FOR BHF USE

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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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0018143

Facility Name: Fair Havens Christian Villag

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
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501(c)(3)

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 7/1/16 to 6/30/17 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) Chuck Schmitz

(Title) CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	26,898	11,799	8,043	46,740	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,898	11,799	8,043	46,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.15%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 6,700

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: 6/30/17 Fiscal Year: 6/30/17

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	330,253	25,770	16,728	372,751		372,751		372,751			1
2	Food Purchase		297,631		297,631		297,631	(3,479)	294,152			2
3	Housekeeping	156,835	26,385		183,220		183,220		183,220			3
4	Laundry	66,738			66,738		66,738		66,738			4
5	Heat and Other Utilities			152,642	152,642		152,642	1,706	154,348			5
6	Maintenance	124,183	24,542	61,451	210,176		210,176	3,034	213,210			6
7	Other (specify):* Trash			8,649	8,649		8,649		8,649			7
8	TOTAL General Services	678,009	374,328	239,470	1,291,807		1,291,807	1,261	1,293,068			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	3,116,675	195,452	15,679	3,327,806		3,327,806	(4,536)	3,323,270			10
10a	Therapy			895,839	895,839		895,839		895,839			10a
11	Activities	67,474	8,266		75,740		75,740		75,740			11
12	Social Services	122,081	473	4,486	127,040		127,040		127,040			12
13	CNA Training											13
14	Program Transportation			6,215	6,215		6,215		6,215			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,306,230	204,191	964,219	4,474,640		4,474,640	(4,536)	4,470,104			16
	C. General Administration											
17	Administrative	146,402		699,481	845,883		845,883	(584,083)	261,800			17
18	Directors Fees											18
19	Professional Services			11,526	11,526		11,526	63,452	74,978			19
20	Dues, Fees, Subscriptions & Promotions			38,258	38,258		38,258	(2,239)	36,019			20
21	Clerical & General Office Expenses	163,883	11,291	319,290	494,464		494,464	167,608	662,072			21
22	Employee Benefits & Payroll Taxes			972,185	972,185		972,185	59,984	1,032,169			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,619	9,619		9,619	35,372	44,991			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			137,732	137,732		137,732	36,282	174,014			26
27	Other (specify):* Marketing	72,253	3,378	4,421	80,052		80,052	(80,052)				27
28	TOTAL General Administration	382,538	14,669	2,192,512	2,589,719		2,589,719	(303,676)	2,286,043			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,366,777	593,188	3,396,201	8,356,166		8,356,166	(306,951)	8,049,215			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 Villag #0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			391,915	391,915		391,915	31,269	423,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,902	69,902		69,902	(69,902)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,488	29,488		29,488		29,488			35
36	Other (specify):*											36
37	**TOTAL Ownership**			491,305	491,305		491,305	(38,633)	452,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			432,178	432,178		432,178	(19,714)	412,464			39
40	Barber and Beauty Shops	7,525	728	17,726	25,979		25,979		25,979			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			327,101	327,101		327,101		327,101			42
43	Other (specify):* **IL Duplexes**	2,281		79,214	81,495		81,495	(81,495)				43
44	**TOTAL Special Cost Centers**	9,806	728	856,219	866,753		866,753	(101,209)	765,544			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,376,583	593,916	4,743,725	9,714,224		9,714,224	(446,793)	9,267,431			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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	(3,323)	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	(69,902)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,536)	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				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	(220,060)	21		24
25	Fund Raising, Advertising and Promotional	(80,052)	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	(91,123)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (468,996)		$	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)	22,203	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 22,203		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (446,793)		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

Fair Havens Christian Villag

ID# 0018143

Report Period Beginning: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment/Congregate	$ (88,708)	43	1
2	Miscellaneous	(20)	21	2
3	Lobbying Expense	(2,239)	20	3
4	Vending Revenue	(156)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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**	(91,123)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	(3,479)	0	0	0	0	0	0	0	0	0	0	(3,479)	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	1,706	0	0	0	0	0	0	0	0	0	1,706	5
6	Maintenance	0	3,034	0	0	0	0	0	0	0	0	0	3,034	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,479)	4,740	0	0	0	0	0	0	0	0	0	1,261	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	(4,536)	0	0	0	0	0	0	0	0	0	0	(4,536)	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**	(4,536)	0	0	0	0	0	0	0	0	0	0	(4,536)	16
	C. General Administration													
17	Administrative	0	(584,083)	0	0	0	0	0	0	0	0	0	(584,083)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	63,452	0	0	0	0	0	0	0	0	0	63,452	19
20	Fees, Subscriptions & Promotions	(2,239)	0	0	0	0	0	0	0	0	0	0	(2,239)	20
21	Clerical & General Office Expenses	(220,080)	387,688	0	0	0	0	0	0	0	0	0	167,608	21
22	Employee Benefits & Payroll Taxes	0	59,984	0	0	0	0	0	0	0	0	0	59,984	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	35,372	0	0	0	0	0	0	0	0	0	35,372	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	36,282	0	0	0	0	0	0	0	0	0	36,282	26
27	Other (specify):*	(80,052)	0	0	0	0	0	0	0	0	0	0	(80,052)	27
28	**TOTAL General Administration**	(302,371)	(1,305)	0	0	0	0	0	0	0	0	0	(303,676)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(310,386)	3,435	0	0	0	0	0	0	0	0	0	(306,951)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Villag # 0018143 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	31,269	0	0	0	0	0	0	0	0	0	31,269	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(69,902)	0	0	0	0	0	0	0	0	0	0	(69,902)	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**	(69,902)	31,269	0	0	0	0	0	0	0	0	0	(38,633)	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	(19,714)	0	0	0	0	0	0	0	0	0	(19,714)	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):*	(88,708)	7,213	0	0	0	0	0	0	0	0	0	(81,495)	43
44	**TOTAL Special Cost Centers**	(88,708)	(12,501)	0	0	0	0	0	0	0	0	0	(101,209)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(468,996)	22,203	0	0	0	0	0	0	0	0	0	(446,793)	45

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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. ☐ 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 Horizons	100.00%	$ 1,706	$ 1,706	1
2	V	6	Maintenance				3,034	3,034	2
3	V	17	Administrative	699,481			115,398	(584,083)	3
4	V	19	Professional Services				63,452	63,452	4
5	V	21	Clerical				351,705	351,705	5
6	V	22	Employee Benefits				59,984	59,984	6
7	V	21	Dues & Subscriptions				7,700	7,700	7
8	V	24	Travel and Seminars				35,372	35,372	8
9	V	26	Insurance				36,282	36,282	9
10	V	30	Depreciation				31,269	31,269	10
11	V	21	Other Administrative Expense				28,283	28,283	11
12	V	43	Independent Living				7,213	7,213	12
13	V	39	Pharmacy Services	371,557	Midwest Senior Ministries d/b/a Senior Care Pharmacy		351,843	(19,714)	13
14	Total			$ 1,071,038			$ 1,093,241	$ * 22,203	14

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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17								17
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19								19
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		6/15/07	$ 1,070,306	$ 1,253,447	5/15/31	0.0567	$ 55,963	1
2	Bond Fund	X		Refinance old debt	Various	10/1/07	287,700	152,167	6/30/32	0.0572	6,837	2
3	Illinois Finance Authority		X	Refinance old debt		3/1/16	207,169	211,461	5/15/40	0.0500	7,103	3
4												4
5												5
	Working Capital											
6	Interest Offset										(69,902)	6
7												7
8												8
9	TOTAL Facility Related						$ 1,565,175	$ 1,617,075			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,565,175	$ 1,617,075			$ 0	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 Villag **#** 0018143 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Villag COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	See attachment	$ 911.24	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 911.24	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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).

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			7,025	2
3	TOTALS	56,500		$ 61,663	3

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$	$ 2,142,461	4
5					384,841						5
6											6
7	6		1983	1983	109,815	2,745		2,745		91,970	7
8	Home Office Allocation				69,692	2,653		2,653		55,946	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	2,151		VARIOUS			2,151	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	179,906	4,080	VARIOUS	4,080		151,686	15
16	1985 Fixed Assets			1985	4,471		VARIOUS			4,471	16
17	1986 Fixed Assets			1986	2,419		VARIOUS			2,419	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			13,970	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		VARIOUS			15,202	24
25	1995 Fixed Assets			1995	26,307		VARIOUS			26,307	25
26	1996 Fixed Assets			1996	36,384		VARIOUS			36,384	26
27	1997 Fixed Assets			1997	35,984	732	VARIOUS	732		35,740	27
28	1998 Fixed Assets			1998	64,787		VARIOUS			64,787	28
29	1999 Fixed Assets			1999	70,755		VARIOUS			70,755	29
30	2000 Fixed Assets			2000	18,680		VARIOUS			18,680	30
31	2001 Fixed Assets			2001	9,412	195	VARIOUS	195		4,830	31
32	2002 Fixed Assets			2002	42,538	136	VARIOUS	136		41,813	32
33	2003 Fixed Assets			2003	122,514	1,571	VARIOUS	1,571		112,565	33
34	2004 Fixed Assets			2004	63,604	298	VARIOUS	298		61,666	34
35	2005 Fixed Assets			2005	117,219	412	VARIOUS	412		115,685	35
36	2006 Fixed Assets			2006	80,189	68	VARIOUS	68		79,939	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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 304,614	$ 28,680	VARIOUS	$ 28,680	$	$ 293,213	37
38	2008 Fixed Assets	2008	425,421	40,855	VARIOUS	40,855		393,592	38
39	2009 Fixed Assets	2009	566,645	60,899	VARIOUS	60,899		451,584	39
40	2010 Fixed Assets	2010	128,389	12,839	10	12,839		90,907	40
41	CoatClosetRoom 111	2011	929	93	10	93		557	41
42	CoatClosetRoom 112	2011	929	93	10	93		557	42
43	CoatClosetRoom 113	2011	929	93	10	93		557	43
44	CoatClosetRoom 114	2011	929	93	10	93		557	44
45	CoatClosetRoom 116	2011	929	93	10	93		557	45
46	CoatClosetRoom 118	2011	929	93	10	93		557	46
47	Hazar dousMat er i al s Abat ement	2011	7,112		5			6,996	47
48	CoatClosetRoom 102	2011	929	93	10	93		557	48
49	CoatClosetRoom 103	2011	929	93	10	93		557	49
50	CoatClosetRoom 104	2011	929	93	10	93		557	50
51	CoatClosetRoom 105	2011	929	93	10	93		557	51
52	CoatClosetRoom 106	2011	929	93	10	93		557	52
53	CoatClosetRoom 107	2011	929	93	10	93		557	53
54	CoatClosetRoom 109	2011	929	93	10	93		557	54
55	CoatClosetRoom 110	2011	929	93	10	93		557	55
56	Front Entry / Recep Desk Base	2011	30,608	3,061	10	3,061		18,365	56
57	Front Entry/ Recep Desk Ceiling	2011	13,244	1,324	10	1,324		7,836	57
58	Front Entry/Recep Desk Ceramic Tiling	2011	580	58	10	58		338	58
59	Cabinets for Beauty Shop	2011	3,800	380	10	380		2,470	59
60	Awning	2011	2,625	263	10	263		1,619	60
61	Hinds Environmental Testing Tiles	2011	5,610	561	10	561		3,413	61
62	Beauty Shop - Flooring	2011	691	69	10	69		432	62
63	Trane	2011	8,154	815	10	815		4,960	63
64	Front Entry/Tape, Paint, Wallpaper	2011	6,840		5			6,728	64
65	Smoke hut for staff	2011	4,700	470	10	470		2,859	65
66	Nursing Storage Shed	2011	3,905	391	10	391		2,376	66
67	Walkin Cooler / Freezer	2013	16,602	1,660	10	1,660		7,194	67
68	Walkin Coolor Install - Wiring	2013	9,836	492	20	492		2,008	68
69	Water Heater - 100gal Laundry	2013	5,980	598	10	598		2,542	69
70	TOTAL (lines 4 thru 69)		$ 5,336,132	$ 221,057		$ 221,057	$	$ 4,582,973	70

