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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 South Fairview Avenue (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 07-01-2011 to 06/30/2012 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) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, 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: 07-01-2011 Ending: 06/30/2012

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	56,364	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	56,364	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	24,398	18,643	9,799	52,840	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,398	18,643	9,799	52,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.75%

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 9,384

Medicare Intermediary Wiconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	364,895	25,211	15,857	405,963		405,963	(1,086)	404,877			1
2	Food Purchase		394,994		394,994		394,994	(1,818)	393,176			2
3	Housekeeping	198,445	48,093		246,538		246,538		246,538			3
4	Laundry	113,518	8,840		122,358		122,358		122,358			4
5	Heat and Other Utilities			177,379	177,379	(14,621)	162,758	(17,726)	145,032			5
6	Maintenance	109,924	11,255	52,915	174,094		174,094	4,258	178,352			6
7	Other (specify):* Trash Removal					14,621	14,621		14,621			7
8	**TOTAL General Services**	786,782	488,393	246,151	1,521,326		1,521,326	(16,372)	1,504,954			8
	B. Health Care and Programs											
9	Medical Director			40,350	40,350		40,350		40,350			9
10	Nursing and Medical Records	3,485,917	548,698	155,934	4,190,549	(247,048)	3,943,501	(3,995)	3,939,506			10
10a	Therapy			970,720	970,720		970,720		970,720			10a
11	Activities	109,564	8,525		118,089		118,089	70	118,159			11
12	Social Services	120,262	1,744	5,814	127,820		127,820		127,820			12
13	CNA Training											13
14	Program Transportation			262	262		262		262			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,715,743	558,967	1,173,080	5,447,790	(247,048)	5,200,742	(3,925)	5,196,817			16
	C. General Administration											
17	Administrative	101,432	315	687,254	789,001		789,001	(593,601)	195,400			17
18	Directors Fees											18
19	Professional Services			36,334	36,334		36,334	49,391	85,725			19
20	Dues, Fees, Subscriptions & Promotions			36,441	36,441		36,441		36,441			20
21	Clerical & General Office Expenses	177,515	16,222	192,436	386,173		386,173	172,936	559,109			21
22	Employee Benefits & Payroll Taxes			955,276	955,276		955,276	46,652	1,001,928			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,171	13,171		13,171	17,088	30,259			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			119,639	119,639		119,639	(10,102)	109,537			26
27	Other (specify):* Marketing	85,931	4,156	11,419	101,506		101,506	(101,506)				27
28	**TOTAL General Administration**	364,878	20,693	2,051,970	2,437,541		2,437,541	(419,142)	2,018,399			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,867,403	1,068,053	3,471,201	9,406,657	(247,048)	9,159,609	(439,439)	8,720,170			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: 07-01-2011 Ending: 06/30/2012

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			407,614	407,614		407,614	34,167	441,781			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,180	59,180		59,180	(57,345)	1,835			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,251	16,251		16,251		16,251			35
36	Other (specify):*											36
37	**TOTAL Ownership**			483,045	483,045		483,045	(23,178)	459,867			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			94,213	94,213	247,048	341,261	(48,916)	292,345			39
40	Barber and Beauty Shops	6,140	385	39,026	45,551		45,551		45,551			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			413,649	413,649		413,649		413,649			42
43	Other (specify):*			55,880	55,880		55,880	(55,880)				43
44	**TOTAL Special Cost Centers**	6,140	385	602,768	609,293	247,048	856,341	(104,796)	751,545			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,873,543	1,068,438	4,557,014	10,498,995		10,498,995	(567,413)	9,931,582			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: 07-01-2011 Ending: 06/30/2012

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	(1,818)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19,407)	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	(72,985)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,995)	10		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	(1,315)	21		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	(44,338)	21		24
25	Fund Raising, Advertising and Promotional	(101,506)	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	(56,896)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (302,260)		$	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)	(265,153)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (265,153)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (567,413)		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	S		247,048	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 247,048		47

STATE OF ILLINOIS **Page 5A**

Fair Havens Christian Home

ID# **0018143**

Report Period Beginning: **07-01-2011**

Ending: **06/30/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment/Congregate	$ (55,880)	43	1
2	Vending Revenue	(1,086)	1	2
3	Activity Revenue	70	11	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
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**	(56,896)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** 07-01-2011 **Ending:** 06/30/2012

