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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 S 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 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314-587-7924
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 7/1/14 to 6/30/15 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) Dr. Timothy Phillippe
(Title) CEO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Amanda Tinney, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800 St. Louis MO 63101
(Telephone) 314-925-4389 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: 7/1/14 Ending: 6/30/15

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 N/A

	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	28,077	10,269	7,501	45,847	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,077	10,269	7,501	45,847	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.56%

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 6,181

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: 6/30/15 Fiscal Year: 6/30/15

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	378,323	27,679	16,103	422,105		422,105		422,105			1
2	Food Purchase		329,489		329,489		329,489	(1,298)	328,191			2
3	Housekeeping	174,206	34,910	403	209,519		209,519		209,519			3
4	Laundry	93,853	3,969		97,822		97,822		97,822			4
5	Heat and Other Utilities			161,617	161,617		161,617	2,165	163,782			5
6	Maintenance	118,244	16,829	89,343	224,416		224,416	5,053	229,469			6
7	Other (specify):* Trash			21,141	21,141		21,141		21,141			7
8	TOTAL General Services	764,626	412,876	288,607	1,466,109		1,466,109	5,920	1,472,029			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	3,052,328	205,145	156,015	3,413,488		3,413,488		3,413,488			10
10a	Therapy			879,327	879,327		879,327		879,327			10a
11	Activities	94,818	7,490		102,308		102,308		102,308			11
12	Social Services	97,803	1,283	5,189	104,275		104,275		104,275			12
13	CNA Training											13
14	Program Transportation			16,257	16,257		16,257		16,257			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,244,949	213,918	1,098,788	4,557,655		4,557,655		4,557,655			16
	C. General Administration											
17	Administrative	80,334	1,833	650,000	732,167		732,167	(499,030)	233,137			17
18	Directors Fees											18
19	Professional Services			25,603	25,603		25,603	45,224	70,827			19
20	Dues, Fees, Subscriptions & Promotions			39,402	39,402		39,402		39,402			20
21	Clerical & General Office Expenses	173,646	12,025	290,440	476,111		476,111	151,975	628,086			21
22	Employee Benefits & Payroll Taxes			861,876	861,876		861,876	50,859	912,735			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,686	10,686		10,686	26,932	37,618			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,026	123,026		123,026	(11,942)	111,084			26
27	Other (specify):* Marketing	57,470	1,876	10,850	70,196		70,196	(70,196)				27
28	TOTAL General Administration	311,450	15,734	2,011,883	2,339,067		2,339,067	(306,178)	2,032,889			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,321,025	642,528	3,399,278	8,362,831		8,362,831	(300,258)	8,062,573			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: 7/1/14 Ending: 6/30/15

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			373,017	373,017		373,017	42,418	415,435			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,009	93,009		93,009	(87,493)	5,516			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,505	38,505		38,505		38,505			35
36	Other (specify):*											36
37	**TOTAL Ownership**			504,531	504,531		504,531	(45,075)	459,456			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		295,063	114,570	409,633		409,633	(10,586)	399,047			39
40	Barber and Beauty Shops	8,035	389	22,996	31,420		31,420		31,420			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			325,064	325,064		325,064		325,064			42
43	Other (specify):* **Apt/Congregate**			53,916	53,916		53,916	(53,916)				43
44	**TOTAL Special Cost Centers**	8,035	295,452	516,546	820,033		820,033	(64,502)	755,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,329,060	937,980	4,420,355	9,687,395		9,687,395	(409,835)	9,277,560			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: 7/1/14 Ending: 6/30/15

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	(1,298)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(87,493)	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	(136,046)	21		24
25	Fund Raising, Advertising and Promotional	(70,196)	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 See Pg5A For Support	(55,859)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (350,892)		$	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)	(58,943)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,943)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (409,835)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Fair Havens Christian Home

ID# **0018143**

Report Period Beginning: **7/1/14**

Ending: **6/30/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment / Congregate	$ (53,916)	43	1
2	Miscellaneous	(1,600)	21	2
3	Late Fees, Finance Charges	(146)	6	3
4	Late Fees, Finance Charges	(197)	21	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**	(55,859)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,298)	0	0	0	0	0	0	0	0	0	0	(1,298)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,165	0	0	0	0	0	0	0	0	0	2,165	5
6	Maintenance	(146)	5,199	0	0	0	0	0	0	0	0	0	5,053	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,444)	7,364	0	0	0	0	0	0	0	0	0	5,920	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(499,030)	0	0	0	0	0	0	0	0	0	(499,030)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	45,224	0	0	0	0	0	0	0	0	0	45,224	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(137,843)	289,818	0	0	0	0	0	0	0	0	0	151,975	21
22	Employee Benefits & Payroll Taxes	0	50,859	0	0	0	0	0	0	0	0	0	50,859	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	26,932	0	0	0	0	0	0	0	0	0	26,932	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	(11,942)	0	0	0	0	0	0	0	0	0	(11,942)	26
27	Other (specify):*	(70,196)	0	0	0	0	0	0	0	0	0	0	(70,196)	27
28	**TOTAL General Administration**	(208,039)	(98,139)	0	0	0	0	0	0	0	0	0	(306,178)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(209,483)	(90,775)	0	0	0	0	0	0	0	0	0	(300,258)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	42,418	0	0	0	0	0	0	0	0	0	42,418	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(87,493)	0	0	0	0	0	0	0	0	0	0	(87,493)	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**	(87,493)	42,418	0	0	0	0	0	0	0	0	0	(45,075)	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	(10,586)	0	0	0	0	0	0	0	0	0	(10,586)	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):*	(53,916)	0	0	0	0	0	0	0	0	0	0	(53,916)	43
44	**TOTAL Special Cost Centers**	(53,916)	(10,586)	0	0	0	0	0	0	0	0	0	(64,502)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(350,892)	(58,943)	0	0	0	0	0	0	0	0	0	(409,835)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Board of Directors Attachment						

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%	$ 2,165	$ 2,165	1
2	V	6	Maintenance				5,199	5,199	2
3	V	17	Administrative	650,000			150,970	(499,030)	3
4	V	19	Professional Services				45,224	45,224	4
5	V	21	Clerical				288,892	288,892	5
6	V	22	Employee Benefits				50,859	50,859	6
7	V	21	Dues & Subscriptions				203	203	7
8	V	24	Travel and Seminars				26,932	26,932	8
9	V	26	Insurance				(11,942)	(11,942)	9
10	V	30	Depreciation				42,418	42,418	10
11	V	21	Other Administrative Expense				723	723	11
12	V	39	Pharmacy Services	341,492	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	330,906	(10,586)	12
13	V								13
14	Total			$ 991,492			$ 932,549	$ * (58,943)	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: 7/1/14 Ending: 6/30/15

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

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 [X]

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 N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Illinois Finance Authority		X	REFINANCE OLD DEBT		6/15/2007	$ 1,070,306	$ 1,460,615	5/15/2031	0.0567	$ 80,878	1
2	Bond Fund	X		REFINANCE OLD DEBT	$1,327.00	10/01/2007	287,700	186,492	6/30/2032	0.0572	10,562	2
3	Illinois Finance Authority		X	REFINANCE OLD DEBT		7/29/2010	53,720	60,682	5/15/2027	0.0613	1,569	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,327.00		$ 1,411,726	$ 1,707,789			$ 93,009	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,411,726	$ 1,707,789			$ 93,009	15

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

*** 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: 7/1/14 Ending: 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 Kenna

TELEPHONE 314-587-7924 FAX #: 314-587-7916

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	See Attachment	$ 804.10	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 804.10	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 7/1/14 Ending: 6/30/15

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? [ ] (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).

Duplex/IL - 10 Units

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			7,847	2
3	TOTALS	56,500		$ 62,485	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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		$ 53,450	$	$ 2,035,561	4
5					384,841						5
6											6
7	6		1983	1983	109,815	2,745		2,745		86,479	7
8	Home Office Allocation				76,099	8,182		8,182		56,422	8
	Improvement Type**										
9	1976 Fixed Assets			1976	541		VARIOUS			541	9
10	1979 Fixed Assets			1979	5,193		VARIOUS			5,193	10
11	1980 Fixed Assets			1980	2,150		VARIOUS			2,150	11
12	1981 Fixed Assets			1981	18,981		VARIOUS			18,981	12
13	1982 Fixed Assets			1982	22,636		VARIOUS			22,636	13
14	1983 Fixed Assets			1983	5,616		VARIOUS			5,616	14
15	1984 Fixed Assets			1984	183,432	4,080	VARIOUS	4,080		147,052	15
16	1985 Fixed Assets			1985	6,824		VARIOUS			6,824	16
17	1986 Fixed Assets			1986	9,297		VARIOUS			9,297	17
18	1987 Fixed Assets			1987	12,923		VARIOUS			12,923	18
19	1989 Fixed Assets			1989	5,265		VARIOUS			5,265	19
20	1990 Fixed Assets			1990	1,507		VARIOUS			1,507	20
21	1991 Fixed Assets			1991	13,817		VARIOUS			13,817	21
22	1992 Fixed Assets			1992	24,970		VARIOUS			24,970	22
23	1993 Fixed Assets			1993	28,684		VARIOUS			28,684	23
24	1994 Fixed Assets			1994	15,202	131	VARIOUS	131		15,202	24
25	1995 Fixed Assets			1995	29,427		VARIOUS			29,427	25
26	1996 Fixed Assets			1996	36,384		VARIOUS			36,384	26
27	1997 Fixed Assets			1997	38,844	732	VARIOUS	732		37,136	27
28	1998 Fixed Assets			1998	79,884		VARIOUS			79,884	28
29	1999 Fixed Assets			1999	74,182		VARIOUS			74,182	29
30	2000 Fixed Assets			2000	18,680	69	VARIOUS	69		18,680	30
31	2001 Fixed Assets			2001	9,412	195	VARIOUS	195		4,440	31
32	2002 Fixed Assets			2002	48,118	415	VARIOUS	415		45,145	32
33	2003 Fixed Assets			2003	122,514	1,571	VARIOUS	1,571		109,424	33
34	2004 Fixed Assets			2004	65,003	328	VARIOUS	328		62,469	34
35	2005 Fixed Assets			2005	117,219	3,901	VARIOUS	3,901		113,784	35
36	2006 Fixed Assets			2006	80,189	3,044	VARIOUS	3,044		77,489	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: 7/1/14 Ending: 6/30/15