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		$ 5,336,132	$ 221,057		$ 221,057	$	$ 4,582,973	1
2	12 Gal Hot Water Heater Therapy	2013	652	65	10	65		261	2
3	Trane Roof Top Air Conditioner	2013	13,542	1,354	10	1,354		5,304	3
4	Serving Line Upgrade (Tray Slide)	2013	82,049	8,205	10	8,205		32,819	4
5	Serving Line Upgrade	2013	2,125	213	10	213		779	5
6	Closets Coat Station Rooms 200-300	2013	25,992	1,733	15	1,733		6,931	6
7	#1292F Vinyl Flooring	2014	715	71	10	71		250	7
8	Build Kitchen Office/Remodel Breakroom	2013	21,543	2,154	10	2,154		7,899	8
9	100 gallon water heater (2)	2014	11,400	1,140	10	1,140		3,420	9
10	Trane AC rooftop unit	2014	9,241	924	10	924		2,772	10
11	Trane AC rooftop unit	2014	9,241	924	10	924		2,772	11
12	Electrical boxes upgrade	2014	15,793	1,579	10	1,579		4,212	12
13	Back Door lock/alarm	2014	1,150	115	10	115		307	13
14	Replace carpet 1210 Fairview	2014	1,836	367	5	367		949	14
15	Replace Carpet unit 1230 Fair Haven	2014	1,835	367	5	367		978	15
16	kitchen faucet & sink replace	2015	746	75	10	75		180	16
17	Install of Trane rooftop HVAC	2015	6,742	674	10	674		1,517	17
18	Screened Pourch Sunroom	2015	29,413	2,941	10	2,941		6,373	18
19	Install Larson storm doors	2015	4,150	593	7	593		1,285	19
20	1790 Fairwiew concrete replacement	2014	2,526	168	15	168		449	20
21	Fulton Ave sidewalk & road repair	2015	29,333	2,933	10	2,933		6,111	21
22	Station 2 new fence and rail	2015	7,153	715	10	715		1,372	22
23	Bradford White Water heater	2015	6,045	605	10	605		957	23
24	Accutech wounder guard courtyard doors	2016	8,970	897	10	897		1,196	24
25	Therapy Gym AC with damper controls	2016	2,762	276	10	276		345	25
26	Asphalt back parking lot	2016	33,597	3,360	10	3,360		3,920	26
27	35 LED ARD light fixtures pathways	2016	24,688	2,469	10	2,469		2,675	27
28	Paint Exterior windows & Soffits	2016	24,000	2,400	10	2,400		2,600	28
29	Dining hall new roofing system	2016	30,297	3,030	10	3,030		3,282	29
30	Remodel kitchen & dishwasher area floor	2016	15,632.8	1,563	10	1,563		1,563	30
31	Southwest wing Roof	2016	4,081.6	408	10	408		408	31
32	HVAC 24x24x8 Supply Diffuser power unit	2016	1,564.6	156	10	156		156	32
33	Parking blocks at rear parking lot	2016	2,295.0	210	10	210		210	33
34	TOTAL (lines 1 thru 33)		$ 5,767,242	$ 263,742		$ 263,742	$	$ 4,687,225	34

