FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 South Fairview Ave. (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-429-2551 **Fax #** 217-429-2942

HFS ID Number:

Date of Initial License for Current Owners: 12/12/1975

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Susan McGhee **Telephone Number:** 314-587-7903
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/1/2010 to 06/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Susan McGhee
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Chad D. Kunze, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington, Suite 1800, St Louis, MO 63101
(Telephone) 614-925-4321 Fax # 314-925-4350

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 Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	154	Skilled (SNF)	154	56,210	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	154	TOTALS	154	56,210	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,275	17,820	11,310	54,405	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,275	17,820	11,310	54,405	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.79%

D. How many bed-hold days during this year were paid by the Department?
NONE (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)
Meals, Lawn, Maintenance Care, Housekeeping, & Laundry Services for IL Residents

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 154 and days of care provided 10,303

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	358,606	28,951	17,339	404,896		404,896	(3,070)	401,826			1
2	Food Purchase		410,246		410,246		410,246	(1,622)	408,624			2
3	Housekeeping	192,110	44,723		236,833		236,833		236,833			3
4	Laundry	105,312	7,561		112,873		112,873		112,873			4
5	Heat and Other Utilities			183,363	183,363		183,363	(15,828)	167,535			5
6	Maintenance	108,043	15,867	53,802	177,712		177,712	21,180	198,892			6
7	Other (specify):* Trash Removal			13,575	13,575		13,575		13,575			7
8	TOTAL General Services	764,071	507,348	268,079	1,539,498		1,539,498	660	1,540,158			8
	B. Health Care and Programs											
9	Medical Director			38,400	38,400		38,400		38,400			9
10	Nursing and Medical Records	3,319,068	593,400	41,111	3,953,579	(286,303)	3,667,276		3,667,276			10
10a	Therapy			1,411,787	1,411,787		1,411,787		1,411,787			10a
11	Activities	107,375	7,357		114,732		114,732	(62)	114,670			11
12	Social Services	123,828	2,784	4,996	131,608		131,608		131,608			12
13	CNA Training											13
14	Program Transportation			560	560		560		560			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,550,271	603,541	1,496,854	5,650,666	(286,303)	5,364,363	(62)	5,364,301			16
	C. General Administration											
17	Administrative	156,206	145	682,438	838,789		838,789	(600,369)	238,420			17
18	Directors Fees											18
19	Professional Services			41,135	41,135		41,135	29,848	70,983			19
20	Dues, Fees, Subscriptions & Promotions			23,928	23,928		23,928	6,956	30,884			20
21	Clerical & General Office Expenses	163,509	21,525	158,173	343,207		343,207	128,067	471,274			21
22	Employee Benefits & Payroll Taxes			891,402	891,402		891,402	43,339	934,741			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,338	11,338		11,338	13,890	25,228			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			113,170	113,170		113,170	1,187	114,357			26
27	Other (specify):* Marketing	113,179	4,717	16,470	134,366		134,366	(134,366)				27
28	TOTAL General Administration	432,894	26,387	1,938,054	2,397,335		2,397,335	(511,448)	1,885,887			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,747,236	1,137,276	3,702,987	9,587,499	(286,303)	9,301,196	(510,850)	8,790,346			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Havens Christian Home #0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			382,657	382,657		382,657	25,019	407,676			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,860	71,860		71,860	(66,280)	5,580			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,400	33,400		33,400	5,629	39,029			35
36	Other (specify):* Finan. Fee/ Fines			552	552		552	(552)				36
37	TOTAL Ownership			488,469	488,469		488,469	(36,184)	452,285			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			99,470	99,470	286,303	385,773	(35,302)	350,471			39
40	Barber and Beauty Shops	8,050	387	35,191	43,628		43,628		43,628			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,315	84,315		84,315		84,315			42
43	Other (specify):* Apt/ Congregate			58,054	58,054		58,054	(58,054)				43
44	TOTAL Special Cost Centers	8,050	387	277,030	285,467	286,303	571,770	(93,356)	478,414			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,755,286	1,137,663	4,468,486	10,361,435		10,361,435	(640,390)	9,721,045			45

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	(1,622)	2		4
5	Telephone, TV & Radio in Resident Rooms	(18,318)	5		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	(67,159)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,046)	21		24
25	Fund Raising, Advertising and Promotional	(134,366)	27		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	(63,064)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (352,575)		$	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)	(287,815)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (287,815)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (640,390)		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	X		286,303	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 286,303		47

