

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>5/1/2019</u> to <u>4/30/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>100 FAITH DRIVE</u> <u>HIGHLAND</u> <u>62249</u>																																																		
Number City Zip Code																																																		
County: <u>MADISON</u>																																																		
Telephone Number: <u>618-654-4600</u> Fax # <u>618-654-4604</u>																																																		
HFS ID Number: _____			<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td colspan="2">(Title) _____</td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>LISA BOHNENSTIEHL, CPA</u> <u>MANAGER</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>PO BOX 374 HIGHLAND, IL 62249</u></td><td></td></tr><tr><td>(Telephone) <u>618-654-9895</u></td><td>Fax # <u>618-654-9898</u></td></tr><tr><td colspan="2">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</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) <u>LISA BOHNENSTIEHL, CPA</u> <u>MANAGER</u>		(Firm Name & Address) <u>SCHEFFEL BOYLE</u> <u>PO BOX 374 HIGHLAND, IL 62249</u>		(Telephone) <u>618-654-9895</u>	Fax # <u>618-654-9898</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																												
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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>☐</td><td>_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td>☐</td><td></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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		☐	Other _____	☐																																														
In the event there are further questions about this report, please contact:																																																		
Name: _____ Telephone Number: <u>618-654-4600</u>																																																		
Email Address: _____																																																		

Facility Name & ID Number FAITH CARE CENTER

0044552 Report Period Beginning: 5/1/2019 Ending: 4/30/2020

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	4,177	15,579	2,093	21,849
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	4,177	15,579	2,093	21,849

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.55%

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)

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 2,093

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 4/30/2020 Fiscal Year: 4/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **FAITH CARE CENTER** # **0044552** Report Period Beginning: **5/1/2019** Ending: **4/30/2020**
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	254,742	9,259	20,986	284,987		284,987		284,987			1
2	Food Purchase		140,805		140,805		140,805		140,805			2
3	Housekeeping	92,238	14,581	1,059	107,878		107,878		107,878			3
4	Laundry	92,238		2,439	94,677		94,677		94,677			4
5	Heat and Other Utilities			246,701	246,701		246,701		246,701			5
6	Maintenance	72,739	11,788	40,675	125,202		125,202		125,202			6
7	Other (specify):*			14,589	14,589		14,589		14,589			7
8	TOTAL General Services	511,957	176,433	326,449	1,014,839		1,014,839		1,014,839			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,957,755	82,263	22,912	2,062,930		2,062,930		2,062,930			10
10a	Therapy		204	289,964	290,168		290,168		290,168			10a
11	Activities	129,154	5,005	6,346	140,505		140,505		140,505			11
12	Social Services	36,939		528	37,467		37,467		37,467			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,123,848	87,472	332,750	2,544,070		2,544,070		2,544,070			16
	C. General Administration											
17	Administrative	60,511			60,511		60,511		60,511			17
18	Directors Fees											18
19	Professional Services			30,186	30,186		30,186		30,186			19
20	Dues, Fees, Subscriptions & Promotions			38,906	38,906		38,906	(14,865)	24,041			20
21	Clerical & General Office Expenses	100,866	44,370	565,811	711,047		711,047	(448,512)	262,535			21
22	Employee Benefits & Payroll Taxes			403,158	403,158		403,158		403,158			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,377	4,377		4,377		4,377			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,327	80,327		80,327		80,327			26
27	Other (specify):*											27
28	TOTAL General Administration	161,377	44,370	1,122,765	1,328,512		1,328,512	(463,377)	865,135			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,797,182	308,275	1,781,964	4,887,421		4,887,421	(463,377)	4,424,044			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			362,345	362,345		362,345		362,345			30
31	Amortization of Pre-Op. & Org.			5,419	5,419		5,419		5,419			31
32	Interest			202,819	202,819		202,819		202,819			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			570,583	570,583		570,583		570,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			121,723	121,723		121,723		121,723			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,067	154,067		154,067		154,067			42
43	Other (specify):* RETIREMENT CL	411,406		744,605	1,156,011		1,156,011	(1,156,011)				43
44	TOTAL Special Cost Centers	411,406		1,020,395	1,431,801		1,431,801	(1,156,011)	275,790			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,208,588	308,275	3,372,942	6,889,805		6,889,805	(1,619,388)	5,270,417			45

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

	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				4
5	Telephone, TV & Radio in Resident Rooms	(2,066)	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	(4)	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	(146,701)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,714)	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	(438,728)	21		24
25	Fund Raising, Advertising and Promotional	(14,865)	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	(1,009,310)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,619,388)		\$	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))	\$ (1,619,388)		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	\$ (411,406)	43	1
2	AL - HOUSEKEEPING	(9,567)	43	2
3	AL - MAINTENANCE	(20,294)	43	3
4	AL - ADMISTRATIVE	(29,522)	43	4
5	AL - OPERATING	(172,580)	43	5
6	AL - DEPRECIATION	(203,099)	43	6
7	AL - EMPLOYEE BENEFITS	(59,430)	43	7
8	AL - MIP EXPENSE	(23,362)	43	8
9	AL - DIETARY	(80,050)	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	(1,009,310)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **FAITH CARE CENTER**# **0044552**

Report Period Beginning:

5/1/2019

Ending:

4/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(14,865)	0	0	0	0	0	0	0	0	0	0	(14,865)	20
21	Clerical & General Office Expenses	(448,512)	0	0	0	0	0	0	0	0	0	0	(448,512)	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	(463,377)	0	0	0	0	0	0	0	0	0	0	(463,377)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(463,377)	0	0	0	0	0	0	0	0	0	0	(463,377)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,156,011)	0	0	0	0	0	0	0	0	0	0	(1,156,011)	43
44	TOTAL Special Cost Centers	(1,156,011)	0	0	0	0	0	0	0	0	0	0	(1,156,011)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,619,388)	0	0	0	0	0	0	0	0	0	0	(1,619,388)	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.

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

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: 5/1/2019 Ending: 1/30/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		<u>This workpaper is N/A</u>				\$	\$			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	\$ 6,014,971	10/1/2041	0.0320	\$ 202,819	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	\$ 6,014,971			\$ 202,819	9
	B. Non-Facility Related*											
10	Series 2001 A & B Bonds		X	Construction of facility	\$57,637.00	7/31/2012	5,765,672	4,726,048	10/1/2041	0.0320	146,701	10
11	secured by HUD mortgage											11
12												12
13												13
14	TOTAL Non-Facility Related				\$57,637.00		\$ 5,765,672	\$ 4,726,048			\$ 146,701	14
15	TOTALS (line 9+line14)						\$ 13,103,800	\$ 10,741,019			\$ 349,520	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 55,623 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

[illegible]

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

FACILITY IDPH LICENSE NUMBER 0044552

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **49,963**

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

C. Does the Operating Entity? ☒ (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	Nursing Home	372,834	1989	\$ 18,549	1
2					2
3	TOTALS	372,834		\$ 18,549	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number FAITH CARE CENTER

#

0044552

Report Period Beginning:

5/1/2019

Ending:

4/30/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2003	2003	\$ 7,127,061	\$ 239,877	30.5	\$ 239,877	\$	\$ 3,950,471	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		5,333	10
11	2007 Fixed Assets			12/31/2007	14,731	600	various	600		13,731	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	1,929	30	1,929		20,417	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		2,430	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		5,743	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		573	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:

5/1/2019

Ending:

4/30/2020

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	
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		969	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		4,228	43
44 Cooling Tower	8/1/2011	9,946	497	5	497		4,350	44
45 Hear Pumps	8/1/2011	6,500	650	5	650		5,688	45
46 Cooling Tower	9/1/2011	9,946	497	5	497		4,309	46
47 Maedge Trucking	9/1/2011	2,000	100	5	100		866	47
48 Cooling Tower	9/1/2011	561	28	5	28		243	48
49 Cooling Tower	10/1/2011	1,683	84	5	84		722	49
50 Cooling Tower	10/1/2011	9,397	470	5	470		4,033	50
51 Loading Dock Railing	11/1/2011	2,320	116	5	116		986	51
52 Midwest Machinerv	12/1/2011	8,875	888	5	888		7,471	52
53 Valve & Piping	12/1/2011	3,933	393	5	393		3,309	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		1,166	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		2,554	61
62 Patio Awning	7/1/2012	6,400	640	10	640		5,013	62
63 Kitchen Repairs	7/1/2012	1,195	120	10	120		938	63
64 Dry Sprinkler Repairs	7/1/2012	3,703		5			3,703	64
65 Door Controls	7/1/2012	1,764		5			1,764	65
66 Heating/Cooling	8/1/2012	4,032	403	10	403		3,124	66
67 Awning Power	8/1/2012	493	49	10	49		381	67
68 Wet Prinkler Repairs	8/1/2012	4,362		5			4,362	68
69 Shingle Replacement	9/1/2012	970	97	10	97		744	69
70 TOTAL (lines 4 thru 69)		\$ 7,446,436	\$ 249,590		\$ 249,590	\$	\$ 4,226,665	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:

5/1/2019

Ending:

4/30/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,446,436	\$ 249,590		\$ 249,590	\$	\$ 4,226,665	1
2	Cooling Tower Pump Motor	9/1/2012	1,728	173	10	173		1,325	2
3	Door Closers	9/1/2012	1,141		5			1,141	3
4	Door Alarm	9/1/2012	1,700		5			1,700	4
5	Parking Lot Paving	10/1/2012	53,461		3			53,461	5
6	Sprinkler Upgrade	10/1/2012	8,619		5			8,619	6
7	Fire Door - Apt 211	10/1/2012	598		5			598	7
8	Cooling Tower Pump	11/1/2012	759	76	10	76		569	8
9	Controller for Cooling Tower	11/1/2012	961	96	10	96		720	9
10	Labor for Apt 211 Door Installation	11/1/2012	473		5			473	10
11	Plumbing Upgrades	12/1/2012	2,468	247	10	247		1,831	11
12	Supply/Return Air Boxes	12/1/2012	337	33	10	33		250	12
13	Control Board for HVAC	1/1/2013	3,688	369	10	369		2,705	13
14	Kone - Elevator Upgrades	3/1/2013	2,396	240	10	240		1,719	14
15	Korte Services - AL Laundry	3/1/2013	4,675	312	15	312		2,235	15
16	Session Freedom Dishwasher	3/1/2013	4,111	411	10	411		2,946	16
17	S Horn - #30 Window/Frame	4/1/2013	772	51	15	51		363	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		5			3,986	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		5			1,974	21
22	Essenpreis - Mixing Values - Basement - Main System	10/1/2013	712		5			712	22
23	Foresight - Roofing - Building Exterior Roofing	10/1/2013	5,702	380	15	380		2,502	23
24	Pro-Alarm - Security Upgrades - Common Area	10/1/2013	8,350	835	10	835		5,497	24
25	Simplex Grinnell - Intercom Upgrades - Hallways	10/1/2013	2,720	272	10	272		1,791	25
26	Water Cooling Equip - Sheaves in Tower - Main Cooling Unit	10/1/2013	2,900		5			2,900	26
27	Door Controls - Alarms in Freedom Hall	11/1/2013	1,926		5			1,926	27
28	Essenpreis - Water Line Replacement - Main Water System	11/1/2013	1,694		5			1,694	28
29	Prost - Water Heater Parts - Main Distribution System	11/1/2013	785		5			785	29
30	Simplex - Dry Sprinkler System Upgrades - Common Area	11/1/2013	4,609		5			4,609	30
31	Steinmann - Gaskets/Seals for Freezers - Main Kitchen	11/1/2013	865		5			865	31
32	Torbits - Carpeting - Room #61	11/1/2013	982		5			982	32
33	Pro Alarm - Camera System - Freedom Hall	1/1/2014	3,775	378	10	378		2,392	33
34	TOTAL (lines 1 thru 33)		\$ 7,577,690	\$ 253,463		\$ 253,463	\$	\$ 4,342,322	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:

5/1/2019

Ending:

4/30/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,577,690	\$ 253,463		\$ 253,463	\$	\$ 4,342,322	1
2	Lakeside Roofing - Building Exterior Roof	12/1/2013	258,911	17,261	15	17,261		110,757	2
3	Pro Alarm - DVR for Security System - Common Area	12/1/2013	1,455		5			1,455	3
4	Probst Heating & Cooling - 2 Actuators - Main System	12/1/2013	1,603		5			1,603	4
5	BBC Lighting - 8 Dining Room Lights - Main Dining Rooms	2/1/2014	1,090	109	10	109		681	5
6	Connor Co - 3 Heat Pumps - #21,61 & 45	2/1/2014	4,041		5			4,041	6
7	Direct Supply - 5 Bedside Tables - Resident Rooms	2/1/2014	1,435	144	10	144		898	7
8	Omni Refrig - Ice Machine Upgrades - Main Kitchen	2/1/2004	3,089		5			3,089	8
9	Essenpreis - Mixing Valves & Lines - Main Hot Water System	3/1/2004	4,172		5			4,172	9
10	Highland Auto Glass - NC Windows - Main Sprinkler system	3/1/2014	1,391	139	10	139		857	10
11	Prost - Motor for Fail Coil - Alpine Hall HVAC	3/1/2014	906		5			906	11
12	Ron Wiegmann - Nightstands - Resident Rooms	4/1/2014	720		5			720	12
13	Simplex - Sprinkler Upgrades - Main Sprinkler System	4/1/2014	1,422		5			1,422	13
14	Luitjohan Flooring - Flooring Room 50	8/1/2013	1,281	128	10	128		864	14
15	S Horn Const. - Drywall Room 50	8/1/2013	754	75	10	75		508	15
16	Connor Co - 1 Heat Pump	5/1/2014	1,891		5			1,891	16
17	Foresight - Roof	5/1/2014	5,702	570	10	570		3,420	17
18	Simplex - Fire Board Replacement	5/1/2014	1,564		5			1,564	18
19	Ehret, Inc - Replaced Switches in Water System	6/1/2014	1,133	19	5	19		1,134	19
20	Prost Heating - Upgraded McQuay System	6/1/2014	1,798	30	5	30		1,799	20
21	Simplex - 6 Dry Heats on Sprinkler System	6/1/2014	3,060	51	5	51		3,060	21
22	Simplex - 2 Sprinkler Fittings	6/1/2014	3,364	56	5	56		3,364	22
23	Murphy Company - Water Heater	8/1/2014	12,883	1,288	10	1,288		7,407	23
24	Rakers Electric - Kitchen on Generator	8/1/2014	6,123	306	5	306		6,124	24
25	Finley Flooring - Cove Base	9/1/2014	435	29	5	29		435	25
26	Prost Heating - Upgraded McQuay System - Monitor	9/1/2014	1,596	107	5	107		1,596	26
27	Rakers Electric - Emergency B/U Additions	9/1/2014	1,236	83	5	83		1,236	27
28	Simplex Grinnell - New Sprinkler Piping	9/1/2014	9,749	650	5	650		9,749	28
29	Rakers Electric - Generator Upgrades	10/1/2014	2,447	204	5	204		2,446	29
30	Simplex Grinnell - Wet Sprinkler Piping	10/1/2014	2,512	209	5	209		2,511	30
31	Simplex Grinnell - Dry Sprinkler Piping	11/1/2014	1,647	165	5	165		1,646	31
32	Essenpreis - New Water Lines	12/1/2014	1,776	178	10	178		963	32
33	Meyer Contracting - Doors	1/1/2015	1,444	144	10	144		769	33
34	TOTAL (lines 1 thru 33)		\$ 7,920,320	\$ 275,408		\$ 275,408	\$	\$ 4,525,409	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:

5/1/2019

Ending:

4/30/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,920,320	\$ 275,408		\$ 275,408	\$	\$ 4,525,409	1
2	Firestoppers - Fire Caulking for Sprinklers System Piping	3/1/2015	6,823	682	10	682		3,524	2
3	Finley Flooring	6/1/2014	1,799	180	10	180		1,065	3
4	Flooring	9/1/2013	1,761	176	10	176		1,173	4
5	Flooring	4/1/2014	951		5			951	5
6	Connor Co - Heat Pumps	5/1/2015	9,061	1,812	5	1,812		9,060	6
7	Simplex - Relay for Fire System	5/1/2015	600	120	5	120		600	7
8	Prost - McQuay Drier and Keypad Display	6/1/2015	2,329	465	5	465		2,290	8
9	City of Highland - Exterior Sign	8/1/2015	100		3			100	9
10	Digital Artz - Exterior Sign	8/1/2015	2,917		3			2,917	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		2			1,836	14
15	Kunz Capentry - Kitchenette Cabinets	8/1/2015	1,350		1			1,350	15
16	Simplex - Hood System for Deep Fryer	9/1/2015	2,525	505	5	505		2,357	16
17	Prost - McQuay Compressor	9/1/2015	4,181	836	5	836		3,902	17
18	Crest - Nurse Call Boxes	10/1/2015	711		5			711	18
19	Essempreis Plumbing - Backflow Preventor	10/1/2015	1,008	202	5	202		925	19
20	Prost Heating - Ignition Moduel on Water Heater	10/1/2015	758	152	5	152		696	20
21	Roger Echeimeier - Chemical Pump on Cooling Tower	10/1/2015	3,975	795	5	795		3,644	21
22	Simplex - Relay for Fire System	10/1/2015	909	182	5	182		834	22
23	Simplex - Relay for Fire System	10/1/2015	1,092	218	3	218		1,000	23
24	Simplex - Power Interface on Fire Alarm	10/1/2015	2,627	525	5	525		2,407	24
25	Weeke Sales - Garbage Disposal Main Kitchen	11/1/2015	2,171	217	10	217		977	25
26	Capital One - Room Signs	11/1/2015	1,157	231	5	231		1,040	26
27	Magnum Rotating - Motor For Water Pump	11/1/2015	881		2			881	27
28	Simplex - Nurse Call System	12/1/2015	2,973	595	5	595		2,628	28
29	Simplex - Extinguisher Nozzle - Kitchen	1/1/2016	2,725	545	5	545		2,362	29
30	Simplex - Fire Alarm Batteries	1/1/2016	1,322		1			1,322	30
31	Torbitts - Flooring Room 61	2/1/2016	2,145	429	5	429		1,823	31
32	Door Controls	3/1/2016	620	124	5	124		517	32
33	Essenpries Plumbing - 2 Shower Valves	3/1/2016	1,376	275	5	275		1,146	33
34	TOTAL (lines 1 thru 33)		\$ 7,985,985	\$ 284,674		\$ 284,674	\$	\$ 4,580,835	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:

5/1/2019

Ending:

4/30/2020

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	\$ 284,674		\$ 284,674		\$ 4,580,835	1
2	<u>Ideal Home Solutions - Kitchen Wash Bay</u>	3/1/2016	5,621	375	15	375		1,562	2
3	<u>Rakers Electric - Cooling Tower Motor</u>	3/1/2016	9,442	944	10	944		3,978	3
4	<u>S. Horn Const - Kitchen Wash Bay</u>	3/1/2016	842	56	15	56		234	4
5	<u>Weeke Sales - Parts for Kitchen Slicer</u>	3/1/2016	978		3			978	5
6	<u>Essenpreis Plumbing - Mixing Vavles in Kitchen</u>	4/1/2016	963	193	5	193		788	6
7	<u>Simplex Grinnell - Valve in Wet Sprinkler System</u>	4/1/2016	934		2			934	7
8	<u>Simplex Grinnell - Line Replacement in Dry Sprinkler</u>	4/1/2016	945		2			945	8
9	<u>Simplex Grinnell - Line Replacement in Beauty Shop</u>	4/1/2016	760		2			760	9
10	<u>Weeke Sales - Booster</u>	4/1/2016	5,366	671	8	671		2,740	10
11	<u>Kunz Carpentry - Kitchenette Cabinets</u>	8/1/2016	675		2			675	11
12	<u>Gerstner Plumbing - Sink Mixing Vavles</u>	8/1/2016	709		2			709	12
13	<u>Rakers Electric - Cooling Tower Improvements</u>	8/1/2016	1,240	103	3	103		1,239	13
14	<u>Simplex - Wet Sprinkler Piping - Beauty Shop</u>	8/1/2016	8,049	805	10	805		3,010	14
15	<u>Torbits - Flooring Room 30</u>	9/1/2016	1,961	392	5	392		1,438	15
16	<u>Coonor Co - Heat Pumps</u>	9/1/2016	6,153	1,236	5	1,236		4,386	16
17	<u>Dorma USA Door - Front Door Lock</u>	2/1/2017	1,151	288	3	288		1,152	17
18	<u>Essenpries - Boiler Pipe Replacement</u>	2/1/2017	3,145	629	5	629		2,044	18
19	<u>Weeke - NC Dishwasher</u>	2/1/2017	3,800	950	3	950		3,800	19
20	<u>Weeke - Pilot Assembly on Stove</u>	2/1/2017	561		2			561	20
21	<u>Prost - Flow Switches on Cooling Tower</u>	2/1/2017	786		2			786	21
22	<u>Pro-Alarm - 2 Color Cameras</u>	3/1/2017	518		2			518	22
23	<u>Climate Company - Linden DR Heat Pump Condensor</u>	3/1/2017	859	172	5	172		544	23
24	<u>Ellis & Associates - #62 Flooring</u>	4/1/2017	2,044	409	5	409		1,261	24
25	<u>Ellis & Associates - #76</u>	4/1/2017	1,234	247	5	247		761	25
26	<u>Climate Company - Condenser for ADON Office</u>	4/1/2017	859	172	5	172		530	26
27	<u>Simplex - Sprinkler Pipe</u>	7/1/2016	22,719	3,982	5	3,982		16,745	27
28	<u>Simplex - Dry Sprinkler Pipe</u>	12/1/2016	60,700	6,070	10	6,070		19,656	28
29	<u>Climate Company - Living Room AC Condenser</u>	4/1/2017	859	172	5	172		530	29
30	<u>Connor Co - Heat Pump</u>	9/1/2017	4,366	873	5	873		2,328	30
31	<u>Connor Co - Heat Pump</u>	10/1/2017	4,171	834	5	834		2,155	31
32	<u>Crest - Single Station Call System</u>	10/1/2017	645	134	2	134		644	32
33	<u>Door Controls - NC Side Entrance Door Closure</u>	11/1/2017	2,599		10			22	33
34	TOTAL (lines 1 thru 33)		\$ 8,141,639	\$ 304,381		\$ 304,381		\$ 4,659,248	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:

5/1/2019

Ending:

4/30/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,141,639	\$ 304,381		\$ 304,381	\$	\$ 4,659,248	1
2	<u>Ellis & Assoc</u>	9/1/2017	241	48	5	48		128	2
3	<u>Ellis & Assoc - Nurses Station Flooring</u>	8/1/2017	2,011	402	5	402		1,106	3
4	<u>Essenpreis Plumbing</u>	9/1/2017	905	302	3	302		805	4
5	<u>Essenpreis Plumbing - Boiler Piping</u>	10/1/2017	1,786	357	5	357		922	5
6	<u>Essenpreis - Boiler Valve</u>	4/1/2018	646	129	5	129		269	6
7	<u>Kelley Daniels - Phone Card</u>	6/1/2017	1,185	395	3	395		1,152	7
8	<u>Kelley Daniels - Phone System Batteries & Power Supply</u>	4/1/2018	764	153	5	153		319	8
9	<u>Parking Lot Striping</u>	11/1/2017	2,900	725	2	725		2,900	9
10	<u>Prost Heating - Boiler Room Piping</u>	11/1/2017	2,167		5			36	10
11	<u>Prost Heating - McQuay Upgrades</u>	11/1/2017	615		2			26	11
12	<u>Prost Heating - McQuay Upgrades</u>	11/1/2017	1,302		2			54	12
13	<u>Rakers Electric - Parking Lot Light & Pole</u>	9/1/2017	2,400	240	10	240		640	13
14	<u>Rakers Electric - Add Elevator & Kitchen to Generator</u>	7/1/2017	2,773	555	5	555		1,572	14
15	<u>S Horn Construction - Kitchen Dishwasher Wall Redesign</u>	7/1/2017	904	301	3	301		853	15
16	<u>Simplex - Accelerator for Wet System</u>	4/1/2018	1,491	298	5	298		621	16
17	<u>Simplex - New Pipe for Dry System</u>	4/1/2018	3,770	754	5	754		1,571	17
18	<u>Simplex - Nurse Call System Upgrade</u>	10/1/2017	832	173	2	173		832	18
19	<u>The Korte Company - Roof Hatch</u>	12/1/2017	4,637	464	10	464		1,121	19
20	<u>Torbit's - Flooring</u>	8/1/2017	717	143	5	143		393	20
21	<u>Water Cooling Equip - Drift Eliminators</u>	6/1/2017	4,975	498	10	498		1,452	21
22	<u>Weeke Sales - Cooler Fan Motor</u>	6/1/2017	1,035	207	5	207		604	22
23	<u>Weeke Sales - Garbage Disposal</u>	6/1/2017	2,948	590	5	590		1,721	23
24	<u>Weeke Sales - NC Freezer Compressor</u>	4/1/2018	819	164	5	164		342	24
25	<u>Weeke Sales - Walk-In Freezer Valves</u>	10/1/2017	1,068	356	3	356		920	25
26	<u>Connor Co - heat pump</u>	7/1/2018	2,273	455	5	455		834	26
27	<u>Capital One - Johnson Controls - sprinkler piping</u>	9/1/2018	2,371	237	10	237		395	27
28	<u>Magnum Rotating & Pumps - heat pump</u>	12/1/2018	2,565	513	5	513		727	28
29	<u>Prost Heating & Cooling - accurators for fire alarm</u>	12/1/2018	990	99	10	99		140	29
30	<u>Gateway Industrial - generator upgrades</u>	1/1/2019	1,796	180	10	180		240	30
31	<u>Cardinal Portable Buildings - shed</u>	2/2/2019	10,443	522	20	522		653	31
32	<u>City of Highland - permit for shed</u>	2/2/2019	100	5	20	5		6	32
33	<u>Essenpreis Plumbing</u>	2/2/2019	2,695	539	5	539		674	33
34	TOTAL (lines 1 thru 33)		\$ 8,207,763	\$ 314,185		\$ 314,185	\$	\$ 4,683,276	34