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		$ 5,767,242	$ 263,742		$ 263,742	$	$ 4,687,225	1
2	Front parking lot asphalt	2016	59,981.0	4,499	10	4,499		4,499	2
3									3
4	Landscaping trees emerald grass seeds	2016	356.4	24	10	24		24	4
5	Install outdoor light pole w/ fixture	2016	1,679.6	112	10	112		112	5
6	Kitchen fixtures and faucet handles	2016	781.2	46	10	46		46	6
7	Install kitchen sink for dishwashing	2016	6,167.5	360	10	360		360	7
8	Install bathroom exhaust fans (34)	2017	3,349.8	167	10	167		167	8
9	New vinyl flooring in kitchen 30x15	2017	1,250.0	63	10	63		63	9
10	Life Safety emergency pannel	2017	4,795.0	200	10	200		200	10
11	New Fire Alarm board	2017	3,818.9	159	10	159		159	11
12	Bradford White Water heater D100T	2017	6,000.0	100	10	100		100	12
13									13
14									14
15									15
16	Flooring in Bathroom unit 313 311	2017	2,793.8	23	10	23		23	16
17	Therapy Room Plank Flooring	2017	2,296.4	19	10	19		19	17
18	Wing 400 Women/Mens Restrooms - Tile Flooring, Paint, Toilets,	2016	21,791	484	30	484		484	18
19	Awning	2016	3,930	87	30	87		87	19
20	Wing 400 Remodel - Painting, Flooring, Electrical, Hand Rails, Ba	2016	427,722	9,506	30	9,506		9,506	20
21	Wing 1 - 10 Bathrooms, New toilets, and Vinyl Tile	2017	3,479	29	10	29		29	21
22	Wing 1 - New Vinyl Planking Floor and Base for 18 Resident Roor	2017	17,288	144	10	144		144	22
23	Wing 2 - 12 Bathrooms, New toilets, and Vinyl Tile	2017	3,796	32	10	32		32	23
24	Wing 2 - New Vinyl Planking Floor and Base for 21 Resident Roor	2017	18,029	150	10	150		150	24
25	Wing 3 - 11 Bathrooms, New toilets, and Vinyl Tile	2017	3,854	32	10	32		32	25
26	Wing 3 - New Vinyl Planking Floor and Base for 20 Resident Roor	2017	15,586	130	10	130		130	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 6,375,987**	**$ 280,108**		**$ 280,108**	**$**	**$ 4,703,591**	34

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 723,891	$ 85,351	$ 85,351	$	Various	$ 555,581	71
72	Current Year Purchases	85,296	14,363	14,363		Various	14,363	72
73	Fully Depreciated Assets	871,931				Various	871,931	73
74	Home Office allocation	228,271	27,468	27,468			174,058	74
75	TOTALS	$ 1,909,389	$ 127,182	$ 127,182	$		$ 1,615,933	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	2017 Dodge Grand Caravan	2017	$ 35,105	$ 731	$ 731	$	4	$ 731	76
77	Patient Transportation	2016 Ford Starcraft	2015	56,060	14,015	14,015		4	22,191	77
78										78
79	Home Office Allocation			10,091	1,148	1,148			8,590	79
80	TOTALS			$ 101,256	$ 15,894	$ 15,894	$		$ 31,512	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)	$ 8,448,295	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 423,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 423,184	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)	$ 6,351,036	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	1,011,479	28,244	757,912	87
88					88
89					89
90					90
91	TOTALS	$ 1,058,716	$ 28,244	$ 757,912	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 16,250	92
93			93
94			94
95		$ 16,250	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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 29,488 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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$	7,364	$ 400,533	$	7,364	$ 400,533	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,405	133,172		2,405	133,172	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		8,516	362,134		8,516	362,134	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				376,854		376,854	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab						19,090		19,090	12
13	Other (specify): Radiology						16,520		16,520	13
14	TOTAL			$	18,285	$ 895,839	$ 412,464	18,285	$ 1,308,303	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 Villag **#** 0018143 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/17 **(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	$ 5,431	$	1
2	Cash-Patient Deposits	42,151		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 285,448)	2,720,348		3
4	Supply Inventory (priced at)	19,138		4
5	Short-Term Investments	3,291,559		5
6	Prepaid Insurance	14,795		6
7	Other Prepaid Expenses	15,315		7
8	Accounts Receivable (owners or related parties)	7,302,940		8
9	Other(specify): AR - Other/ Acc Int Rec	8,896		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,420,573	$	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	6,896,419		14
15	Leasehold Improvements, at Historical Cost	335,057		15
16	Equipment, at Historical Cost	1,858,582		16
17	Accumulated Depreciation (book methods)	(6,870,355)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	26,642		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	10,067		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,358,287	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,778,860	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,151		28
29	Short-Term Notes Payable	13,593		29
30	Accrued Salaries Payable	197,120		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,258		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 263,122	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,617,075		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		8,203		43
44		146,967		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,772,245	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,035,367	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,743,493	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,778,860	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,322,553	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,322,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,938	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) Rounding	2	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 420,940	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)**	$ 13,743,493	24 *

