

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0018143</u></p> <p>Facility Name: <u>Fair Havens Christian Home</u></p> <p>Address: <u>1790 South Fairview Avenue</u> <u>Decatur</u> <u>62521</u> Number City Zip Code</p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>217-429-2551</u> Fax # <u>217-429-2942</u></p> <p>HFS ID Number: <u>370987659001</u></p> <p>Date of Initial License for Current Owners: <u>12/12/1975</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Susan McGhee</u> Telephone Number: <u>217-732-5175</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2008</u> to <u>June 30, 2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Tim Phillippe</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Allan B. Larson</u> <u>Principal</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr, Ste 100, St. Louis, MO 63131</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</u></td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Tim Phillippe</u>			(Title) <u>CEO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Allan B. Larson</u> <u>Principal</u>		(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr, Ste 100, St. Louis, MO 63131</u>		(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</u>	
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Facility Name & ID Number Fair Havens Christian Home

0018143 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	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	161	Skilled (SNF)	154	58,478	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	161	TOTALS	154	58,478	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	24,726	15,413	12,677	52,816	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,726	15,413	12,677	52,816	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.32%

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

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

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 154 and days of care provided 11,409

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	348,891	35,012	18,930	402,833		402,833	1,677	404,510		1
2	Food Purchase		368,571		368,571		368,571	(4,971)	363,600		2
3	Housekeeping	283,042	46,225		329,267		329,267		329,267		3
4	Laundry		6,414		6,414		6,414		6,414		4
5	Heat and Other Utilities			187,666	187,666		187,666	11,746	199,412		5
6	Maintenance	110,184	16,242	58,657	185,083		185,083	3,055	188,138		6
7	Other (specify):* Trash Removal			10,812	10,812		10,812		10,812		7
8	TOTAL General Services	742,117	472,464	276,065	1,490,646		1,490,646	11,507	1,502,153		8
	B. Health Care and Programs										
9	Medical Director			34,500	34,500		34,500		34,500		9
10	Nursing and Medical Records	3,041,354	628,800	28,369	3,698,523	(354,996)	3,343,527	(24)	3,343,503		10
10a	Therapy		76	1,206,199	1,206,275		1,206,275		1,206,275		10a
11	Activities	97,827			97,827		97,827	32	97,859		11
12	Social Services	179,948	9,383	4,921	194,252		194,252		194,252		12
13	CNA Training										13
14	Program Transportation			578	578		578		578		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,319,129	638,259	1,274,567	5,231,955	(354,996)	4,876,959	8	4,876,967		16
	C. General Administration										
17	Administrative	166,749	5,145	577,548	749,442		749,442	(493,253)	256,189		17
18	Directors Fees										18
19	Professional Services			9,566	9,566		9,566	39,067	48,633		19
20	Dues, Fees, Subscriptions & Promotions			33,938	33,938		33,938		33,938		20
21	Clerical & General Office Expenses	153,775	16,426	14,222	184,423		184,423	282,466	466,889		21
22	Employee Benefits & Payroll Taxes			647,253	647,253		647,253	36,162	683,415		22
23	Inservice Training & Education										23
24	Travel and Seminar			20,588	20,588		20,588	16,620	37,208		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			160,214	160,214		160,214	1,944	162,158		26
27	Other (specify):* Marketing	54,681	5,619	10,971	71,271		71,271	(120,197)	(48,926)		27
28	TOTAL General Administration	375,205	27,190	1,474,300	1,876,695		1,876,695	(237,191)	1,639,504		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,436,451	1,137,913	3,024,932	8,599,296	(354,996)	8,244,300	(225,676)	8,018,624		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Fair Havens Christian Home

#0018143

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			312,655	312,655		312,655	22,778	335,433			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,818	71,818		71,818	(40,936)	30,882			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,726	20,726		20,726		20,726			35
36	Other (specify):* Purchased services/Finan.fees/Fines			552	552		552		552			36
37	TOTAL Ownership			405,751	405,751		405,751	(18,158)	387,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			92,423	92,423	354,996	447,419		447,419			39
40	Barber and Beauty Shops	7,613	372	30,447	38,432		38,432		38,432			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,148	88,148		88,148		88,148			42
43	Other (specify):* Apt/ Congregate			59,825	59,825		59,825	(59,825)				43
44	TOTAL Special Cost Centers	7,613	372	270,843	278,828	354,996	633,824	(59,825)	573,999			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,444,064	1,138,285	3,701,526	9,283,875		9,283,875	(303,659)	8,980,216			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,971)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,330)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(43,394)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	50,281	21		24
25	Fund Raising, Advertising and Promotional	(120,197)	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	(62,690)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (182,301)		\$	30

