3	AL - Dietary	(114,979)	43	3
4	AL - Housekeeping	(11,874)	43	4
5	AL - Maintenance	(25,013)	43	5
6	AL - Administrative	(32,807)	43	6
7	AL - Operating	(158,003)	43	7
8	AL - Depreciation	(203,106)	43	8
9	AL - MIP Expense	(25,585)	43	9
10	AL - Interest Expense	(165,949)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,135,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Faith Care Center# 0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(26,842)	0	0	0	0	0	0	0	0	0	0	(26,842)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(26,842)	0	0	0	0	0	0	0	0	0	0	(26,842)	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	(8,040)	0	0	0	0	0	0	0	0	0	0	(8,040)	20
21	Clerical & General Office Expenses	(6,268)	0	0	0	0	0	0	0	0	0	0	(6,268)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,308)	0	0	0	0	0	0	0	0	0	0	(14,308)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,150)	0	0	0	0	0	0	0	0	0	0	(41,150)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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):*	(1,135,000)	0	0	0	0	0	0	0	0	0	0	(1,135,000)	43
44	TOTAL Special Cost Centers	(1,135,000)	0	0	0	0	0	0	0	0	0	0	(1,135,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,176,150)	0	0	0	0	0	0	0	0	0	0	(1,176,150)	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dr. Robert Hellige	President							\$		1
2	Kathy Harris	Vice President									2
3	Louise Hemann	Secretary									3
4	Susan Bowman	Treasurer									4
5	Pastor Chris Hill	Board Member									5
6	Robert Nagel	Board Member									6
7	Robert Sudhoff	Board Member									7
8	Marietta Miller	Board Member									8
9	Michael Marchal	Board Member									9
10	Chris Cooper	Board Member									10
11											11
12											12
13								TOTAL	\$		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 60,917 Line # 21-3 & 43-3

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
 - 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	Faith Care Center	COUNTY	Madison
---------------	-------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

A. Square Feet: 49,963

B. General Construction Type: Exterior Vinyl Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

FCH Apartments, Independent Living, 84 Units

FCH Assisted Living, Assisting Living Apartments, 36 Units

FCH Countryside Center, Independent Senior Citizen Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

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

*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:

5/1/2015

Ending:

4/30/2016

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

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

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

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

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

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

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

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

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

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning:

5/1/2015

Ending:

4/30/2016

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

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$151,296	\$39,760	\$39,760	\$	Various	\$80,406	71
72	Current Year Purchases	30,653	3,851	3,851		Various	3,851	72
73	Fully Depreciated Assets	907,960	2,028	2,028		Various	907,960	73
74								74
75	TOTALS	\$1,089,909	\$45,639	\$45,639	\$		\$992,217	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care, Maintenance	Golf Cart	2011	\$5,600	\$1,120	\$1,120	\$	5	\$5,133	76
77	Patient Care	Southern IL Bus	2013	52,922	5,212	5,212		10	13,464	77
78										78
79										79
80	TOTALS			\$58,522	\$6,332	\$6,332	\$		\$18,597	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,178,804	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$381,619	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$381,619	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,398,302	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL - Building & Improvements	\$5,867,658	\$198,700	\$2,463,013	86
87	AL - Equipment	34,509	4,388	21,919	87
88					88
89					89
90					90
91	TOTALS	\$5,902,167	\$203,088	\$2,484,932	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number	Faith Care Center
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0044552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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?

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 2017 \$

13. /2018 \$

14. _____ /2019 \$ _____

*** 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.**

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(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.

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	

(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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,467	\$ 111,973	\$	2,467	\$ 111,973	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		252	11,438		252	11,438	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,688	76,615		1,688	76,615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	4,407	\$ 200,026	\$	4,407	\$ 200,026	14

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

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,544,348)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,544,348)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(195,495)	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)	\$ (195,495)	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)	\$ (2,739,843)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Faith Care Center

0044552

Report Period Beginning: 5/1/2015

Ending: 4/30/2016

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

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

1

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

2

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

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

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

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

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

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

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

(This schedule must cover the entire reporting period.)

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

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	170	\$ 8,176	1-3	35
36	Medical Director	128	12,800	9-3	36
37	Medical Records Consultant	16	1,076	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,735	10a-3	39
40	Physical Therapy Consultant	144	10,000	10a-3	40
41	Occupational Therapy Consultant	144	10,000		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	144	10,000		43
44	Activity Consultant	6	425	11-3	44
45	Social Service Consultant	6	424	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	854	\$ 56,636		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Gerald Harman	Executive Director		\$ 53,341
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,341
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Donovan Rose Nester	Legal		\$ 16,233
CliftonLarsonAllen, LLP	Audit		33,223
Benefit Plans Plus	401K		2,327
Donald Johannes	Legal		175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 51,958
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 101,742
Unemployment Compensation Insurance			2,855
FICA Taxes			174,315
Employee Health Insurance			104,101
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Misc. Employee Benefits Expenses			10,999
TOTAL (agree to Schedule V, line 22, col.8)			\$ 394,012
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			5,378
Health Care Worker Background Check (Indicate # of checks performed 27)			892
Patient Background Checks	137		1,370
Advertising/Marketing/Promo			8,040
Dues & Subscriptions			6,574
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,254
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			2,142
Seminar Expense			1,883
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 4,025

*** 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 - \$4,765
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 2-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,599 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 182,080
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 26,842
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees