

Facility Name & ID Number Fair Havens Christian Home

0018143 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>161</u>	Skilled (SNF)	<u>161</u>	<u>58,765</u>	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	<u>161</u>	TOTALS	<u>161</u>	<u>58,765</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	4 Other		
8	SNF	<u>32,004</u>	<u>10,277</u>	<u>6,993</u>	<u>49,274</u>	8
9	SNF/PED					9
10	ICF	<u>117</u>	<u>2,987</u>		<u>3,104</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,121</u>	<u>13,264</u>	<u>6,993</u>	<u>52,378</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.13%

D. How many bed-hold days during this year were paid by the Department?

366 (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)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 161 and days of care provided 6,993

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

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

STATE OF ILLINOIS

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Facility Name & ID Number

Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2004

Ending:

June 30, 2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	270,770	38,347	14,006	323,123		323,123		323,123		1
2	Food Purchase		269,847		269,847		269,847	3,852	273,699		2
3	Housekeeping	264,148	55,614		319,762		319,762		319,762		3
4	Laundry										4
5	Heat and Other Utilities			144,349	144,349		144,349	1,973	146,322		5
6	Maintenance	68,606	15,508	36,396	120,510		120,510	11,219	131,729		6
7	Other (specify):*										7
8	TOTAL General Services	603,524	379,316	194,751	1,177,591		1,177,591	17,044	1,194,635		8
	B. Health Care and Programs										
9	Medical Director			28,000	28,000		28,000		28,000		9
10	Nursing and Medical Records	2,322,104	345,336	14,759	2,682,199		2,682,199	(6,633)	2,675,566		10
10a	Therapy			445,478	445,478		445,478		445,478		10a
11	Activities	39,184			39,184		39,184		39,184		11
12	Social Services	102,860	7,286	8,053	118,199		118,199		118,199		12
13	CNA Training										13
14	Program Transportation			89	89		89		89		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,464,148	352,622	496,379	3,313,149		3,313,149	(6,633)	3,306,516		16
	C. General Administration										
17	Administrative	71,488	1,424	492,816	565,728		565,728	(420,194)	145,534		17
18	Directors Fees										18
19	Professional Services			78,689	78,689		78,689	12,636	91,325		19
20	Dues, Fees, Subscriptions & Promotions			52,228	52,228		52,228	(29,453)	22,775		20
21	Clerical & General Office Expenses	184,567	16,943	145,371	346,881		346,881	30,687	377,568		21
22	Employee Benefits & Payroll Taxes			701,215	701,215		701,215	35,925	737,140		22
23	Inservice Training & Education										23
24	Travel and Seminar			22,633	22,633		22,633	7,382	30,015		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			151,172	151,172		151,172	1,095	152,267		26
27	Other (specify):*										27
28	TOTAL General Administration	256,055	18,367	1,644,124	1,918,546		1,918,546	(361,922)	1,556,624		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,323,727	750,305	2,335,254	6,409,286		6,409,286	(351,511)	6,057,775		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

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			189,789	189,789		189,789	45,174	234,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,840	20,840		20,840	(20,840)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Financing Fee			420	420		420		420			36
37	TOTAL Ownership			211,049	211,049		211,049	24,334	235,383			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			54,324	54,324		54,324		54,324			39
40	Barber and Beauty Shops	24,845	846		25,691		25,691		25,691			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,148	88,148		88,148		88,148			42
43	Other (specify):* Apt/Cong			472,116	472,116		472,116		472,116			43
44	TOTAL Special Cost Centers	24,845	846	614,588	640,279		640,279		640,279			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,348,572	751,151	3,160,891	7,260,614		7,260,614	(327,177)	6,933,437			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

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	3,852	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,200)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,842	30		9
10	Interest and Other Investment Income	(73,067)	32		10
11	Discounts, Allowances, Rebates & Refunds	2,399	21		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	(66,346)	21		24
25	Fund Raising, Advertising and Promotional	(2,410)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	16,708			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,222)		\$	30

OHF 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	2	
		Amount	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)	(219,955)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (219,955)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (327,177)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Fair Havens Christian Home

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (1,752)	17	1
2	Activity Expense	77	17	2
3	Increase in Cash Value of Life Insurance	(287)	17	3
4	Interest Income on Endowment Investments	28,690	32	4
5	Loss on Equipment Disposal	607	17	5
6	Marketing	(27,043)	20	6
7	Related Pharmacy Profit	(6,633)	10	7
8	Miscellaneous	(55)	17	8
9	Interest income in excess of expense	23,104	32	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	16,708		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2004

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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	3,852	0	0	0	0	0	0	0	0	0	0	3,852	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	(11,200)	13,173	0	0	0	0	0	0	0	0	0	1,973	5
6	Maintenance	0	11,219	0	0	0	0	0	0	0	0	0	11,219	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,348)	24,392	0	17,044	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	(6,633)	0	0	0	0	0	0	0	0	0	0	(6,633)	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	(6,633)	0	0	0	0	0	0	0	0	0	0	(6,633)	16
	C. General Administration													
17	Administrative	(1,410)	(418,784)	0	0	0	0	0	0	0	0	0	(420,194)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,636	0	0	0	0	0	0	0	0	0	12,636	19
20	Fees, Subscriptions & Promotions	(29,453)	0	0	0	0	0	0	0	0	0	0	(29,453)	20
21	Clerical & General Office Expenses	(63,947)	94,634	0	0	0	0	0	0	0	0	0	30,687	21
22	Employee Benefits & Payroll Taxes	0	35,925	0	0	0	0	0	0	0	0	0	35,925	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,382	0	0	0	0	0	0	0	0	0	7,382	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,095	0	0	0	0	0	0	0	0	0	1,095	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(94,810)	(267,112)	0	(361,922)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,791)	(242,720)	0	(351,511)	29								

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc	100.00%	\$ 13,173	\$ 13,173 1
2	V	6 Maintenance				11,219	11,219 2
3	V	17 Administrative	492,816			74,032	(418,784) 3
4	V	19 Professional Services				12,636	12,636 4
5	V	21 Clerical				94,634	94,634 5
6	V	22 Employee Benefits				35,925	35,925 6
7	V	24 Travel & Seminar				7,382	7,382 7
8	V	26 Insurance				1,095	1,095 8
9	V	30 Depreciation				22,332	22,332 9
10	V	32 Interest				433	433 10
11	V						
12	V						
13	V						
14	Total		\$ 492,816			\$ 272,861	\$ * (219,955) 14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	This workpaper is not applicable.								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2004 Ending: ne 30, 2005

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	This workpaper is not applicable.				\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

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	1993-A GR Bond	x		Debt Restructure	\$3,110.63	01/01/93	\$ 420,000	\$ 317,310	01/01/18	0.0650	\$ 20,840	1								
2	T/E Bonds/Village of Forsythe	x		Construction int capitalized	\$19,097.00	10/12/04	6,800,000	6,800,000	11/12/09	0.0337		2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$22,207.63		\$ 7,220,000	\$ 7,117,310			\$ 20,840	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 7,220,000	\$ 7,117,310			\$ 20,840	15								

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Fair Havens Christian Home**# **0018143** Report Period Beginning: **July 1, 2004** Ending: **June 30, 2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2004 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.)		\$ n/a	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3
4.	Real Estate Tax accrual used for 2005 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.		\$ #VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2000	_____	8	
	2001	_____	9	
	2002	_____	10	
	2003	_____	11	
	2004	_____	12	
FOR OHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-12-21-428-011</u>	<u>21-16-2 Mueller's 3rd RSVY</u>	\$ <u>355.48</u>	\$ _____
2. <u>07-07-15-451-006</u>	<u>Hickory Point Christian Village Lot 1</u>	\$ <u>3,010.04</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>3,365.52</u>	\$ _____

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Fair Havens Christian Home

0018143 Report Period Beginning:

July 1, 2004 Ending:

June 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,500 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	57,000	1972	\$ 54,638	1
2	Home Office Allocation			9,594	2
3	TOTALS	57,000		\$ 64,232	3

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155	1977	1977	\$ 2,180,767	\$ 51,312	40	\$ 54,519	\$ 3,207	\$ 1,505,554	4
5				384,841		20	19,242	19,242		5
6	6	1983	1983	109,815	2,745	35	3,138	393	59,018	6
7										7
8	Home Office Allocation			69,442	2,238		2,238		34,887	8
	Improvement Type**									
9	Wall Guards		1979	485		15			485	9
10	Garage		1979	4,167	139	30	139		3,683	10
11	Heat Tapes		1980	2,151		15			2,151	11
12	Heating System		1981	14,100		10			14,100	12
13	Wall Coverings		1981	1,277		10			1,277	13
14	Heating Control System		1982	20,503		20			20,503	14
15	Fence Guard Rail		1982	2,027		10			2,027	15
16	Electric Work		1982	2,133		10			2,133	16
17	Fire Alarm		1982	858		20			858	17
18	New Office		1983	2,700	90	30	90		2,025	18
19	Wallcovering		1983	2,301		10			2,301	19
20	Tiling		1983	615		10			615	20
21	Office Remodel		1984	2,594	86	30	86		1,842	21
22	Window Installation		1984	2,083		10			2,083	22
23	Down Spouts		1984	639		10			639	23
24	Floor Covering		1984	550		10			550	24
25	Roof Work		1984	163,201	4,080	40	4,080		91,203	25
26	Electric Door		1984	10,229		10			10,229	26
27	Floor Covering		1985	3,457		10			3,457	27
28	Fire Alarm		1985	1,705	54	20	54		1,705	28
29	Windows		1985	3,558		10			3,558	29
30	Roof		1985	29,843		15			29,843	30
31	Door Kick Guards		1985	419		10			419	31
32	Electrical Recepticals		1986	2,419	121	20	121		2,318	32
33	Wiring		1987	7,530	376	20	376		6,923	33
34	Ceiling		1987	300		10			300	34
35	Rewiring		1987	1,600	80	20	80		1,413	35
36	Wallpapering		1989	505		5			505	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Signs	1989	\$ 1,224	\$	5	\$	\$	\$ 1,224		37
38	Soap Dispensers	1989	672		5			672		38
39	Compressor Freezer	1989	810		5			810		39
40	Storage Cabinet	1990	1,100	48	15	48		1,100		40
41	Tempering Valve	1990	3,199	146	15	146		3,199		41
42	Remodel Dining Room	1991	4,708	235	20	235		3,525		42
43	Install Panic Bars	1991	780		10			780		43
44	Install Window	1991	988	66	15	66		941		44
45	Flooring	1991	4,380		5			4,380		45
46	Roof Repair	1991	29,860	1,991	15	1,991		28,206		46
47	A/C Compressor	1991	1,076		5			1,076		47
48	Touchpads Exit Door	1991	792		10			792		48
49	Stainless Steel Sink	1991	1,630		10			1,630		49
50	Walkway Canopy	1991	4,412	221	20	221		3,039		50
51	Showers	1991	3,669		10			3,669		51
52	Remodel Office	1992	8,715	436	20	436		5,704		52
53	Door Locks & Magnets	1992	2,540		10			2,540		53
54	Interior Landscaping	1992	3,839		10			3,839		54
55	Handrails	1993	12,800	853	15	853		10,663		55
56	Wall Cabinets	1993	2,564	171	15	171		2,109		56
57	Bathroom Remodel	1993	12,341	617	20	617		7,507		57
58	Nurses Station Desks	1994	18,588	929	20	929		10,606		58
59	Alarm/Auto Door	1994	4,257		10			4,257		59
60	Cabinets	1994	1,480	99	15	99		1,097		60
61	Carpeting in Office	1993	979		5			979		61
62	Gas Rooftop Piping	1994	4,905	245	20	245		2,634		62
63	Heating & A/C Unit	1994	5,565	278	20	278		2,989		63
64	Remodel Garage	1995	3,704	220	10	220		3,704		64
65	Remodel Nurses Station	1995	15,656	1,301	10	1,301		15,656		65
66	Thru Wall A/C Unit	1995	3,120		8			3,120		66
67	Flourescent Light Covers	1995	1,218		5			1,218		67
68	Roof Work	1995	52,000	3,467	15	3,467		34,959		68