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	(1,086)	0	0	0	0	0	0	0	0	0	0	(1,086)	1
2	Food Purchase	(1,818)	0	0	0	0	0	0	0	0	0	0	(1,818)	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	(19,407)	1,681	0	0	0	0	0	0	0	0	0	(17,726)	5
6	Maintenance	0	4,258	0	0	0	0	0	0	0	0	0	4,258	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22,311)	5,939	0	0	0	0	0	0	0	0	0	(16,372)	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	(3,995)	0	0	0	0	0	0	0	0	0	0	(3,995)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	70	0	0	0	0	0	0	0	0	0	0	70	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**	(3,925)	0	0	0	0	0	0	0	0	0	0	(3,925)	16
	C. General Administration													
17	Administrative	0	(593,601)	0	0	0	0	0	0	0	0	0	(593,601)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	49,391	0	0	0	0	0	0	0	0	0	49,391	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(45,653)	218,589	0	0	0	0	0	0	0	0	0	172,936	21
22	Employee Benefits & Payroll Taxes	0	46,652	0	0	0	0	0	0	0	0	0	46,652	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,088	0	0	0	0	0	0	0	0	0	17,088	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	(10,102)	0	0	0	0	0	0	0	0	0	(10,102)	26
27	Other (specify):*	(101,506)	0	0	0	0	0	0	0	0	0	0	(101,506)	27
28	**TOTAL General Administration**	(147,159)	(271,983)	0	0	0	0	0	0	0	0	0	(419,142)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,395)	(266,044)	0	0	0	0	0	0	0	0	0	(439,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 07-01-2011 **Ending:** 06/30/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	34,167	0	0	0	0	0	0	0	0	0	34,167	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72,985)	15,640	0	0	0	0	0	0	0	0	0	(57,345)	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**	(72,985)	49,807	0	0	0	0	0	0	0	0	0	(23,178)	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	(48,916)	0	0	0	0	0	0	0	0	0	(48,916)	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):*	(55,880)	0	0	0	0	0	0	0	0	0	0	(55,880)	43
44	**TOTAL Special Cost Centers**	(55,880)	(48,916)	0	0	0	0	0	0	0	0	0	(104,796)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(302,260)	(265,153)	0	0	0	0	0	0	0	0	0	(567,413)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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%	$ 1,681	$ 1,681	1
2	V	6	Maintenance				4,258	4,258	2
3	V	17	Administrative	687,254			93,653	(593,601)	3
4	V	19	Professional Services				49,391	49,391	4
5	V	21	Clerical				218,589	218,589	5
6	V	22	Employee Benefits				46,652	46,652	6
7	V	24	Travel and Seminars				17,088	17,088	7
8	V	26	Insurance				(10,102)	(10,102)	8
9	V	30	Depreciation				34,167	34,167	9
10	V	32	Interest				15,640	15,640	10
11	V								11
12	V								12
13	V	39	Pharmacy Services	247,048	Senior Care Pharmacy Services	0.00%	198,132	(48,916)	13
14	Total			$ 934,302			$ 669,149	$ * (265,153)	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: 07-01-2011 Ending: 06/30/2012

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: 07-01-2011 Ending: 6/30/2012

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: 07-01-2011 Ending: 06/30/2012

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		6/15/2007	$ 1,070,306	$ 1,012,158	5/15/2031	5.6700	$ 45,623	1
2	Bond Fund	X		refinance debt	$1,327.00		256,682	229,091	6/30/2032	5.7200	13,557	2
3	* This is an allocation of the total GO bond debt which includes several different series with several different rates of interest.											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,327.00		$ 1,326,988	$ 1,241,249			$ 59,180	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	$ 1,241,249			$ 59,180	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:** 07-01-2011 **Ending:** 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	See Attachment	$ 834.64	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 834.64	$

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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).