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	2007 Fixed Assets	2007	$ 327,640	$ 30,723	VARIOUS	$ 30,723	$	$ 253,922	37
38	2008 Fixed Assets	2008	439,421	42,254	VARIOUS	42,254		321,680	38
39	2009 Fixed Assets	2009	624,625	61,376	VARIOUS	61,376		374,241	39
40	LANDSCAPI NG	2010	5,090	509	10	509		2,587	40
41	Light Fixtures	2010	610	61	10	61		336	41
42	Shower Room Updates	2010	265	27	10	27		141	42
43	Shower Room Remodel	2010	19,208	1,921	10	1,921		9,764	43
44	RoofTop A/C for Dining Room	2010	13,403	1,340	10	1,340		6,813	44
45	Electric Panel &Circuitry for Generat	2010	22,765	2,277	10	2,277		11,572	45
46	DryerVents	2010	651	65	10	65		331	46
47	A/ C for Therapy Room	2010	4,295	430	10	430		2,183	47
48	Height Adjustable Supine Tub	2010	9,791	979	10	979		4,895	48
49	Side Entry Tub	2010	8,803	880	10	880		4,401	49
50	Asphalt Paving of Parking Lot	2010	32,989	3,299	10	3,299		16,769	50
51	New Signage	2010	10,520	1,052	10	1,052		5,435	51
52	CoatClosetRoom 111	2011	929	93	10	93		372	52
53	CoatClosetRoom 112	2011	929	93	10	93		372	53
54	CoatClosetRoom 113	2011	929	93	10	93		372	54
55	CoatClosetRoom 114	2011	929	93	10	93		372	55
56	CoatClosetRoom 116	2011	929	93	10	93		372	56
57	CoatClosetRoom 118	2011	929	93	10	93		372	57
58	Hazar dousMat er i al s Abat ement	2011	7,112	1,422	5	1,422		5,689	58
59	CoatClosetRoom 102	2011	929	93	10	93		372	59
60	CoatClosetRoom 103	2011	929	93	10	93		372	60
61	CoatClosetRoom 104	2011	929	93	10	93		372	61
62	CoatClosetRoom 105	2011	929	93	10	93		372	62
63	CoatClosetRoom 106	2011	929	93	10	93		372	63
64	CoatClosetRoom 107	2011	929	93	10	93		372	64
65	CoatClosetRoom 109	2011	929	93	10	93		372	65
66	CoatClosetRoom 110	2011	929	93	10	93		372	66
67	Front Entry / Recep Desk Base	2011	30,608	3,061	10	3,061		12,244	67
68	Front Entry/ Recep Desk Ceiling	2011	13,244	1,324	10	1,324		5,186	68
69	Front Entry/Recep Desk Ceramic Tiling	2011	580	58	10	58		222	69
70	TOTAL (lines 4 thru 69)		$ 5,413,042	$ 233,203		$ 233,203	$	$ 4,231,183	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: 7/1/14 Ending: 6/30/15

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		$ 5,413,042	$ 233,203		$ 233,203	$	$ 4,231,183	1
2	Cabinets for Beauty Shop	2011	3,800	380	10	380		1,709	2
3	Awning	2011	2,625	263	10	263		1,094	3
4	Hinds Environmental Testing Tiles	2011	5,610	561	10	561		2,290	4
5	Beauty Shop - Flooring	2011	691	69	10	69		293	5
6	Trane	2011	8,154	815	10	815		3,328	6
7	Front Entry/Tape, Paint, Wallpaper	2011	6,840	1,368	5	1,368		5,471	7
8	Smoke hut for staff	2011	4,700	470	10	470		1,919	8
9	Nursing Storage Shed	2011	3,905	391	10	391		1,596	9
10	Walkin Cooler / Freezer	2013	16,602	1,660	10	1,660		3,873	10
11	Walkin Coolor Install - Wiring	2013	9,836	492	20	492		1,025	11
12	Water Heater - 100gal Laundry	2013	5,981	598	10	598		1,347	12
13	12 Gal Hot Water Heater Therapy	2013	652	65	10	65		130	13
14	Trane Roof Top Air Conditioner	2013	13,542	1,354	10	1,354		2,595	14
15	Serving Line Upgrade (Tray Slide)	2013	82,049	8,205	10	8,205		16,410	15
16	Serving Line Upgrade	2013	2,125	213	10	213		355	16
17	Closets Coat Station Rooms 200-300	2013	25,992	1,733	15	1,733		3,466	17
18	#1292F Vinyl Flooring	2014	715	71	10	71		107	18
19	Build Kitchen Office/Remodel Breakroom	2013	21,543	2,154	10	2,154		3,590	19
20	100 gallon water heater (2)	2014	11,400	1,140	10	1,140		1,140	20
21	Trane AC rooftop unit	2014	9,241	924	10	924		924	21
22	Trane AC rooftop unit	2014	9,241	924	10	924		924	22
23	Electrical boxes upgrade	2014	15,793	1,053	10	1,053		1,053	23
24	Back Door lock/alarm	2014	1,150	77	10	77		77	24
25	Replace carpet 1210 Fairview	2014	1,836	214	5	214		214	25
26	Replace Carpet unit 1230 Fair Haven	2014	1,835	245	5	245		245	26
27	kitchen faucet & sink replace	2015	746	31	10	31		31	27
28	Install of Trane rooftop HVAC	2015	6,742	169	10	169		169	28
29	Screened Pourch Sunroom	2015	29,413	490	10	490		490	29
30	Install Larson storm doors	2015	4,150	99	7	99		99	30
31	1790 Fairwiew concrete replacement	2014	2,526	112	15	112		112	31
32	Fulton Ave sidewalk & road repair	2015	29,333	244	10	244		244	32
33	Adjustment to tie to TB		(5)	199		199		152	33
34	TOTAL (lines 1 thru 33)		$ 5,751,805	$ 259,986		$ 259,986	$	$ 4,287,655	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: 7/1/14 Ending: 6/30/15