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)	(121,358)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (121,358)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (303,659)		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	X		354,996	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 354,996	47

BHF USE ONLY

48		49		50		51		52	
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Fair Havens Christian Home

ID# 0018143

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees	\$ (171)	6	1
2	Late Fees	(24)	10	2
3	Late Fees	(29)	21	3
4	Apartment/Congregate	(59,825)	43	4
5	Vending Expense	1,677	1	5
6	Activity Revenue	32	11	6
7	Increase in Cash Value of Life Insurance	(331)	17	7
8	Charity Care	(4,019)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(62,690)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home# 0018143

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	1,677	0	0	0	0	0	0	0	0	0	0	1,677	1
2	Food Purchase	(4,971)	0	0	0	0	0	0	0	0	0	0	(4,971)	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	(1,330)	13,076	0	0	0	0	0	0	0	0	0	11,746	5
6	Maintenance	(171)	3,226	0	0	0	0	0	0	0	0	0	3,055	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,795)	16,302	0	11,507	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	(24)	0	0	0	0	0	0	0	0	0	0	(24)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	32	0	0	0	0	0	0	0	0	0	0	32	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	8	0	0	0	0	0	0	0	0	0	0	8	16
	C. General Administration													
17	Administrative	(331)	(492,922)	0	0	0	0	0	0	0	0	0	(493,253)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	39,067	0	0	0	0	0	0	0	0	0	39,067	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	46,233	236,233	0	0	0	0	0	0	0	0	0	282,466	21
22	Employee Benefits & Payroll Taxes	0	36,162	0	0	0	0	0	0	0	0	0	36,162	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	16,620	0	0	0	0	0	0	0	0	0	16,620	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	1,944	0	0	0	0	0	0	0	0	0	1,944	26
27	Other (specify):*	(120,197)	0	0	0	0	0	0	0	0	0	0	(120,197)	27
28	TOTAL General Administration	(74,295)	(162,896)	0	(237,191)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,082)	(146,594)	0	(225,676)	29								

STATE OF ILLINOIS

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2008 Ending:

Summary B

June 30, 2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	22,778	0	0	0	0	0	0	0	0	0	22,778	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43,394)	2,458	0	0	0	0	0	0	0	0	0	(40,936)	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	(43,394)	25,236	0	(18,158)	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(59,825)	0	0	0	0	0	0	0	0	0	0	(59,825)	43
44	TOTAL Special Cost Centers	(59,825)	0	0	0	0	0	0	0	0	0	0	(59,825)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(182,301)	(121,358)	0	(303,659)	45								

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 listing of board members						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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%	\$ 13,076	\$ 13,076	1
2	V	6 Maintenance				3,226	3,226	2
3	V	17 Administrative	577,548			84,626	(492,922)	3
4	V	19 Professional Services				39,067	39,067	4
5	V	21 Clerical				236,233	236,233	5
6	V	22 Employee Benefits				36,162	36,162	6
7	V	24 Travel and Seminars				16,620	16,620	7
8	V	26 Insurance				1,944	1,944	8
9	V	30 Depreciation				22,778	22,778	9
10	V	32 Interest				2,458	2,458	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 577,548			\$ 456,190	\$ * (121,358)	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, 2008

Ending: ne 30, 2009

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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, 2008 Ending:

June 30, 2009

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										
										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	Series 2007 Project Fund		X	Renovation Projects		6/30/07	\$ 987,219	\$ 987,219	6/30/2031	0.0563	\$ 55,555	1							
2	Bond Fund	X		Refinance debt	\$725.00	Varies	281,635	271,512	6/30/2032	Various	16,263	2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$725.00		\$ 1,268,854	\$ 1,258,731			\$ 71,818	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,268,854	\$ 1,258,731			\$ 71,818	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, 2008 Ending:

June 30, 2009

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? (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).

NONE

F. 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>56,500</u>	<u>1972</u>	<u>\$ 54,638</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>7,003</u>	<u>2</u>
3	TOTALS	56,500		\$ 61,641	3

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	148		1977	1977	\$ 2,180,767	\$ 53,450	40	\$ 53,450		\$ 1,714,859	4
5					384,841		20				5
6	6		1983	1983	109,815	2,745	35	2,745		70,007	6
7											7
8	Home Office Allocation				66,516	4,871		4,871		125,283	8
	Improvement Type**										
9	Wall Guards			1979	485		15			485	9
10	Garage			1979	4,167	127	30	127		4,167	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	New Office			1983	2,700	90	30	90		2,385	17
18	Wallcovering			1983	2,301		10			2,301	18
19	Tiling			1983	615		10			615	19
20	Office Remodel			1984	2,594	86	30	86		2,198	20
21	Window Installation			1984	2,083		10			2,083	21
22	Down Spouts			1984	639		10			639	22
23	Floor Covering			1984	550		10			550	23
24	Roof Work			1984	163,201	4,080	40	4,080		102,341	24
25	Electric Door			1984	10,229		10			10,229	25
26	Floor Covering			1985	3,457		10			3,457	26
27	Fire Alarm			1985	1,705		20			1,705	27
28	Windows			1985	3,558		10			3,558	28
29	Roof			1985	29,843		15			29,843	29
30	Door Kick Guards			1985	419		10			419	30
31	Electrical Recepticals			1986	2,419		20			2,419	31
32	Wiring			1987	7,530		20			7,530	32
33	Ceiling			1987	300		10			300	33
34	Rewiring			1987	1,600		20			1,600	34
35	Wallpapering			1989	505		5			505	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		15			1,100	40
41	Tempering Valve	1990	3,199		15			3,199	41
42	Remodel Dining Room	1991	4,708	235	20	235		4,571	42
43	Install Panic Bars	1991	780		10			780	43
44	Install Window	1991	988		15			988	44
45	Flooring	1991	4,380		5			4,380	45
46	Roof Repair	1991	29,860		15			29,860	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	Showers	1991	3,669		10			3,669	50
51	Remodel Office	1992	8,715	436	20	436		7,444	51
52	Door Locks & Magnets	1992	2,540		10			2,540	52
53	Interior Landscaping	1992	3,839		10			3,839	53
54	Handrails	1993	12,800		15			12,800	54
55	Wall Cabinets	1993	2,564		15			2,564	55
56	Bathroom Remodel	1993	12,341	617	20	617		9,976	56
57	Nurses Station Desks	1994	18,588	929	20	929		14,328	57
58	Alarm/Auto Door	1994	4,257		10			4,257	58
59	Cabinets	1994	1,480	90	15	90		1,480	59
60	Carpeting in Office	1993	979		5			979	60
61	Gas Rooftop Piping	1994	4,905	245	20	245		3,617	61
62	Heating & A/C Unit	1994	5,565	278	20	278		4,104	62
63	Remodel Garage	1995	3,704		10			3,704	63
64	Remodel Nurses Station	1995	15,656		10			15,656	64
65	Thru Wall A/C Unit	1995	3,120		8			3,120	65
66	Flourescent Light Covers	1995	1,218		5			1,218	66
67	Roof Work	1995	52,000	3,467	15	3,467		48,822	67
68	Service Sink	1995	1,003		10			1,003	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,235,192	\$ 71,747		\$ 71,747	\$	\$ 2,327,871	70

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

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		\$ 3,235,192	\$ 71,747		\$ 71,747	\$	\$ 2,327,871	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		10			1,807	5
6	Resident Room Signs	1995	1,516		5			1,516	6
7	Utility Room Cabinet	1995	599	40	15	40		549	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		10			557	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		10			11,975	16
17	Floorwork Dayroom	1996	2,247		5			2,247	17
18	Heating & A/C Station	1996	7,550		10			7,550	18
19	Floorwork Dining Room	1996	6,974		10			6,974	19
20	Water Softener	1996	10,580		10			10,580	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		10			1,155	24
25	Heating & A/C Rooftop	1997	8,950		10			8,950	25
26	Floorwork Station 4 Hall	1997	10,153		10			10,153	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		8,538	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		10			7,597	32
33	Carpet Chapel/Lobby/Office	1998	2,483		5			2,483	33
34	TOTAL (lines 1 thru 33)		\$ 3,375,973	\$ 72,519		\$ 72,519	\$	\$ 2,462,504	34

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

Facility Name & ID Number Fair Havens Christian Home

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Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		\$ 3,375,973	\$ 72,519		\$ 72,519	\$	\$ 2,462,504	1
2	Wood Cove BS/60 Rooms	1998	9,412		5			9,412	2
3	Alarm System	1998	11,937		10			11,937	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	75	10	75		2,256	7
8	Install Grab Bars	1999	2,401	120	10	120		2,401	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		18,166	11
12	Back Door Alarm Pad	1999	2,874	216	10	216		2,874	12
13	Front Countertop	1999	881	59	15	59		597	13
14	Mixing Valve/Install	1999	524		5			524	14
15	Pella Storm Window - 13	1999	527		5			527	15
16	Smoke Detectors-4	1999	553	51	10	51		553	16
17	Carrier Rooftop Unit	1999	6,779	621	10	621		6,779	17
18	Wallpaper Station 3 Rooms	1999	23,706		5			23,706	18
19	Compressors (3)	2000	2,239		3			2,239	19
20	Cove Base-Station 3	2000	1,408		5			1,408	20
21	Baseboard	2000	1,371		5			1,371	21
22	Light Fixtures (2 Day Room)	2000	947	95	10	95		923	22
23	Floor Tile-Hall/Bath/Kitchen	2000	3,079		5			3,079	23
24	Panic	2000	1,059		5			1,059	24
25	Security Locks-Front Door	2000	900		5			900	25
26	Exhaust Fans (6)	2000	702		5			702	26
27	Carrier Rooftop Unit	2000	7,637	764	10	764		7,001	27
28	Ceiling Grid Covers	2000	1,418		8			1,418	28
29	Compressor Room 101	2000	1,131	75	15	75		685	29
30	REMODELING FHCH	2000	6,395	640	10	640		5,702	30
31	REMODELING PROJECT	2000	7,075	708	10	708		6,073	31
32	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001	20,942	2,094	10	2,094		16,928	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,563,737	\$ 79,809		\$ 79,809	\$	\$ 2,634,750	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, 2008 Ending: June 30, 2009

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		\$ 3,563,737	\$ 79,809		\$ 79,809		\$ 2,634,750	1
2	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		1,036	2
3	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001	782	78	10	78		626	3
4	Compressor - Dining Room A/C	10/6/2001	646		3			646	4
5	Replace (8) Fire Alarm-A/C Relays	4/17/2002	1,519		3			1,519	5
6	Heating & Cooling System - Office	6/14/2002	2,275	228	10	228		1,611	6
7	Locks (3) for Fire Doors	6/15/2002	4,077	408	10	408		2,888	7
8	2-Compressors-Station One Day Room	7/12/2002	1,128		3			1,128	8
9	Tile Work-Kitchen, Mechanical Room & 7D	8/14/2002	5,580	279	20	279		1,930	9
10	Water Cooler-Station #1	9/6/2002	715		5			715	10
11	(22) Carrier through the wall A/C units	9/1/2002	28,380	3,548	8	3,548		24,241	11
12	Floor Covering/Cove Base - 11 Baths	9/18/2002	3,960		5			3,960	12
13	(2) Exit doors & Installation	11/21/2002	2,718	136	20	136		906	13
14	Reroof Garage	1/8/2003	1,665	139	6	139		1,665	14
15	(36) Bathroom Grab Bars-Stats	1/19/2003	7,677	768	10	768		4,990	15
16	Install New Circuit for Food Well	3/22/2003	511		5			511	16
17	Install New Locks on all doors	5/1/2003	2,550	255	10	255		1,573	17
18	Fire Alarm Door Closure/Holder	6/24/2003	895	90	10	90		544	18
19	Roof Top A/C Unit	6/30/2003	5,090	509	10	509		3,096	19
20	Data/Phone Lines - Cabling	7/17/2003	12,404	1,240	10	1,240		7,442	20
21	Replace Staff Dr A/C Compressor	7/17/2003	711		3			711	21
22	Hand sinks in resident rooms	8/13/2003	1,428	143	10	143		845	22
23	Additional Smoke Alarms on Fire System	9/11/2003	1,337	134	10	134		780	23
24	New Partitions in Front Restrooms	10/29/2003	2,794	279	10	279		1,607	24
25	Electrical Updates - Breakers/Panel	11/14/2003	31,417	1,571	20	1,571		8,901	25
26	Plans & Specs-Delayed Egress Locks	11/25/2003	2,571	257	10	257		1,414	26
27	Installation Panic Bar on Front Door	9/19/2003	735	25	5	25		735	27
28	High Efficiency Ballasts and Lights	12/11/2003	49,970	4,997	10	4,997		27,900	28
29	Replace Breakers	1/12/2004	5,962	298	20	298		1,640	29
30	10x12 Canopy Bldg	1/28/2004	1,500	150	10	150		825	30
31	Delayed Egress Locking System	1/21/2004	10,945	1,095	10	1,095		6,020	31
32	Resurface Dishwashing Area w/Gritty Floor	2/6/2004	2,150	251	5	251		2,150	32
33	(12) YLLW Generator Powered Emergency	5/4/2004	518	52	10	52		268	33
34	TOTAL (lines 1 thru 33)		\$ 3,759,642	\$ 96,868		\$ 96,868		\$ 2,749,572	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, 2008 Ending: June 30, 2009

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		\$ 3,759,642	\$ 96,868		\$ 96,868	\$	\$ 2,749,572	1
2	Replace Compressor in PT Area A/C	5/19/2004	855		3			855	2
3	Delayed Egress Locking System	6/29/2004	12,373	1,237	10	1,237		6,290	3
4	Remodel Therapy Room w/Nurse Station	6/22/2004	8,101	810	10	810		4,118	4
5	Fully depreciated land improvements	10/21/1985	69,531		20			69,531	5
6	Sidewalk, landscaping, fence etc.	6/10/1992	24,404		20			24,404	6
7	Entrance sidewalk replacement	6/28/2001	7,850	377	10	377		7,850	7
8	Concrete work	5/30/2003	4,230	277	10	277		1,707	8
9	Fence - Garbage Area	7/3/2003	1,596	160	10	160		958	9
10	Consult/Replace Sidewalks - NH to Parking Lot	5/20/2004	11,455	1,146	10	1,146		5,920	10
11	In Sink Erator - Disposal	8/24/2004	1,399	140	10	140		688	11
12	Replace Compressor in Admin Ofc	8/18/2004	779		10			779	12
13	Door w/Interior Keypad & Request to Enter	9/13/2004	1,922	192	10	192		929	13
14	Install Steel Full View Hinged Patio Door	9/13/2004	1,085	109	3	109		524	14
15	Engineering Services - Door Systems Design	9/27/2004	810	162	10	162		783	15
16	Install New Computer On Energy Mgmt Sys	11/2/2004	6,000		10			6,000	16
17	(45) GE Zonelight Units	1/14/2005	49,747	6,219	5	6,219		27,983	17
18	Engin/Arch SVC-Potential Lighting	1/17/2005	5,507	551	3	551		2,478	18
19	Installation of 20 New A/C	8/22/2005	21,841	4,368	5	4,368		17,109	19
20	Painting 400 Wing Labor & mat	12/31/2005	28,576	2,858	10	2,858		10,240	20
21	400 Wing Remodeling Project	12/31/2005	3,559	356	10	356		1,275	21
22	Painting Kitchen & Storeroom	12/31/2005	1,806	361	5	361		1,294	22
23	Addtl Painting Supplies 400 Wing	2/1/2006	1,375	138	10	138		470	23
24	(13) Floor Mounted Toilets & 1.6 G	6/15/2006	5,254	525	10	525		1,620	24
25	Installation of (23) P-TAC Units	6/23/2006	4,300	860	5	860		2,652	25
26	Carrier 10 Ton Unit W/Gas Heat W/O	5/18/2006	11,998	1,200	10	1,200		3,799	26
27	(25) GE Heat/Cool Wall Units 28	6/27/2006	15,174	3,035	5	3,035		9,357	27
28	Install 2 New Sidewalks W/Railings	5/4/2006	8,368	837	10	837		2,650	28
29	16X32 Garage With Brown Roof	8/23/2005	6,184	412	15	412		1,615	29
30	HPCV Club House Desig	1/24/2001	7,800	195	10	195		1,658	30
31	12X12 Liquid Oxygen Bu	6/2/2003	1,995	200	10	200		1,214	31
32	Ridge Vent/Wall Vent	8/29/2003	1,936	194	10	194		1,145	32
33	Painting - Front Office, Admin., Admissions & Dietary	7/27/2006	772	155	5	155		466	33
34	TOTAL (lines 1 thru 33)		\$ 4,088,224	\$ 123,942		\$ 123,942	\$	\$ 2,967,933	34