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,207,763	\$ 314,185		\$ 314,185	\$	\$ 4,683,276	1
2	Johnson Controls-Piping Parts and Labor	3/1/2019	4,661	466	10	466		544	2
3	Weeke Sales & Service, Inc.-Dishwasher parts/repair	3/1/2019	1,459	292	5	292		341	3
4	Essenpreis Plumbin-Piping	3/1/2019	1,407	281	5	281		328	4
5	Johnson Controls-Piping Parts and Labor	3/1/2019	3,794	379	10	379		442	5
6	Climate Co. Inc- 2 replacement A/C Heat units	4/1/2019	770	154	5	154		167	6
7	Essenpreis Plumging - piping	4/1/2019	1,268	253	5	253		274	7
8	Prost Heating & Cooling - heat pump/boiler	4/1/2019	3,136	627	5	627		679	8
9	Automatic Door Systems - board for Freedom	10/1/2018	1,109	111	10	111		176	9
10	Prost Heating - fire dampers - Freedom	10/1/2018	1,243	166	10	166		228	10
11	Crest-med equip	5/1/2019	699	350	2	350		350	11
12	Otis Elevator-repair	5/1/2019	1,843	921	2	921		921	12
13	Gateway Industrial - fix generators	5/1/2019	963	192	5	192		192	13
14	Weeke Sales - Freezer fix	5/1/2019	1,610	322	5	322		322	14
15	Weeke Sales - Dietary Steamer	5/1/2019	11,847	1,185	10	1,185		1,185	15
16	Crest-med equip	6/1/2019	837	384	2	384		384	16
17	Joerns Healthcare-Actuators/Circuit Board Covers	6/1/2019	571	105	5	105		105	17
18	Prost Heating&Cooling-Boiler valves	6/1/2019	5,562	1,020	5	1,020		1,020	18
19	Rakers Electric-Outside Post Light Repair	6/1/2019	2,384	437	5	437		437	19
20	Weeke Sales-Dishwasher	6/1/2019	3,391	622	5	622		622	20
21	World Class Const. & Painting-Painting	6/1/2019	2,688	493	5	493		493	21
22	Metro East Pond Maintenance	7/1/2019	2,561	427	5	427		427	22
23	Conner Co-Geo Console	7/1/2019	9,360	1,560	5	1,560		1,560	23
24	Finley Flooring-Flooring	7/1/2019	1,477	246	5	246		246	24
25	Rakers Electric-cooling tower	7/1/2019	1,663	277	5	277		277	25
26	Joerns Healthcare-Control Box	7/1/2019	824	229	3	229		229	26
27	World Class Const. & Painting-Painting	7/1/2019	2,688	448	5	448		448	27
28	Essenpreis-Plumbing	7/1/2019	1,755	282	5	282		282	28
29	Weeke Sales-Ice Maker Repair	7/1/2019	698	194	3	194		194	29
30	St. Jacob Auto Glass-replacement windows	7/1/2019	1,681	140	10	140		140	30
31	Mike Maedge Trucking-grounds maint.	7/1/2019	5,588	931	5	931		931	31
32	Prost Heating-Heat Pump	7/1/2019	2,937	490	5	490		490	32
33	Murphy Co-boiler leak	7/1/2019	477	133	3	133		133	33
34	TOTAL (lines 1 thru 33)		\$ 8,290,711	\$ 328,302		\$ 328,302	\$	\$ 4,697,843	34

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

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 12G, Carried Forward		\$ 8,290,711	\$ 328,302		\$ 328,302	\$	\$ 4,697,843	1
2 Aviston Lumber-Countertop	8/1/2019	692	104	5	104		104	2
3 Finley Flooring-Flooring	8/1/2019	1,279	192	5	192		192	3
4 Joerns-Actuators	8/1/2019	597	90	5	90		90	4
5 Johnson Controls-Sprinkler Maintenance	8/1/2019	9,183	689	10	689		689	5
6 Murphy Co-water storage leak	8/1/2019	850	127	5	127		127	6
7 Weeke's- Dishwasher and Hot well repair	8/1/2019	5,211	782	5	782		782	7
8 Prost Heating &Cooling-NC new boiler guages	9/1/2019	648	86	5	86		86	8
9 Torbit's-NC vinyl flooring/base plates & labot	9/1/2019	7,783	1,038	5	1,038		1,038	9
10 Weeke's-NC Latches on front line cooler	9/1/2019	627	84	5	84		84	10
11 Climate Co-NC Thermostat/Blower & labor	10/1/2019	710	83	5	83		83	11
12 Johnson Control-Sprinkler, hood, extinguisher, gauges	10/1/2019	5,864	684	5	684		684	12
13 Rakers- Wire Compressor to Generator	11/1/2019	1,000	100	5	100		100	13
14 Johnson Control-Providence Sprinkler Leak	12/1/2019	8,534	711	5	711		711	14
15 Finley Flooring-Flooring	1/1/2020	2,317	154	5	154		154	15
16 Essenpreis-Plumbing	3/1/2020	827	28	5	28		28	16
17 Johnson Control- NC sprinkler repair	4/1/2020	2,287	38	5	38		38	17
18 Johnson Control-NC sprinkler repair	4/1/2020	3,674	61	5	61		61	18
19 Weeke Sales-Freedom water pump for ice machine	9/1/2019	619	83	5	83		83	19
20 Tie Out to Support		(10)	9		9		(10)	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)		\$ 8,343,403	\$ 333,445		\$ 333,445	\$	\$ 4,702,967	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	\$ 86,536	\$ 13,899	\$ 13,899	\$		\$ 49,756	71
72	Current Year Purchases	31,117	3,008	3,008			3,008	72
73	Fully Depreciated Assets	1,065,547	6,782	6,782			1,065,547	73
74								74
75	TOTALS	\$ 1,183,200	\$ 23,689	\$ 23,689	\$		\$ 1,118,311	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	\$	\$	\$	5	\$ 6,701
77	Patient Care	Southern IL Bus	2013	52,922	5,212	5,212		10	34,313
78									
79									
80	TOTALS			\$ 59,623	\$ 5,212	\$ 5,212	\$		\$ 41,014