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	$ 635,985	$ 95,289	$ 95,289	$		$ 383,739	71
72	Current Year Purchases	54,906	4,689	4,689			4,689	72
73	Fully Depreciated Assets	964,750	21,252	21,252			964,750	73
74	Home Office Allocation	305,543	32,853	32,853			208,516	74
75	TOTALS	$ 1,961,184	$ 154,083	$ 154,083	$		$ 1,561,694	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	2006	$ 52,505	$	$	$		$ 52,505	76
77										77
78										78
79	Home Office Allocation			12,862	1,383	1,383			8,895	79
80	TOTALS			$ 65,367	$ 1,383	$ 1,383	$		$ 61,400	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)	$ 7,840,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 415,452	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,452	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,910,749	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	963,485	25,267	732,908	87
88					88
89					89
90					90
91	TOTALS	$ 1,010,722	$ 25,267	$ 732,908	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 37,869	92
93	Home Office Allocation	117	93
94			94
95		$ 37,986	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: 7/1/14 Ending: 6/30/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 38,506 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: 7/1/14 Ending: 6/30/15

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: 7/1/14 Ending: 6/30/15

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	$	5,465	$ 317,354	$	5,465	$ 317,354	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,805	166,260		2,805	166,260	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		9,811	395,713		9,811	395,713	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			$	18,081	$ 879,327	$	18,081	$ 879,327	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: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (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	$ 9,992,872	$	1
2	Cash-Patient Deposits	43,497		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 173,004)	1,104,041		3
4	Supply Inventory (priced at)	28,879		4
5	Short-Term Investments	2,009,679		5
6	Prepaid Insurance	13,930		6
7	Other Prepaid Expenses	18,146		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int./AR-Other	10,068		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,221,112	$	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	6,352,063		14
15	Leasehold Improvements, at Historical Cost	215,711		15
16	Equipment, at Historical Cost	1,779,562		16
17	Accumulated Depreciation (book methods)	(6,369,825)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,054,651		21
22	Other Long-Term Assets (spe CIP	37,869		22
23	Other(specify): Other Assets	7,893		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,179,799	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,400,911	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,984	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,497		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,498		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	409		32
33	Accrued Interest Payable	10,878		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Liab/Due to Auxillary	328,108		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 779,374	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,707,789		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	44,532		43
44	Apt & Congergate	55,350		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,807,671	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,587,045	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,813,866	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,400,911	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,819,871	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,819,871	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,005)	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)**	$ (6,005)	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)**	$ 13,813,866	24 *