69	Service Sink	1995	1,003	86	10	86		1,003		69
70	TOTAL (lines 4 thru 69)		\$ 3,243,388	\$ 72,730		\$ 95,572	\$ 22,842	\$ 1,978,231		70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,243,388	\$ 72,730		\$ 95,572	\$ 22,842	\$ 1,978,231	1
2	Wallcovering Dayroom Station 1	1995	2,573		5			2,573	2
3	Baseboard Pipe	1995	2,978		5			2,978	3
4	Thru Wall A/C	1995	3,120		8			3,120	4
5	Shower Valves	1995	1,807	181	10	181		1,765	5
6	Resident Room Signs	1995	1,516		5			1,516	6
7	Utility Room Cabinet	1995	599	40	15	40		390	7
8	Magnets for Fire Doors	1995	795		5			795	8
9	Fire Door Closers	1995	1,200		5			1,200	9
10	Install 2 Deck Faucets	1995	826		5			826	10
11	Install Sprinkler Laundry	1995	557	56	10	56		541	11
12	Electronic Thermostats	1995	733		5			733	12
13	Breakers 6/receptacles	1995	883		5			883	13
14	Remodel Main Lobby	1995	4,569		5			4,569	14
15	Remodel Station	1996	12,472		5			12,472	15
16	Rooftop Heating/AC Dining Room	1996	11,975	1,198	10	1,198		11,381	16
17	Floorwork Dayroom	1996	2,247		5			2,247	17
18	Heating & A/C Station	1996	7,550	755	10	755		7,110	18
19	Floorwork Dining Room	1996	6,974	697	10	697		6,563	19
20	Water Softener	1996	10,580	1,058	10	1,058		9,698	20
21	2 Sprinkler Cooler	1996	772		5			772	21
22	Remodel Station	1996	8,261		5			8,261	22
23	Shelving Linen Closet	1997	540		5			540	23
24	Gas Piping in Laundry	1997	1,155	116	10	116		957	24
25	Heating & A/C Rooftop	1997	8,950	895	10	895		7,309	25
26	Floorwork Station 4 Hall	1997	10,153	1,015	10	1,015		8,205	26
27	Dining Room Announcement	1997	549		5			549	27
28	Remodel Beauty Shop	1997	1,370		5			1,370	28
29	Energy Management System	1997	14,637	732	20	732		5,612	29
30	Remove Slab Freezer Area	1997	2,860		3			2,860	30
31	Floor Tile - Station 4 Rooms	1998	7,500		5			7,500	31
32	Station 3 Carrier FR A/C	1998	7,597	760	10	760		5,383	32
33	Carpet Chapel/Lobby/Office	1998	2,483		5			2,483	33
34	TOTAL (lines 1 thru 33)		\$ 3,384,169	\$ 80,233		\$ 103,075	\$ 22,842	\$ 2,101,392	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:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,384,169	\$ 80,233		\$ 103,075	\$ 22,842	\$ 2,101,392		1
2	Wood Cove BS/60 Rooms	1998 9,412		5			9,412		2
3	Alarm System	1998 11,937	1,194	10	1,194		8,452		3
4	Wallpaper Station 1 & 2 Rooms	1998 38,443		5			38,443		4
5	Ventilation - Electric Room	1999 1,875		5			1,875		5
6	48-Safety Grab Bars	1999 864		5			864		6
7	161-Glass/Resident Walls	1999 2,256	226	10	226		1,507		7
8	Install Grab Bars	1999 2,401	240	10	240		1,560		8
9	Install 24V Door Closer	1999 1,189		5			1,189		9
10	Water Heater - Station 3	1999 655		5			655		10
11	Remodel Station 4	1999 26,585	1,772	15	1,772		11,067		11
12	Back Door Alarm Pad	1999 2,874	287	10	287		1,794		12
13	Nurse Call Units	1999 598	60	10	60		370		13
14	Front Countertop	1999 881	59	15	59		364		14
15	Mixing Valve/Install	1999 524		5			524		15
16	Pella Storm Window - 13	1999 527		5			527		16
17	Smoke Detectors-4	1999 553	55	10	55		335		17
18	Carrier Rooftop Unit	1999 6,779	678	10	678		4,124		18
19	Wallpaper Station 3 Rooms	1999 23,706		5			23,706		19
20	Compressors (3)	2000 2,239		3			2,239		20
21	Cove Base-Station 3	2000 1,408	45	5	45		1,408		21
22	Baseboard	2000 1,371	69	5	69		1,371		22
23	Light Fixtures (2 Day Room)	2000 947	95	10	95		546		23
24	Floor Tile-Hall/Bath/Kitchen	2000 3,079	204	5	204		3,079		24
25	Panic	2000 1,059	123	5	123		1,059		25
26	Security Locks-Front Door	2000 900	135	5	135		900		26
27	Exhaust Fans (6)	2000 702	107	5	107		702		27
28	Carrier Rooftop Unit	2000 7,637	764	10	764		3,947		28
29	Ceiling Grid Covers	2000 1,418	177	8	177		900		29
30	Compressor Room 101	2000 1,131	75	15	75		381		30
31	REMODELING FHCH	2000 6,395	640	10	640		3,147		31
32	REMODELING PROJECT	2000 7,075	708	10	708		3,245		32
33	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001 20,942	2,094	10	2,094		8,551		33
34	TOTAL (lines 1 thru 33)	\$ 3,572,531	\$ 90,040		\$ 112,882	\$ 22,842	\$ 2,239,635		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:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,572,531	\$ 90,040		\$ 112,882	\$ 22,842	\$ 2,239,635	1
2	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		520	2
3	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001	782	78	10	78		312	3
4	Compressor - Dining Room A/C	10/6/2001	646	55	3	55		646	4
5	Replace (8) Fire Alarm-A/C Relays	4/17/2002	1,519	380	3	380		1,519	5
6	Heating & Cooling System - Office	6/14/2002	2,275	228	10	228		703	6
7	Locks (3) for Fire Doors	6/15/2002	4,077	408	10	408		1,258	7
8	2-Compressors-Station One Day Room	7/12/2002	1,128	376	3	376		1,128	8
9	Tile Work-Kitchen, Mechanical Room & 7D	8/14/2002	5,580	279	20	279		814	9
10	Water Cooler-Station #1	9/6/2002	715	143	5	143		405	10
11	(22) Carrier through the wall A/C units	9/1/2002	28,380	3,548	8	3,548		10,053	11
12	Floor Covering/Cove Base - 11 Baths	9/18/2002	3,960	792	5	792		2,244	12
13	(2) Exit doors & Installation	11/21/2002	2,718	136	20	136		363	13
14	Reroof Garage	1/8/2003	1,665	278	6	278		695	14
15	(36) Bathroom Grab Bars-Stats	1/19/2003	7,677	768	10	768		1,920	15
16	Install New Circuit for Food Well	3/22/2003	511	102	5	102		238	16
17	Install New Locks on all doors	5/1/2003	2,550	255	10	255		553	17
18	Fire Alarm Door Closure/Holder	6/24/2003	895	90	10	90		188	18
19	Roof Top A/C Unit	6/30/2003	5,090	509	10	509		1,060	19
20	Blank								20
21	Data/Phone Lines - Cabling	7/17/2003	12,404	1,240	10	1,240		2,480	21
22	Replace Staff Dr A/C Compressor	7/17/2003	711	237	3	237		474	22
23	Hand sinks in resident rooms	8/13/2003	1,428	143	10	143		274	23
24	Additional Smoke Alarms on Fire System	9/11/2003	1,337	134	10	134		246	24
25	New Partitions in Front Restrooms	10/29/2003	2,794	279	10	279		488	25
26	Electrical Updates - Breakers/Panel	11/14/2003	31,417	1,571	20	1,571		2,618	26
27	Plans & Specs-Delayed Egress Locks	11/25/2003	2,571	257	10	257		386	27
28	Installation Panic Bar on Front Door	9/19/2003	735	147	5	147		270	28
29	High Efficiency Ballasts and Lights	12/11/2003	49,970	4,997	10	4,997		7,912	29
30	Replace Breakers	1/12/2004	5,962	298	20	298		447	30
31	10x12 Canopy Bldg	1/28/2004	1,500	150	10	150		213	31
32	Delayed Egress Locking System	1/21/2004	10,945	1,095	10	1,095		1,551	32
33	Resurface Dishwashing Area w/Gritty Floor	2/6/2004	2,150	430	5	430		573	33
34	TOTAL (lines 1 thru 33)		\$ 3,767,918	\$ 109,573		\$ 132,415	\$ 22,842	\$ 2,282,186	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:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 3,767,918	\$ 109,573		\$ 132,415	\$ 22,842	\$ 2,282,186		1
2	(12) YLLW Generator Powered Emergency	5/4/2004 518	52	10	52		61		2
3	Replace Compressor in PT Area A/C	5/19/2004 855	285	3	285		333		3
4	Delayed Egress Locking System	6/29/2004 12,373	1,237	10	1,237		1,340		4
5	Remodel Therapy Room w/Nurse Station	6/22/2004 8,101	810	10	810		878		5
6	Fully depreciated land improvements	10/21/1985 69,531		20			69,531		6
7	Sidewalk, landscaping, fence etc.	6/10/1992 24,404	1,221	20	1,221		19,176		7
8	Entrance sidewalk replacement	6/28/2001 7,850	786	10	786		7,114		8
9	Concrete work	5/30/2003 4,230	423	10	423		904		9
10	Storage shed (Disposed)	4/4/2000 1,495	25	10	25		663		10
11	New Liquid O2 Building	6/2/2003 1,995	200	10	200		417		11
12	Fire Rated Door on Oxygen Bldg	8/29/2003 1,936	194	10	194		372		12
13	Fence - Garbage Area	7/3/2003 1,596	160	10	160		320		13
14	Consult/Replace Sidewalks - NH to Parking Lot	5/20/2004 11,455	1,146	10	1,146		1,337		14
15	In Sink Erator - Disposal	8/24/2004 1,399	140	10	140		140		15
16	Replace Compressor in Admin Ofc	8/18/2004 779	238	3	238		238		16
17	Door w/Interior Keypad & Request to Enter	9/13/2004 1,922	160	10	160		160		17
18	Install Steel Full View Hinged Patio Door	9/13/2004 1,085	91	10	91		91		18
19	Engineering Services - Door Systems Design	9/27/2004 810	135	5	135		135		19
20	Install New Computer On Energy Mgmt Sys	11/2/2004 6,000	1,333	3	1,333		1,333		20
21	(45) GE Zonelight Units	1/14/2005 49,747	1,555	8	1,555		1,555		21
22	Engin/Arch SVC-Potential Lighting	1/17/2005 5,507	276	10	276		276		22
23									23
24									24
25									25
26									26
27									27
28	Less: Disposals		(1,495)				(663)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,980,011	\$ 120,040		\$ 142,882	\$ 22,842	\$ 2,387,897		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 556,808	\$ 67,471	\$ 67,471	\$	Various	\$ 374,095	71
72	Current Year Purchases	51,258	4,516	4,516		Various	4,516	72
73	Fully Depreciated Assets	601,481				Various	601,481	73
74	Home Office Allocation	122,908	16,974	16,974			65,481	74
75	TOTALS	\$ 1,332,455	\$ 88,961	\$ 88,961	\$		\$ 1,045,573	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77	Patient Transportation	Van	1988	3,317				3	3,317	77
78										78
79	Home Office Allocation			14,431	3,120	3,120			5,490	79
80	TOTALS			\$ 17,748	\$ 3,120	\$ 3,120	\$		\$ 8,807	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)	\$ 5,394,446	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 212,121	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 234,963	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,842	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,442,277	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	\$ 359,816	\$	\$	86
87	Duplex/Equipent	6,811,355	190,631	1,728,983	87
88	Forysth Land & Assist Living	3,425,676			88
89	Other Equipment/Buildings	11,494	195	4,572	89
90	Land Improvements	661,994	36,799	312,487	90
91	TOTALS	\$ 11,270,335	\$ 227,625	\$ 2,046,042	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.
 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