10-unit Duplex/Independent Living facility

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			7,165	2
3	TOTALS	56,500		$ 61,803	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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	$	$ 1,875,209	4
5					384,841						5
6	6		1983	1983	109,815	2,745	35	2,745		78,242	6
7	Home Office Allocation				70,209	7,968		7,968		43,262	7
8											8
	Improvement Type**										
9	1979 Fixed Assets			12/31/1979	4,652		Various			4,652	9
10	1980 Fixed Assets			12/31/1980	2,151		Various			2,151	10
11	1981 Fixed Assets			12/31/1981	15,377		Various			15,377	11
12	1982 Fixed Assets			12/31/1982	24,663		Various			24,663	12
13	1983 Fixed Assets			12/31/1983	5,616	90	Various	90		5,571	13
14	1984 Fixed Assets			12/31/1984	179,296	4,166	Various	4,166		130,538	14
15	1985 Fixed Assets			12/31/1985	18,774		Various			18,774	15
16	1986 Fixed Assets			12/31/1986	2,419		Various			2,419	16
17	1987 Fixed Assets			12/31/1987	9,430		Various			9,430	17
18	1989 Fixed Assets			12/31/1989	2,539		Various			2,539	18
19	1990 Fixed Assets			12/31/1990	4,299		Various			4,299	19
20	1991 Fixed Assets			12/31/1991	12,523		Various			12,523	20
21	1992 Fixed Assets			12/31/1992	39,498	399	Various	399		39,498	21
22	1993 Fixed Assets			12/31/1993	28,684	617	Various	617		28,170	22
23	1994 Fixed Assets			12/31/1994	15,202	523	Various	523		14,023	23
24	1995 Fixed Assets			12/31/1995	22,543		Various			22,543	24
25	1996 Fixed Assets			12/31/1996	36,384		Various			36,384	25
26	1997 Fixed Assets			12/31/1997	38,844	732	Various	732		38,844	26
27	1998 Fixed Assets			12/31/1998	74,889		Various			74,889	27
28	1999 Fixed Assets			12/31/1999	70,133	1,772	Various	1,772		66,976	28
29	2000 Fixed Assets			12/31/2000	27,724	296	Various	296		27,724	29
30	2001 Fixed Assets			12/31/2001	17,531	324	Various	324		12,103	30
31	2002 Fixed Assets			12/31/2002	48,833	1,642	Various	1,642		46,781	31
32	2003 Fixed Assets			12/31/2003	125,085	11,086	Various	11,086		96,992	32
33	2004 Fixed Assets			12/31/2004	58,354	441	Various	441		41,589	33
34	2005 Fixed Assets			12/31/2005	114,128	10,808	Various	10,808		97,721	34
35	2006 Fixed Assets			12/31/2006	76,006	12,250	Various	12,250		73,989	35
36	2007 Fixed Assets			12/31/2007	320,848	33,434	Various	33,434		158,068	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: 07-01-2011 Ending: 06/30/2012

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	2008 Fixed Assets	12/31/2008	$ 436,166	$ 45,186	Various	$ 45,186	$	$ 190,299	37
38	Fire Alarm System	1/19/2009	1,151	115	10	115		288	38
39	Fire Alarm System	3/1/2009	14,396	1,440	10	1,440		4,800	39
40	Blinds	5/12/2009	896	104	10	104		312	40
41	2 Side Entry Tub	5/14/2009	17,547	1,755	10	1,755		5,557	41
42	Locks	6/1/2009	8,320	69	5	69		277	42
43	Vinyl Flooring	6/5/2009	9,766	1,953	10	1,953		6,022	43
44	Artwork	6/23/2009	21,044	2,104	10	2,104		6,487	44
45	Cabinets - Nurses Station and Office	6/23/2009	15,750	1,575	10	1,575		4,856	45
46	Water Closets	6/24/2009	8,540	854	10	854		2,633	46
47	Window Treatments	6/26/2009	15,688	1,569	10	1,569		4,838	47
48	Mixing Valve	6/30/2009	966	97	10	97		299	48
49	Designer Services	7/17/2009	1,200	120	10	120		360	49
50	Shower room repairs	8/5/2009	1,630	149	10	149		624	50
51	Prayer decals for windows	8/10/2009	968	88	10	88		273	51
52	New roof	8/21/2009	372,567	34,151	10	34,151		105,559	52
53	Water replacement	8/26/2009	142	13	10	13		40	53
54	Ceramic tile	8/28/2009	143	13	10	13		40	54
55	Ceramic tile	8/28/2009	2,152	197	10	197		609	55
56	Ceramic tile	8/31/2009	1,233	113	10	113		349	56
57	Shower room tile replacement	9/16/2009	1,182	99	10	99		316	57
58	Ceramic tile for shower rooms	9/18/2009	5,707	476	10	476		1,523	58
59	Tapered Rod Pocket Valance	9/21/2009	202	17	10	17		54	59
60	Landscape deposit	9/22/2009	19,000	1,583	10	1,583		5,066	60
61	Completion of shower rooms	9/25/2009	1,211	101	10	101		323	61
62	Ceramic tile Trane heat Pump/ Air handler	9/30/2009	5,520	460	10	460		1,472	62
63	Install trane air handler	9/30/2009	307	26	10	26		83	63
64	New water heaters	10/1/2009	57,980	4,349	10	4,349		14,496	64
65	Water replacement project	10/16/2009	1,469	110	10	110		367	65
66	Ceramic tile for shower rooms	10/19/2009	2,631	197	10	197		657	66
67	Glass replacement	10/23/2009	2,631	197	10	197		657	67
68	shower romodel	10/28/2009	1,376	103	10	103		344	68
69	Shower room remodel	10/28/2009	5,889	442	10	442		1,473	69
70	TOTAL (lines 4 thru 69)		$ 5,177,426	$ 242,568		$ 242,568	$	$ 3,467,296	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: 07-01-2011 Ending: 06/30/2012