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 8,441,444	1
2	Discounts and Allowances for all Levels	(3,528,840)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,912,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,797,005	6
7	Oxygen	16,818	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,813,823	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	38,512	13
14	Non-Patient Meals	1,298	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	501,329	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,093	19
20	Radiology and X-Ray	19,940	20
21	Other Medical Services	105,995	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 700,167	23
	D. Non-Operating Revenue		
24	Contributions	25,381	24
25	Interest and Other Investment Income***	87,493	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112,874	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	125,652	28
28a	Miscellaneous	16,270	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 141,922	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,681,390	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,466,109	31
32	Health Care	4,557,655	32
33	General Administration	2,339,067	33
	B. Capital Expense		
34	Ownership	504,531	34
	C. Ancillary Expense		
35	Special Cost Centers	494,969	35
36	Provider Participation Fee	325,064	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,687,395	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,005)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,005)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,935,471	44
45	Private Pay - Net Inpatient Revenue	1,920,484	45
46	Medicare - Net Inpatient Revenue	(690,623)	46
47	Other-(specify) HOM	(213,476)	47
48	Other-(specify) Nursing/Medicare Advantage	(39,252)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,912,604	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 7/1/14 Ending: 6/30/15

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	1,080	1,352	$ 45,750	$ 33.84	1
2	Assistant Director of Nursing	1,152	1,200	33,703	28.09	2
3	Registered Nurses	15,484	16,978	453,774	26.73	3
4	Licensed Practical Nurses	37,296	40,228	829,251	20.61	4
5	CNAs & Orderlies	109,831	118,483	1,393,988	11.77	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,872	2,180	35,797	16.42	9
10	Activity Assistants	5,161	5,757	56,775	9.86	10
11	Social Service Workers	8,998	9,998	144,874	14.49	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	1,920	2,080	57,383	27.59	13
14	Head Cook	8,668	9,292	93,811	10.10	14
15	Cook Helpers/Assistants	21,461	23,104	234,788	10.16	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	5,863	6,485	118,960	18.34	17
18	Housekeepers	15,057	16,180	165,905	10.25	18
19	Laundry	7,228	8,279	93,755	11.32	19
20	Administrator	1,712	1,955	80,334	41.09	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	3,622	4,269	110,036	25.78	23
24	Clerical	4,287	4,653	62,059	13.34	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	2,979	3,222	56,784	17.62	31
32	Other Health Care(specify)	8,722	9,630	253,298	26.30	32
33	Other(specify)	742	802	8,035	10.02	33
34	TOTAL (lines 1 - 33)	263,135	286,127	$ 4,329,060 *	$ 15.13	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	$ 16,103	V01-3	35
36	Medical Director	416	42,000	V09-3	36
37	Medical Records Consultant	16	1,198	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,803	V10-3	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	79	5,159	V12-3	45
46	Other(specify) Admin	471	41,738	V21-3	46
47	Interim DON	465	50,372	V10-3	47
48	Interim RN Consultant	91	9,015	V10-3	48
49	TOTAL (lines 35 - 48)	2,077	$ 169,388		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	66	2,702	V10-3	51
52	Certified Nurse Assistants/Aides	2,769	75,804	V10-3	52
53	TOTAL (lines 50 - 52)	2,835	$ 78,506		53

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Krug	ADMINISTRATION	0	$ 55,884
Maryann Walker	ADMINISTRATION	0	24,150
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,034

B. Administrative - Other

Description	Amount
Management Fee	$ 650,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 650,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Survey	$ 1,596
Davis & Campbell	Legal	23,275
Sevastianos & Associates, PC	Legal	732
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 25,603

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 165,459
Unemployment Compensation Insurance	14,717
FICA Taxes	318,214
Employee Health Insurance	341,610
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	2,034
Employee Uniforms	1,114
Employee Expese	17,603
457 Plan Expense	1,125
Home Office Adjustment	50,859
TOTAL (agree to Schedule V, line 22, col.8)	$ 912,735

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,583
Health Care Worker Background Check	
(Indicate # of checks performed 275)	
Patient Background Checks	2,750
License	4,849
Dues	18,263
Subscriptions	4,956
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,402

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,047
In-State Travel	5,784
Seminar Expense	855
Home Office Adjustment	26,932
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,618

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 N/A		$		$	$	$	$	$	$	$	$	$
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:** 7/1/14 **Ending:** 6/30/15

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 - $11,508.16**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **67,157** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **324,064**
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. $ **1,298**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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? **N/A**
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.