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

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 9,715,057	1
2	Discounts and Allowances for all Levels	(6,397,677)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,317,380	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,716,165	6
7	Oxygen	13,676	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,729,841	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	26,894	13
14	Non-Patient Meals	3,323	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	504,012	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,490	19
20	Radiology and X-Ray	33,087	20
21	Other Medical Services	174,065	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 778,871	23
	D. Non-Operating Revenue		
24	Contributions	25,142	24
25	Interest and Other Investment Income***	72,146	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97,288	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	IL Duplex Revenue	124,096	28
28a	Misc Revenue	87,686	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 211,782	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,135,162	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,291,807	31
32	Health Care	4,474,640	32
33	General Administration	2,589,719	33
	B. Capital Expense		
34	Ownership	491,305	34
	C. Ancillary Expense		
35	Special Cost Centers	539,652	35
36	Provider Participation Fee	327,101	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,714,224	40
41	**Income before Income Taxes (line 30 minus line 40)****	420,938	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 420,938	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,496,698	44
45	Private Pay - Net Inpatient Revenue	1,523,385	45
46	Medicare - Net Inpatient Revenue	(2,501,752)	46
47	Other-(specify) HMO/HMO Ancillary/Med Adv	(200,951)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,317,380	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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,336	2,432	$ 105,678	$ 43.45	1
2	Assistant Director of Nursing	956	1,038	39,031	37.60	2
3	Registered Nurses	17,950	18,946	530,828	28.02	3
4	Licensed Practical Nurses	35,431	38,223	851,165	22.27	4
5	CNAs & Orderlies	122,136	129,871	1,543,762	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,228	2,310	34,731	15.04	9
10	Activity Assistants	3,306	3,414	32,743	9.59	10
11	Social Service Workers	6,312	6,727	122,081	18.15	11
12	Dietician					12
13	Food Service Supervisor	1,669	1,786	35,992	20.15	13
14	Head Cook	5,895	6,165	59,749	9.69	14
15	Cook Helpers/Assistants	23,871	25,548	234,512	9.18	15
16	Dishwashers					16
17	Maintenance Workers	5,807	6,260	124,183	19.84	17
18	Housekeepers	15,837	16,723	156,835	9.38	18
19	Laundry	5,896	6,501	66,738	10.27	19
20	Administrator	2,042	2,152	137,634	63.96	20
21	Assistant Administrator	348	372	8,768	23.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,241	9,800	163,884	16.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,983	2,177	46,210	21.23	31
32	Other Health C: Marketing/Barber	2,933	3,089	79,778	25.83	32
33	Other(specify) Duplex	227	239	2,281	9.54	33
34	TOTAL (lines 1 - 33)	266,404	283,773	$ 4,376,583 *	$ 15.42	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	378	$ 15,957	V01-3	35
36	Medical Director	416	42,000	V09-3	36
37	Medical Records Consultant	24	1,660	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	3,913	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	62	4,486	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,071	$ 68,016		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 Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer West	Administrator	0	$ 137,634
David Mabry	Asst Administrator	0	8,768
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 146,402

B. Administrative - Other

Description	Amount
Management Fee	$ 699,481
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 699,481

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Employee Survey	$ 238
Davis & Campbell	Legal	7,406
Sevastianos & Associates	Legal	90
Receivable Mgmt Services	Legal	3,791
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 11,526

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,084
Unemployment Compensation Insurance	14,715
FICA Taxes	317,873
Employee Health Insurance	481,388
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	23,322
Employee Uniforms	(3,895)
Employee Expense	14,573
457 Plan Expense	1,125
Home Office Adjustment	59,984
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,032,169

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License	6,908
Dues	14,275
Subscriptions	14,836
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,019

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,506
In-State Travel	4,859
Seminar Expense	1,254
Home Office Adjustment	35,372
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 44,991

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Villag # 0018143 Report Period Beginning: 7/1/16 Ending: 6/30/17

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. **Leading Age - $16,429.20**

(3) Did the nursing home make political contributions or payments to a politica 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. $ **45,776** 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 fo 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 Departmen during this cost report period. $ **327,101**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. $ **3,323**

(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 fo 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: **PLANTE MORAN PLLC**

(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