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		$ 5,177,426	$ 242,568		$ 242,568	$	$ 3,467,296	1
2	Shower room remodel	10/28/2009	2,176	163	10	163		544	2
3	Shower room remodel	10/28/2009	75	6	10	6		20	3
4	Installation of Trane	10/30/2009	2,631	197	10	197		657	4
5	Shower room remodel	10/30/2009	509	38	10	38		127	5
6	Area Rugs	11/2/2009	310	21	10	21		73	6
7	Landscaping- 2009	11/5/2009	18,256	1,217	10	1,217		4,260	7
8	Light Fixtures	12/30/2009	610	30	10	30		121	8
9	Painting of shower rooms	1/2/2010	923	69	10	69		230	9
10	Shower room remodel - painting	3/13/2010	408	24	10	24		89	10
11	New Signage	5/31/2010	10,520	175	10	175		1,402	11
12	Landscaping	6/4/2010	5,090	42	10	42		593	12
13	Asphalt Paving of Parking lot	6/10/2010	32,989	275	10	275		3,848	13
14	Electric Panael & Circuitry for Generator	6/29/2010	22,765	190	10	190		2,657	14
15	Roof Top A/C for Dining Room	6/29/2010	13,403	112	10	112		1,564	15
16	Dryer Vents	6/29/2010	651	6	10	6		77	16
17	A/C for Therapy Room	6/29/2010	4,295	36	10	36		502	17
18	Painting of Shower Room	6/30/2010	265	9	10	9		45	18
19	Remove Tile	2010	848	7	10	7		99	19
20	Corinthian Mosiac and Installation of Tile	2010	8,984	75	10	75		1,048	20
21	Ceramic Tile and Base	2010	115	1	10	1		13	21
22	Shower Fixtures	2010	1,096	9	10	9		128	22
23	Shower Curtains	2010	608	5	10	5		71	23
24	Wall Protectors and Curtains	2010	7,558	63	10	63		882	24
25	Height Adjustable Supine Tub	7/29/2010	9,791	813	10	813		1,958	25
26	Side Entry Tub	7/29/2010	8,803	732	10	732		1,761	26
27	Cabinets for Beauty Shop	1/20/2011	3,800	316	10	316		570	27
28	Beauty Shop - Flooring	4/30/2011	691	576	10	576		605	28
29	Awning	5/31/2011	2,625	218	10	218		306	29
30	Hinds Environmental Testing Tiles	6/30/2011	5,610	466	10	466		608	30
31	Trane	6/30/2011	8,154	677	10	677		883	31
32	Smoke Hut for Staff	6/30/2011	4,700	470	10	470		509	32
33	Nursing Storage Shed	6/30/2011	3,905	390	10	390		423	33
34	TOTAL (lines 1 thru 33)		$ 5,360,589	$ 249,996		$ 249,996	$	$ 3,493,967	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: 07-01-2011 Ending: 06/30/2012