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

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 12E, Carried Forward		\$ 4,088,224	\$ 123,942		\$ 123,942		\$ 2,967,933	1
2	Painting - Resident rooms and Doors	8/9/2006	2,061	412	5	412		1,202	2
3	Painting and Wallpaper - resident rooms and baths	9/27/2006	11,440	2,288	5	2,288		6,483	3
4	31 Door gaurds and kick plates	10/23/2006	2,289	229	10	229		629	4
5	Install Cabling for reclaim unit	10/24/2006	8,506	1,701	5	1,701		4,679	5
6	Install new Pass-through window in front office	10/18/2006	551	55	10	55		151	6
7	34 Braille room signs	11/3/2006	1,161	116	10	116		309	7
8	Paint, wallpaper and misc. supplies	11/8/2006	6,253	1,251	5	1,251		3,335	8
9	Paint, wallpaper and supplies	12/31/2006	1,235	247	5	247		638	9
10	48 carbon monoxide detectors	1/11/2007	904	226	2	226		904	10
11	Heat Pump installation	2/1/2007	1,987	199	10	199		480	11
12	Floor covering and Adhesives	5/1/2007	31,423	3,142	10	3,142		6,808	12
13	2 door reach in freezer	6/26/2007	3,026	303	10	303		630	13
14	Painting - PT, Office, Chapel, and ice cream parlor	6/27/2007	6,875	1,375	5	1,375		2,865	14
15	Concrete pad in shaded area	2/5/2007	550	37	15	37		89	15
16	Labor & Materials- stain wood trim in PT	7/18/2007	725	73	10	73		145	16
17	Ceiling- painting main DR hallway in PT	7/25/2007	1,760	352	5	352		704	17
18	Installed 4 additional cablephone lines	8/20/2007	702	70	10	70		135	18
19	Installed drain in kitchen	9/15/2007	3,190	319	10	319		585	19
20	Installation of new flooring in dining room	9/1/2007	5,917	592	10	592		1,085	20
21	Paint & wallpaper for modeling project	9/17/2007	2,575	258	10	258		472	21
22	LTC series- 2 slot room signs with braille	9/14/2007	3,215	322	10	322		589	22
23									23
24	Front sidewalk entrance canopy	7/1/2007	7,167	478	15	478		956	24
25	Relocate remote annunciator for generator	11/16/2007	753	75	10	75		126	25
26	Install battery Backup emergency lights	11/16/2007	1,625	163	10	163		271	26
27	Install new ceiling tiles and screens	12/18/2007	950	190	5	190		301	27
28	Rubber tile & express tile flooring	7/1/2007	4,674	935	5	935		1,869	28
29	Therapy Gym	12/1/2007	156,119	15,612	10	15,612		24,719	29
30	Install handrails for safety	12/1/2007	2,055	206	10	206		325	30
31	Install new medal door fronts	12/1/2007	4,817	482	10	482		763	31
32	Vinyl plank flooring in dining room	12/1/2007	16,978	1,698	10	1,698		2,688	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,379,707	\$ 157,344		\$ 157,344		\$ 3,032,868	34