Fair Havens Christian Home

ID# 0018143

Report Period Beginning: 07/1/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment/Congregate	$ (58,054)	43	1
2	Vending Revenue	(3,070)	1	2
3	Activity Revenue	(62)	11	3
4	Increase in Cash Value of Life Insurance	(343)	17	4
5	Charity Care	(492)	21	5
6	Fines & Penalties	(552)	36	6
7	Misc Revenue	(418)	21	7
8	Late Fees	(73)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,064)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** 07/1/2010 **Ending:** 06/30/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,070)	0	0	0	0	0	0	0	0	0	0	(3,070)	1
2	Food Purchase	(1,622)	0	0	0	0	0	0	0	0	0	0	(1,622)	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	(18,318)	2,490	0	0	0	0	0	0	0	0	0	(15,828)	5
6	Maintenance	0	21,180	0	0	0	0	0	0	0	0	0	21,180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,010)	23,670	0	0	0	0	0	0	0	0	0	660	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	(62)	0	0	0	0	0	0	0	0	0	0	(62)	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**	(62)	0	0	0	0	0	0	0	0	0	0	(62)	16
	C. General Administration													
17	Administrative	(343)	(600,026)	0	0	0	0	0	0	0	0	0	(600,369)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	29,848	0	0	0	0	0	0	0	0	0	29,848	19
20	Fees, Subscriptions & Promotions	0	6,956	0	0	0	0	0	0	0	0	0	6,956	20
21	Clerical & General Office Expenses	(69,029)	197,096	0	0	0	0	0	0	0	0	0	128,067	21
22	Employee Benefits & Payroll Taxes	0	43,339	0	0	0	0	0	0	0	0	0	43,339	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,890	0	0	0	0	0	0	0	0	0	13,890	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	1,187	0	0	0	0	0	0	0	0	0	1,187	26
27	Other (specify):*	(134,366)	0	0	0	0	0	0	0	0	0	0	(134,366)	27
28	**TOTAL General Administration**	(203,738)	(307,710)	0	0	0	0	0	0	0	0	0	(511,448)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(226,810)	(284,040)	0	0	0	0	0	0	0	0	0	(510,850)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** 07/1/2010 **Ending:** 06/30/2011

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	25,019	0	0	0	0	0	0	0	0	0	25,019	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67,159)	879	0	0	0	0	0	0	0	0	0	(66,280)	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	5,629	0	0	0	0	0	0	0	0	0	5,629	35
36	Other (specify):*	(552)	0	0	0	0	0	0	0	0	0	0	(552)	36
37	**TOTAL Ownership**	(67,711)	31,527	0	0	0	0	0	0	0	0	0	(36,184)	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	(35,302)	0	0	0	0	0	0	0	0	0	(35,302)	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):*	(58,054)	0	0	0	0	0	0	0	0	0	0	(58,054)	43
44	**TOTAL Special Cost Centers**	(58,054)	(35,302)	0	0	0	0	0	0	0	0	0	(93,356)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(352,575)	(287,815)	0	0	0	0	0	0	0	0	0	(640,390)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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
See attached listing of board members						

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	$ 2,490	$ 2,490	1
2	V	6	Maintenance				21,180	21,180	2
3	V	17	Administrative	682,438			82,412	(600,026)	3
4	V	19	Professional Services				29,848	29,848	4
5	V	21	Clerical				197,096	197,096	5
6	V	22	Employee Benefits				43,339	43,339	6
7	V	24	Travel and Seminars				13,890	13,890	7
8	V	26	Insurance				1,187	1,187	8
9	V	30	Depreciation				25,019	25,019	9
10	V	32	Interest				879	879	10
11	V	20	Dues and Subscriptions				6,956	6,956	11
12	V	35	Rental and Leasing				5,629	5,629	12
13	V	39	Pharmacy Services	357,670	Senior Care Pharmacy Services	0.00%	322,368	(35,302)	13
14	Total			$ 1,040,108			$ 752,293	$ * (287,815)	14

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		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 Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 6/30/2011

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		This workpaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority	X		Refinance old debt		6/30/2007	$ 1,070,306	$ 1,042,235	6/30/2031	0.0567	$ 57,561	1
2	Bond Fund	X		refinance debt	$1,192.00	*	256,682	241,253	6/30/2032	0.0572	14,299	2
3												3
4	* This is an allocation of the total GO bond debt which includes several different series with several different rates of interest.											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,192.00		$ 1,326,988	$ 1,283,488			$ 71,860	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,326,988	$ 1,283,488			$ 71,860	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** 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.)**

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 07/1/2010 **Ending:** 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	See attached	$ 846.68	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 846.68	$

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? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,500 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	56,500	1972	$ 54,638	1
2	Home Office Allocation			7,634	2
3	TOTALS	56,500		$ 62,272	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	148		1977	1977	$ 2,180,767	$ 53,450	40	$ 53,450	$	$ 1,821,759	4
5					384,841		20				5
6	6		1983	1983	109,815	2,745	35	2,745		75,497	6
7	Home Office Allocation				78,931	5,094		5,094		181,280	7
8											8
	Improvement Type**										
9	1979 Fixed Assets			1979	4,652		Various			4,652	9
10	1980 Fixed Assets			1980	2,151		Various			2,151	10
11	1981 Fixed Assets			1981	15,377		Various			15,377	11
12	1982 Fixed Assets			1982	24,663		Various			24,663	12
13	1983 Fixed Assets			1983	5,616	90	Various	90		5,481	13
14	1984 Fixed Assets			1984	179,296	4,166	Various	4,166		126,372	14
15	1985 Fixed Assets			1985	18,774		Various			18,774	15
16	1986 Fixed Assets			1986	2,419		Various			2,419	16
17	1987 Fixed Assets			1987	9,430		Various			9,430	17
18	1989 Fixed Assets			1989	2,539		Various			2,539	18
19	1990 Fixed Assets			1990	4,299		Various			4,299	19
20	1991 Fixed Assets			1991	12,523		Various			12,523	20
21	1992 Fixed Assets			1992	39,498	436	Various	436		39,099	21
22	1993 Fixed Assets			1993	28,684	617	Various	617		27,553	22
23	1994 Fixed Assets			1994	15,202	523	Various	523		13,500	23
24	1995 Fixed Assets			1995	28,628	10	Various	10		28,628	24
25	1996 Fixed Assets			1996	36,384		Various			36,384	25
26	1997 Fixed Assets			1997	40,214	732	Various	732		35,579	26
27	1998 Fixed Assets			1998	74,889		Various			74,889	27
28	1999 Fixed Assets			1999	71,014	1,831	Various	1,831		65,973	28
29	2000 Fixed Assets			2000	27,724	422	Various	422		27,428	29
30	2001 Fixed Assets			2001	17,531	324	Various	324		11,779	30
31	2002 Fixed Assets			2002	50,352	1,642	Various	1,642		45,139	31
32	2003 Fixed Assets			2003	125,085	11,086	Various	11,086		85,906	32
33	2004 Fixed Assets			2004	58,354	441	Various	441		41,148	33
34	2005 Fixed Assets			2005	114,128	10,808	Various	10,808		86,913	34
35	2006 Fixed Assets			2006	76,557	12,305	Various	12,305		62,051	35
36	2007 Fixed Assets			2007	320,848	33,434	Various	33,434		124,634	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 Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	
37	Therapy Gym remodeling	2008	$ 17,308	$ 1,731	10	$ 1,731	$	$ 6,058	37
38	Part of wallpaper remodel	2008	805	80	10	80		281	38
39	Door protectors	2008	3,652	365	10	365		1,278	39
40	Wallpaper remodel	2008	569	57	10	57		199	40
41	Wallpaper remodel	2008	10,000	1,000	10	1,000		3,500	41
42	Wallpaper remodel	2008	770	77	10	77		270	42
43	Frame guards	2008	5,589	559	10	559		1,956	43
44	Install 4 wall-mount battery back up	2008	512	51	10	51		179	44
45	Painting station #4	2008	2,950	295	10	295		1,033	45
46	Retainage fee for wallpaper remodel project	2008	7,049	705	10	705		2,408	46
47	Painting walls- Units 1,2,3	2008	144,450	14,445	10	14,445		49,354	47
48	Wallpaper remodel	2008	710	71	10	71		237	48
49	Nurse Call system	2008	61,541	6,154	10	6,154		20,514	49
50	Installation of hallway lights	2008	14,524	1,452	10	1,452		4,841	50
51	Paint/Wallpaper remodel	2008	1,669	334	5	334		1,113	51
52	Wallpaper remodel	2008	2,368	474	5	474		1,500	52
53	Counter tops for offices	2008	1,411	141	10	141		447	53
54	Door Wander guard system	2008	26,523	2,652	5	2,652		8,399	54
55	Trane Evaporator coil	2008	7,210	1,442	5	1,442		4,446	55
56	Station #4 Remodeling Project	2008	14,000	1,399	10	1,399		4,197	56
57	Fire Alarm System	2008	1,350	135	10	135		405	57
58	Fire Alarm Equipment	2008	30,993	3,099	10	3,099		9,039	58
59	Fire Alarm Equipment	2008	13,836	1,268	10	1,268		3,883	59
60	Fire Alarm Equipment	2008	3,346	334	10	334		975	60
61	Toilet Seats - Resident Bathrooms	2008	5,625	1,125	5	1,125		3,281	61
62	Fire Alarm System	2008	11,649	1,164	10	1,164		3,202	62
63	Wheelchair Accessible Curb	2008	1,050	105	10	105		289	63
64	Fire Alarm System	2008	16,101	1,610	10	1,610		4,293	64
65	Tile Flooring - Front Lobby	2008	17,602	1,760	10	1,760		4,693	65
66	Oxygen Room - Instal Fan	2008	1,629	163	10	163		421	66
67	Exterior Lighting	2008	2,750	275	10	275		711	67
68	Oxygen Storage Room	2008	6,627	663	10	663		1,713	68
69	Fire Alarm System	2009	1,151	115	10	115		288	69
70	TOTAL (lines 4 thru 69)		$ 4,598,502	$ 185,457		$ 185,457	$	$ 3,259,220	70