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		$ 5,360,589	$ 249,996		$ 249,996	$	$ 3,493,967	1
2	Coat Closet Room 102	7/1/2011	929	93	10	93		93	2
3	Coat Closet Room 103	7/1/2011	929	93	10	93		93	3
4	Coat Closet Room 104	7/1/2011	929	93	10	93		93	4
5	Coat Closet Room 105	7/1/2011	929	93	10	93		93	5
6	Coat Closet Room 106	7/1/2011	929	93	10	93		93	6
7									7
8	Coat Closet Room 107	7/1/2011	929	93	10	93		93	8
9	Coat Closet Room 109	7/1/2011	929	93	10	93		93	9
10	Coat Closet Room 110	7/1/2011	929	93	10	93		93	10
11	Coat Closet Room 111	7/1/2011	929	93	10	93		93	11
12	Coat Closet Room 112	7/1/2011	929	93	10	93		93	12
13	Coat Closet Room 113	7/1/2011	929	93	10	93		93	13
14	Coat Closet Room 114	7/1/2011	929	93	10	93		93	14
15	Coat Closet Room 116	7/1/2011	929	93	10	93		93	15
16	Coat Closet Room 118	7/1/2011	929	93	10	93		93	16
17	Front entry/ Reception Desk Base Work	7/1/2011	30,608	3,061	10	3,061		27,547	17
18	Front Entry/Recep Dsk-ceiling grid/tile	8/22/2011	13,244	1,214	10	1,214		1,214	18
19	Front Entry - Tape, Paint, Wallpaper	7/1/2011	6,840	1,368	5	1,368		1,368	19
20	Front Entry/recep desk-ceramic tile	9/9/2011	580	48	10	48		48	20
21	Hazardous Materials Abatement	7/30/2011	7,112	1,422	5	1,422		1,422	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)		$ 5,431,979	$ 258,411		$ 258,411	$	$ 3,526,868	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: 07-01-2011 Ending: 06/30/2012

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	$ 788,803	$ 88,655	$ 88,655	$		$ 440,048	71
72	Current Year Purchases	64,609	19,248	19,248			19,248	72
73	Fully Depreciated Assets	703,662	6,668	6,668			703,662	73
74	Home Office	283,821	23,779	23,779			121,457	74
75	TOTALS	$ 1,840,895	$ 138,350	$ 138,350	$		$ 1,284,415	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			21,322	2,420	2,420			7,926	79
80	TOTALS			$ 73,827	$ 2,420	$ 2,420	$		$ 60,431	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)	$ 7,408,504	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 399,181	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 399,181	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,871,714	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	Home Office	$ 99,266	92
93	CIP	46,904	93
94			94
95		$ 146,170	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: 07-01-2011 Ending: 06/30/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 16,886 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: 07-01-2011 Ending: 06/30/2012

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.

   FHCH 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: 07-01-2011 Ending: 06/30/2012

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	7,170	$ 364,366	$	7,170	$ 364,366	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,584	197,948		3,584	197,948	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		11,138	408,406		11,138	408,406	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			$	21,892	$ 970,720	$	21,892	$ 970,720	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: 07-01-2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (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	$ 8,259,823	$	1
2	Cash-Patient Deposits	25,181		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (87,812))	1,633,236		3
4	Supply Inventory (priced at)	26,338		4
5	Short-Term Investments	1,553,091		5
6	Prepaid Insurance	900		6
7	Other Prepaid Expenses	14,405		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accr Int/ Oth A/R	156,478		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,669,452	$	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	6,076,315		14
15	Leasehold Improvements, at Historical Cost	188,736		15
16	Equipment, at Historical Cost	1,674,184		16
17	Accumulated Depreciation (book methods)	(5,357,658)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	872,096		21
22	Other Long-Term Assets (spe CIP	46,904		22
23	Other(specify):	7,893		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,610,345	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,279,797	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 523,789	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,181		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	355,978		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	417		32
33	Accrued Interest Payable	7,114		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	506,647		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,419,126	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,241,249		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance fees	194,414		43
44	Apt & Congregate	126,872		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,562,535	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,981,661	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,298,136	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,279,797	$	48

*(See instructions.)