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
			2	3	4	5				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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

Page 17

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2005 (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 183,376	\$	1
2 Cash-Patient Deposits	23,343		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 181,828)	899,301		3
4 Supply Inventory (priced at FIFO)	12,127		4
5 Short-Term Investments	1,562,120		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	9,631		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Accrued Int & Other A/R</u>	14,009		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,703,907	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	414,453		13
14 Buildings, at Historical Cost	781,056		14
15 Leasehold Improvements, at Historical Cost	10,288,609		15
16 Equipment, at Historical Cost	1,538,595		16
17 Accumulated Depreciation (book methods)	(5,382,461)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	5,276,988		21
22 Other Long-Term Assets (spe CIP)	3,425,676		22
23 Other(specify): <u>Def Bond Cost & Other</u>	106,158		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,449,074	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,152,981	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 289,451	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	28,643		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	164,582		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	3,188		32
33 Accrued Interest Payable			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)	\$ 485,864	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable	6,800,000		40
41 Bonds Payable	317,310		41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 <u>Deferred Apt Income</u>	1,254,448		43
44 <u>Apt & Cong Life Right & Security DP</u>	3,724,843		44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,096,601	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,582,465	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 6,570,516	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,152,981	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,283,802	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,283,802	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	241,714	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)	\$ 241,714	17
B. Transfers (Itemize):			
18	Transfer In from Affiliate	45,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 45,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,570,516	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,799,666	1
2	Discounts and Allowances for all Levels	(1,824,816)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,974,850	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	723,880	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 723,880	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	35,916	13
14	Non-Patient Meals	3,852	14
15	Telephone, Television and Radio	1,200	15
16	Rental of Facility Space		16
17	Sale of Drugs	5,378	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,106	19
20	Radiology and X-Ray	29,427	20
21	Other Medical Services	(382)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,497	23
D. Non-Operating Revenue			
24	Contributions	104,682	24
25	Interest and Other Investment Income***	73,067	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 177,749	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Disposal/Investments	(1,632)	28
28a	Residential/Congregate	508,984	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 507,352	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,502,328	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,177,591	31
32	Health Care	3,313,149	32
33	General Administration	1,918,546	33
B. Capital Expense			
34	Ownership	211,049	34
C. Ancillary Expense			
35	Special Cost Centers	552,131	35
36	Provider Participation Fee	88,148	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,260,614	40
41	Income before Income Taxes (line 30 minus line 40)**	241,714	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 241,714	43

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

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

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

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

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2004

Ending:

June 30, 2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,853	2,192	\$ 61,250	\$ 27.94	1
2	Assistant Director of Nursing	2,058	2,437	56,481	23.18	2
3	Registered Nurses	7,221	8,498	235,950	27.77	3
4	Licensed Practical Nurses	31,808	34,390	607,323	17.66	4
5	CNAs & Orderlies	109,852	116,162	1,302,036	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,998	5,261	59,064	11.23	8
9	Activity Director	1,816	1,895	25,875	13.65	9
10	Activity Assistants	1,007	1,054	13,309	12.63	10
11	Social Service Workers	8,963	9,362	102,860	10.99	11
12	Dietician					12
13	Food Service Supervisor	3,342	3,878	49,286	12.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,683	25,123	221,484	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,783	3,847	68,606	17.83	17
18	Housekeepers	27,409	28,840	264,148	9.16	18
19	Laundry					19
20	Administrator	1,823	2,053	71,488	34.82	20
21	Assistant Administrator					21
22	Other Administrative	2,587	2,818	69,859	24.79	22
23	Office Manager	1,748	2,003	38,631	19.29	23
24	Clerical	5,324	5,822	76,077	13.07	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					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	2,266	2,278	24,845	10.91	33
34	TOTAL (lines 1 - 33)	240,541	257,913	\$ 3,348,572 *	\$ 12.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	306	\$ 14,006	1.3	35
36	Medical Director	82	28,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	173	3,261	10.3	39
40	Physical Therapy Consultant	2,070	160,425	10A.3	40
41	Occupational Therapy Consultant	1,649	124,428	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	378	29,120	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	105	7,963	12.3	45
46	Other(specify) Dental	11	550	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,774	\$ 367,753		49

C. CONTRACT NURSES

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

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2004

Ending: June 30, 2004

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 \$3,489, NAGNA \$2,000, INHAA \$100
- (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? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,289 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 88,148
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. \$ 3,852
- (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. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Fair Havens Christian Home
Allocation on Benefits

6/30/2005

kdb
3/20/2006

<u>Payroll Tax</u>	<u>Unemploy Contrib</u>	<u>Worker's Comp</u>	<u>Health Ins</u>	<u>Employee Comp. Med Ex</u>	<u>Employee Expense</u>	<u>Employee Uniforms</u>	<u>Employee Physicals</u>	
20,693.29	46,271.19	114,042.97	17,180.00		19,797.03	2,401.90	13,836.20	
92.81		1,147.89	5,320.00		72.79			
5,663.78			2,420.00					
20,404.05			19,600.00					
1,862.16								
18,947.49			22,140.00					
170,785.07			177,120.00					
10,375.96			11,040.00					
<u>248,824.61</u>	<u>46,271.19</u>	<u>115,190.86</u>	<u>254,820.00</u>	<u>0.00</u>	<u>19,869.82</u>	<u>2,401.90</u>	<u>13,836.20</u>	<u>701,214.58</u>

0.00

Line 3.22.3 701,214.58