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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		$ 4,598,502	$ 185,457	10	$ 185,457	$	$ 3,259,220	1
2	Fire Alarm System	2009	14,396	1,440	10	1,440		3,360	2
3	Blinds	2009	896	104	10	104		208	3
4	2 Side Entry Tub	2009	17,547	1,755	10	1,755		3,802	4
5	Locks	2009	8,320	69	5	69		208	5
6	Vinyl Flooring	2009	9,766	1,953	10	1,953		4,069	6
7	Artwork	2009	21,044	2,104	10	2,104		4,383	7
8	Cabinets - Nurses Station and Office	2009	15,750	1,575	10	1,575		3,281	8
9	Water Closets	2009	8,540	854	10	854		1,779	9
10	Window Treatments	2009	15,688	1,569	10	1,569		3,269	10
11	Mixing Valve	2009	966	97	10	97		202	11
12	Designer Services	2009	1,200	120	10	120		240	12
13	Shower room repairs	2009	1,630	149	10	149		475	13
14	Prayer decals for windows	2009	968	88	10	88		185	14
15	New roof	2009	372,567	34,151	10	34,151		71,408	15
16	Water replacement	2009	142	13	10	13		27	16
17	Ceramic tile	2009	143	13	10	13		27	17
18	Ceramic tile	2009	2,152	197	10	197		412	18
19	Ceramic tile	2009	1,233	113	10	113		236	19
20	Shower room tile replacement	2009	1,182	99	10	99		217	20
21	Ceramic tile for shower rooms	2009	5,707	476	10	476		1,047	21
22	Tapered Rod Pocket Valance	2009	202	17	10	17		37	22
23	Landscape deposit	2009	19,000	1,583	10	1,583		3,483	23
24	Completion of shower rooms	2009	1,211	101	10	101		222	24
25	Ceramic tile Trane heat Pump/ Air handler	2009	5,520	460	10	460		1,012	25
26	Install trane air handler	2009	307	26	10	26		57	26
27	New water heaters	2009	57,980	4,349	10	4,349		10,147	27
28	Water replacement project	2009	1,469	110	10	110		257	28
29	Ceramic tile for shower rooms	2009	2,631	197	10	197		460	29
30	Glass replacement	2009	2,631	197	10	197		460	30
31	shower romodel	2009	1,376	103	10	103		241	31
32	Shower room remodel	2009	5,889	442	10	442		1,031	32
33	Shower room remodel	2009	2,176	163		163		381	33
34	TOTAL (lines 1 thru 33)		$ 5,198,730	$ 240,144		$ 240,144	$	$ 3,375,843	34