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,585,775	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,585,775	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	712,361	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)**	$ 712,361	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)**	$ 12,298,136	24	*

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,042,920	1
2	Discounts and Allowances for all Levels	(2,681,714)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,361,206	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,849,370	6
7	Oxygen	58,642	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,908,012	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	54,853	13
14	Non-Patient Meals	1,818	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	492,795	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,856	19
20	Radiology and X-Ray	35,307	20
21	Other Medical Services	46,594	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 686,223	23
	D. Non-Operating Revenue		
24	Contributions	36,183	24
25	Interest and Other Investment Income***	72,985	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 109,168	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	91,290	28
28a	Gain/Loss on Investments and Miscellaneous	55,457	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 146,747	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,211,356	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,521,326	31
32	Health Care	5,447,790	32
33	General Administration	2,437,541	33
	B. Capital Expense		
34	Ownership	483,045	34
	C. Ancillary Expense		
35	Special Cost Centers	195,644	35
36	Provider Participation Fee	413,649	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,498,995	40
41	**Income before Income Taxes (line 30 minus line 40)****	712,361	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 712,361	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,326,496	44
45	Private Pay - Net Inpatient Revenue	3,298,013	45
46	Medicare - Net Inpatient Revenue	(258,093)	46
47	Other-(specify) HMO	(5,210)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,361,206	49

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

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

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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	1,100	1,137	$ 45,122	$ 39.69	1
2	Assistant Director of Nursing	1,407	1,578	59,778	37.88	2
3	Registered Nurses	13,753	15,816	419,798	26.54	3
4	Licensed Practical Nurses	38,982	43,670	983,247	22.52	4
5	CNAs & Orderlies	147,484	157,218	1,764,041	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,849	2,074	33,065	15.94	9
10	Activity Assistants	7,422	7,937	76,753	9.67	10
11	Social Service Workers	7,858	8,387	120,520	14.37	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,131	53,038	24.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,715	32,389	311,657	9.62	15
16	Dishwashers					16
17	Maintenance Workers	5,150	5,684	110,071	19.37	17
18	Housekeepers	17,169	19,170	198,445	10.35	18
19	Laundry	9,363	10,162	113,518	11.17	19
20	Administrator	1,461	1,703	101,431	59.56	20
21	Assistant Administrator					21
22	Other Administrative	1,679	1,892	47,464	25.09	22
23	Office Manager	1,818	2,102	40,261	19.15	23
24	Clerical	6,133	6,563	90,124	13.73	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	5,445	5,794	85,109	14.69	31
32	Other Health C: MDS Coordinator	4,723	5,352	128,823	24.07	32
33	Other(specify) Marketing/Beautic	4,375	4,882	91,278	18.70	33
34	TOTAL (lines 1 - 33)	308,840	335,641	$ 4,873,543 *	$ 14.52	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	308	$ 15,857	3.1.3	35
36	Medical Director	416	40,350	3.9.3	36
37	Medical Records Consultant	41	2,928	3.10.3	37
38	Nurse Consultant	18	756	3.10.3	38
39	Pharmacist Consultant	192	4,784	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	87	5,814	3.12.3	45
46	Other(specify) Dental	10	1,000	3.10.3	46
47	Intern Administrator	747	60,006	3.10.3	47
48	Interim DON/MDS	1,379	129,427	3.10.3	48
49	TOTAL (lines 35 - 48)	3,198	$ 260,922		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: 07-01-2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Doug Maris	Administrator		$ 101,432
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,432

B. Administrative - Other

Description	Amount
Management Fee	$ 687,254
TOTAL (agree to Schedule V, line 17, col. 3)	$ 687,254
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview		$ 1,640
Ferry & Assoc		4,518
CliftonLarsonAllen		714
Skaggs LTC, Inc		16,400
Davis and Campbell		12,135
Armstrong Teasdale		183
Sevastianos & Assoc		744
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 36,334

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,736
Unemployment Compensation Insurance	71,151
FICA Taxes	355,129
Employee Health Insurance	364,800
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,452
Employee Expense	16,770
Employee Uniforms	656
PTO	48,582
Home Office Allocation	46,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,001,928

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	17,571
Health Care Worker Background Check	
(Indicate # of checks performed 73)	730
Patient Background Checks 364	3,640
License	2,300
Dues	9,995
Subscriptions	2,205
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,441

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,201
Seminar Expense	2,970
Home Office Allocation	17,088
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30,259

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 07-01-2011 Ending: 06/30/2012

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:** 07-01-2011 **Ending:** 06/30/2012

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/Leading Age $9,141.73**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **110,254** 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.

(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. $ **413,649**
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. $ **1,818**

(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. $
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: **CliftonLarsonAllen LLP**

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

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