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

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 12F, Carried Forward		\$ 4,379,707	\$ 157,344		\$ 157,344		\$ 3,032,868	1
2	Design and Install new fire alarm system	12/28/2007	6,750	675	10	675		1,039	2
3	Design and install sprinkler system	12/20/2007	6,154	615	10	615		974	3
4	Door Wander guard system- 50% down payment	12/26/2007	25,847	2,585	10	2,585		4,092	4
5	Install hand rail and fencing	12/26/2007	5,973	597	10	597		946	5
6	Install hardware on new door assembly	12/7/2007	1,520	152	10	152		241	6
7	Therapy Gym Architectural services	12/1/2007	11,439	1,144	10	1,144		1,811	7
8	Install new floor in activity room	12/6/2007	2,174	435	5	435		688	8
9	Install wall covering in Main dining room	12/7/2007	500	100	5	100		158	9
10	Install 8x10 front entry door	12/18/2007	1,500	150	10	150		238	10
11	Wallpaper remodel	1/9/2008	569	57	10	57		85	11
12	Wallpaper remodel	1/16/2008	10,000	1,000	10	1,000		1,500	12
13	Wallpaper remodel	1/16/2008	770	77	10	77		116	13
14	Painting station #4	1/30/2008	2,950	295	10	295		443	14
15	Frame guards	1/16/2008	5,589	559	10	559		838	15
16	Door protectors	1/3/2008	3,652	365	10	365		548	16
17	Therapy Gym remodeling	1/1/2008	17,308	1,731	10	1,731		2,596	17
18	Install 4 wall-mount battery back up	1/28/2008	512	51	10	51		77	18
19	Retainage fee for wallpaper remodel project	2/18/2008	7,049	705	10	705		999	19
20	Painting walls- Units 1,2,3	2/29/2008	144,450	14,445	10	14,445		20,464	20
21	Wallpaper remodel	3/12/2008	710	71	10	71		95	21
22	Nurse Call system	3/19/2008	61,541	6,154	10	6,154		8,206	22
23	Installation of hallway lights	3/26/2008	14,524	1,452	10	1,452		1,937	23
24	Paint/Wallpaper remodel	3/31/2008	1,669	334	5	334		445	24
25	Door Wander guard system	5/20/2008	26,523	2,652	5	2,652		3,094	25
26	Wallpaper remodel	5/1/2008	2,368	474	5	474		553	26
27	Counter tops for offices	5/1/2008	1,411	141	10	141		165	27
28	Trane Evaporator coil	6/27/2008	7,210	1,442	5	1,442		1,562	28
29	LTC series 2 slot room slides	9/14/2007	1,611	161	10	161		295	29
30	Armstrong Vinyl flooring for dining room	12/20/2007	1,048	105	10	105		166	30
31	Part of wallpaper remodel	1/1/2008	805	80	10	80		121	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,753,833	\$ 196,148		\$ 196,148		\$ 3,087,357	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, 2008 Ending: June 30, 2009

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 12G, Carried Forward		\$ 4,753,833	\$ 196,148		\$ 196,148	\$	\$ 3,087,357	1
2	Install new storm sewers and drains	9/24/2007	9,154	915	10	915		1,678	2
3	Flagpole	11/12/2007	800	80	10	80		133	3
4	Station #4 Remodeling Project	7/1/2008	14,000	1,399	10	1,399		1,399	4
5	Fire Alarm System	7/8/2008	1,350	135	10	135		135	5
6	Activity Room Cable	8/18/2008	506	46	10	46		46	6
7	Fire Alarm Equipment	8/1/2008	30,993	2,841	10	2,841		2,841	7
8	Fire Alarm Equipment	8/1/2008	13,836	1,268	10	1,268		1,268	8
9	Toilet Seats - Resident Bathrooms	8/18/2008	5,625	1,031	5	1,031		1,031	9
10	Fire Alarm Equipment	8/1/2008	3,346	307	10	307		307	10
11	Fire Alarm System	10/16/2008	11,649	874	10	874		874	11
12	Fire Alarm System	11/1/2008	16,101	1,073	10	1,073		1,073	12
13	Tile Flooring - Front Lobby	11/14/2008	17,602	1,173	10	1,173		1,173	13
14	Exterior Lighting	12/17/2008	5,500	321	10	321		321	14
15	Oxygen Room - Instal Fan	12/12/2008	1,629	95	10	95		95	15
16	Oxygen Storage Room	12/31/2008	6,627	387	10	387		387	16
17	Front Lobby Flooring	1/2/2009	1,099	110	5	110		110	17
18	Fire Alarm System	1/19/2009	1,151	58	10	58		58	18
19	Fire Alarm System	3/1/2009	14,396	480	10	480		480	19
20	2 Side Entry Tub	5/14/2009	17,547	292	10	292		292	20
21	Artwork	6/23/2009	21,044	175	10	175		175	21
22	Window Treatments	6/26/2009	15,688	131	10	131		131	22
23	Vinyl Flooring	6/5/2009	9,766	163	5	163		163	23
24	Locks	6/1/2009	8,320	69	10	69		69	24
25	Cabinets - Nurses Station and Office	6/23/2009	15,750	131	10	131		131	25
26	Mixing Valve	6/30/2009	966	8	10	8		8	26
27	Water Closets	6/24/2009	8,540	71	10	71		71	27
28	Wheelchair Accessible Curb	10/22/2008	1,050	79	10	79		79	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,007,865	\$ 209,862		\$ 209,862	\$	\$ 3,101,887	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	\$ 610,698	\$ 86,456	\$ 86,456	\$	Various	\$ 246,888	71
72	Current Year Purchases	83,135	8,082	8,082		Various	8,082	72
73	Fully Depreciated Assets	905,750					905,750	73
74	Home Office Allocation	219,161	16,049	16,049			32,485	74
75	TOTALS	\$ 1,818,744	\$ 110,587	\$ 110,587	\$		\$ 1,193,205	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	Patient Transportation	Van	7/1/1988	\$ 3,317	\$	\$			\$ 3,317	76
77	Patient Transportation	2006 Ford El Dorado Aerotec	2/1/2006	52,505	13,126	13,126				77
78										78
79	Home Office Allocation			25,384	1,859	1,859			11,311	79
80	TOTALS			\$ 81,206	\$ 14,985	\$ 14,985	\$		\$ 14,628	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)	\$ 6,969,456	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 335,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 335,433	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,309,719	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/Congregate Equip.	931,037	27,848	27,848	87
88					88
89					89
90					90
91	TOTALS	\$ 978,274	\$ 27,848	\$ 27,848	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 6,482	92
93			93
94			94
95		\$ 6,482	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: 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: _____ *