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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		$ 5,198,730	$ 240,144		$ 240,144	$	$ 3,375,843	1
2	Shower room remodel	2009	75	6	10	6		14	2
3	Installation of Trane	2009	2,631	197	10	197		460	3
4	Shower room remodel	2009	509	38	10	38		89	4
5	Area Rugs	2009	310	21	10	21		52	5
6	Landscaping- 2009	2009	18,256	1,217	10	1,217		3,043	6
7	Light Fixtures	2009	610	30	10	30		91	7
8	Painting of shower rooms	2010	923	69	10	69		161	8
9	Painting of Shower Room	2010	408	24	10	24		65	9
10	New Signage	2010	10,520	175	10	175		1,227	10
11	Landscaping	2010	5,090	42	10	42		551	11
12	Asphalt Paving of Parking lot	2010	32,989	275	10	275		3,573	12
13	Electric Panael & Circuitry for Generator	2010	22,765	190	10	190		2,467	13
14	Roof Top A/C for Dining Room	2010	13,403	112	10	112		1,452	14
15	Dryer Vents	2010	651	6	10	6		71	15
16	A/C for Therapy Room	2010	4,295	36	10	36		466	16
17	Painting of Shower Room	2010	265	9	10	9		36	17
18	Remove Tile	2010	848	7	10	7		92	18
19	Corinthian Mosiac and Installation of Tile	2010	8,984	75	10	75		973	19
20	Ceramic Tile and Base	2010	115	1	10	1		12	20
21	Shower Fixtures	2010	1,096	9	10	9		119	21
22	Shower Curtains	2010	608	5	10	5		66	22
23	Wall Protectors and Curtains	2010	7,558	63	10	63		819	23
24	Height Adjustable Supine Tub	2010	9,791	1,145	10	1,145		1,145	24
25	Side Entry Tub	2010	8,803	1,029	10	1,029		1,029	25
26	Cabinets for Beauty Shop	2011	3,800	254	10	254		254	26
27	Beauty Shop - Flooring	2011	691	29	10	29		29	27
28	Awning	2011	2,625	88	10	88		88	28
29	Hinds Environmental Testing Tiles	2011	5,610	142	10	142		142	29
30	Trane	2011	8,154	206	10	206		206	30
31	Smoke Hut for Staff	2011	4,700	39	10	39		4,661	31
32	Nursing Storage Shed	2011	3,905	33	10	33		3,872	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,379,717	$ 245,717		$ 245,717	$	$ 3,403,167	34

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	$ 736,211	$ 100,914	$ 106,471	$ 5,557		$ 368,009	71
72	Current Year Purchases	116,410	11,914	11,914			11,914	72
73	Fully Depreciated Assets	657,618	5,625	5,625			657,618	73
74	Home Office Allocation	374,221	24,149	24,149			41,522	74
75	TOTALS	$ 1,884,460	$ 142,602	$ 148,159	$ 5,557		$ 1,079,063	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 Transportation	2006 Ford El Dorado Aerotec	2/1/2006	$ 52,505	$	$	$		$ 52,505	76
77										77
78										78
79	Home Office Allocation			46,191	2,981	2,981			19,343	79
80	TOTALS			$ 98,696	$ 2,981	$ 2,981	$		$ 71,848	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,425,145	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 391,300	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 396,857	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,557	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,554,078	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	Land	$ 47,237	$	$	86
87	Duplex Building and Equipment	947,622	28,311	623,042	87
88					88
89					89
90					90
91	TOTALS	$ 994,859	$ 28,311	$ 623,042	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 56,557	92
93	Home Office Allocation	72,972	93
94			94
95		$ 129,529	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 Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 33,383 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   Fair Havens only hires certified CNAs

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)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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	$	10,114	$ 570,423	$	10,114	$ 570,423	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		6,107	290,999		6,107	290,999	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		15,179	550,365		15,179	550,365	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			$	31,400	$ 1,411,787	$	31,400	$ 1,411,787	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.