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)			\$ 9,604,775
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 362,346
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 362,346
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 5,862,292

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	\$ 5,904,950	\$ 195,644	\$ 3,260,717	86
87	AL - Equipment	35,963	644	34,776	87
88					88
89					89
90					90
91	TOTALS	\$ 5,940,913	\$ 196,288	\$ 3,295,493	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.

		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 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.

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	\$	2,829	\$ 104,233	\$	2,829	\$ 104,233	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		818	46,949		818	46,949	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,559	138,782		3,559	138,782	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			\$	7,206	\$ 289,964	\$	7,206	\$ 289,964	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	\$ 624,221	\$	1
2	Cash-Patient Deposits	22,359		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 678,111)	312,452		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 959,032	\$	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	14,248,353		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,278,786		16
17	Accumulated Depreciation (book methods)	(9,157,880)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	806,729		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing</u>	116,060		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,310,597	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,269,629	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,123,011	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,989		28
29	Short-Term Notes Payable	408,962		29
30	Accrued Salaries Payable	243,125		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,922		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	29,555		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Related Party</u>	2,396,221		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,250,785	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	274,936		39
40	Mortgage Payable	10,741,019		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)	\$ 11,015,955	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,266,740	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,997,111)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,269,629	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,897,562)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(566,512)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,464,074)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,533,037)	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)	\$ (1,533,037)	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)	\$ (6,997,111)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FAITH CARE CENTER

0044552

Report Period Beginning: 5/1/2019

Ending:

4/30/2020

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	\$ 4,225,173	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,225,173	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	508,107	6
7	Oxygen	508	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 508,615	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	2,014	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,066	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	29,348	18
19	Laboratory		19
20	Radiology and X-Ray	225	20
21	Other Medical Services	6,357	21
22	Laundry	27,321	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 67,331	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apt/Garden Home Revenue</u>	547,931	28
28a	<u>Misc. Income</u>	7,714	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 555,645	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,356,768	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,014,839	31
32	Health Care	2,544,070	32
33	General Administration	1,328,512	33
	B. Capital Expense		
34	Ownership	570,583	34
	C. Ancillary Expense		
35	Special Cost Centers	1,277,734	35
36	Provider Participation Fee	154,067	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,889,805	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,533,037)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,533,037)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 547,869	44
45	Private Pay - Net Inpatient Revenue	2,946,959	45
46	Medicare - Net Inpatient Revenue	730,345	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,225,173	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.

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	2,645	3,256	\$ 134,888	\$ 41.43	1
2	Assistant Director of Nursing	2,131	2,441	82,564	33.82	2
3	Registered Nurses	6,194	7,502	186,942	24.92	3
4	Licensed Practical Nurses	27,775	31,894	709,372	22.24	4
5	CNAs & Orderlies	52,404	61,209	776,919	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,529	4,093	59,312	14.49	8
9	Activity Director	2,009	2,194	42,962	19.58	9
10	Activity Assistants	5,198	5,705	86,192	15.11	10
11	Social Service Workers	2,109	2,358	36,939	15.67	11
12	Dietician					12
13	Food Service Supervisor	1,188	1,393	32,641	23.43	13
14	Head Cook	6,197	6,986	89,484	12.81	14
15	Cook Helpers/Assistants	9,316	10,232	103,807	10.15	15
16	Dishwashers	3,052	3,329	28,809	8.65	16
17	Maintenance Workers	2,903	3,345	72,739	21.75	17
18	Housekeepers	8,556	9,642	92,238	9.57	18
19	Laundry	8,556	9,642	92,238	9.57	19
20	Administrator	1,085	1,200	60,511	50.43	20
21	Assistant Administrator					21
22	Other Administrative	2,311	2,437	68,382	28.06	22
23	Office Manager					23
24	Clerical	2,262	2,553	32,484	12.72	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	571	668	7,759	11.62	31
32	Other Health Care(specify)	27,340	30,728	411,406	13.39	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,331	202,807	\$ 3,208,588 *	\$ 15.82	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	162	\$ 8,349	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	13	1,082	10a-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,660	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	8	528	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	783	\$ 55,619		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

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 - \$6,183
- (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. \$ 3,612 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. \$ 154,067
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? No Indicate the amount. \$ 0
- (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? No
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.