STATE OF ILLINOIS

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 07/1/2010 **Ending:** 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,655,165	$	1
2	Cash-Patient Deposits	23,278		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 102,841)	798,088		3
4	Supply Inventory (priced at)	27,717		4
5	Short-Term Investments	1,476,996		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,768		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accr Int/ Oth A/R	16,026		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,012,038	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,875		13
14	Buildings, at Historical Cost	6,015,336		14
15	Leasehold Improvements, at Historical Cost	188,736		15
16	Equipment, at Historical Cost	1,627,350		16
17	Accumulated Depreciation (book methods)	(4,952,017)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	836,351		21
22	Other Long-Term Assets (spe CIP	56,557		22
23	Other(specify): Other Assets	7,893		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,882,081	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,894,119	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 427,366	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,278		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	289,496		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	423		32
33	Accrued Interest Payable	20,334		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	18,063		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 778,960	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,283,488		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	121,659		43
44	Due Life Right Residents	124,237		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,529,384	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,308,344	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,585,775	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,894,119	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** 07/1/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,002,973	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,002,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,582,802	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)**	$ 1,582,802	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)**	$ 11,585,775	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,122,231	1
2	Discounts and Allowances for all Levels	(2,952,170)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,170,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,679,683	6
7	Oxygen	62,902	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,742,585	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	55,560	13
14	Non-Patient Meals	1,622	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	493,491	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,887	19
20	Radiology and X-Ray	50,661	20
21	Other Medical Services	38,189	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 681,410	23
	D. Non-Operating Revenue		
24	Contributions	38,943	24
25	Interest and Other Investment Income***	67,159	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 106,102	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	98,916	28
28a	Gain/Loss on Investments and Miscellaneous	145,163	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 244,079	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,944,237	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,539,498	31
32	Health Care	5,650,666	32
33	General Administration	2,397,335	33
	B. Capital Expense		
34	Ownership	488,469	34
	C. Ancillary Expense		
35	Special Cost Centers	201,152	35
36	Provider Participation Fee	84,315	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,361,435	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,582,802	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,582,802	43

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

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

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	2,127	$ 62,231	$ 29.26	1
2	Assistant Director of Nursing	1,301	1,385	43,778	31.61	2
3	Registered Nurses	14,433	15,535	412,848	26.57	3
4	Licensed Practical Nurses	35,744	39,041	841,376	21.55	4
5	CNAs & Orderlies	141,440	152,261	1,789,671	11.75	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,778	2,000	32,315	16.16	9
10	Activity Assistants	7,633	8,157	75,060	9.20	10
11	Social Service Workers	6,442	6,914	123,828	17.91	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,826	2,000	51,394	25.70	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	29,990	32,368	307,212	9.49	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	5,243	5,845	108,043	18.49	17
18	Housekeepers	20,572	21,778	192,110	8.82	18
19	Laundry	6,197	7,071	105,312	14.89	19
20	Administrator	2,040	2,160	136,703	63.29	20
21	Assistant Administrator	628	674	19,503	28.94	21
22	Other Administrative	1,837	1,991	50,168	25.19	22
23	Office Manager	1,794	2,000	32,188	16.09	23
24	Clerical	5,674	6,208	81,153	13.07	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	4,322	4,681	63,244	13.51	31
32	Other Health C: MDS Coordinator	3,886	4,308	105,920	24.59	32
33	Other(specify) Marketing/ beatici	4,618	5,126	121,229	23.65	33
34	TOTAL (lines 1 - 33)	299,407	323,628	$ 4,755,286 *	$ 14.69	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	347	$ 17,240	3.1.3	35
36	Medical Director	416	38,400	3.9.3	36
37	Medical Records Consultant	27	1,945	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	4,782	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	81	4,996	3.12.3	45
46	Other(specify) Dental	8	800	3.10.3	46
47	Interim DON	122	11,034	3.10.3	47
48					48
49	TOTAL (lines 35 - 48)	1,192	$ 79,197		49

C. CONTRACT NURSES

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Brown	Executive Director	0	$ 136,703
Ricky Goveia	Administration Assistant	0	19,503
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,206

B. Administrative - Other

Description	Amount
Management Fee	$ 682,438
TOTAL (agree to Schedule V, line 17, col. 3)	$ 682,438
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell LLC	Legal	$ 1,802
My Innerview	Employee Survey	958
BKD, LLP	Accounting	2,080
LarsonAllen LLP	Accounting	36,295
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 41,135

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,820
Unemployment Compensation Insurance	67,582
FICA Taxes	347,086
Employee Health Insurance	355,224
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,580
Employee Expense	22,644
457 Plan Expense	5,250
Employee Uniforms	(1,784)
Home Office Allocation	43,339
TOTAL (agree to Schedule V, line 22, col.8)	$ 934,741

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	11,872
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,700
License	140
Dues	8,372
Subscriptions	1,844
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,928

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,784
In-State Travel	5,838
Seminar Expense	2,716
Home Office Allocation	13,890
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,228

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07/1/2010 Ending: 06/30/2011

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. **LSN & AAHSA, $8702.67**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **105,284** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **84,315**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,622**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
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: **LarsonAllen, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.