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: \$ 20,726 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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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				
1	Licensed Occupational Therapist		hrs	\$	7,804	\$ 459,819	\$	7,804	\$ 459,819	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs		2,175	163,423		2,175	163,423	3
4	Licensed Physical Therapist		hrs		9,934	582,957		9,934	582,957	4
5	Physician Care		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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	19,913	\$ 1,206,199	\$	19,913	\$ 1,206,199	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.

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2009 (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	\$ 5,577,783	\$	1
2	Cash-Patient Deposits	48,679		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (37,783))	993,963		3
4	Supply Inventory (priced at)	17,798		4
5	Short-Term Investments	758,180		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/Other A/R</u>	1,491		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,408,224	\$	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	5,630,804		14
15	Leasehold Improvements, at Historical Cost	160,236		15
16	Equipment, at Historical Cost	1,736,751		16
17	Accumulated Depreciation (book methods)	(4,780,477)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	782,155		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Other Assets</u>	7,213		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,638,557	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,046,781	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 269,353	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,679		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	300,385		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	414		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Liabilities</u>	161,138		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 779,969	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,258,731		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	177,019		43
44	<u>Apt & Congregate</u>	143,592		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,579,342	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,359,311	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,687,470	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,046,781	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,081,208	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,081,208	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,606,262	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,606,262	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)	\$ 8,687,470	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fair Havens Christian Home

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Report Period Beginning: July 1, 2008

Ending: June 30, 2009

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	\$ 9,134,079	1
2	Discounts and Allowances for all Levels	(1,586,062)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,548,017	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,994,353	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,994,353	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	50,691	13
14	Non-Patient Meals	4,971	14
15	Telephone, Television and Radio	1,330	15
16	Rental of Facility Space		16
17	Sale of Drugs	81,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,724	19
20	Radiology and X-Ray	25,482	20
21	Other Medical Services	20,202	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 238,791	23
D. Non-Operating Revenue			
24	Contributions	46,727	24
25	Interest and Other Investment Income***	43,394	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 90,121	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	88,281	28
28a	Gain/Loss on Investments and Miscellaneous	(69,426)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,855	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,890,137	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,490,646	31
32	Health Care	5,231,955	32
33	General Administration	1,876,695	33
B. Capital Expense			
34	Ownership	405,751	34
C. Ancillary Expense			
35	Special Cost Centers	190,680	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)*	\$ 9,283,875	40
41	Income before Income Taxes (line 30 minus line 40)**	1,606,262	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,606,262	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.

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Report Period Beginning: July 1, 2008

Ending:

June 30, 2009

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	1,845	1,956	\$ 86,687	\$ 44.32	1
2	Assistant Director of Nursing	3,520	3,701	104,674	28.28	2
3	Registered Nurses	15,569	16,821	460,118	27.35	3
4	Licensed Practical Nurses	28,576	32,054	646,416	20.17	4
5	CNAs & Orderlies	117,418	128,184	1,478,851	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,759	6,336	83,020	13.10	8
9	Activity Director	1,811	2,045	29,746	14.55	9
10	Activity Assistants	6,218	6,740	59,369	8.81	10
11	Social Service Workers	5,398	6,168	114,605	18.58	11
12	Dietician					12
13	Food Service Supervisor	3,601	3,971	70,824	17.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,436	31,116	278,067	8.94	15
16	Dishwashers					16
17	Maintenance Workers	5,098	5,817	110,184	18.94	17
18	Housekeepers	26,533	30,154	283,042	9.39	18
19	Laundry					19
20	Administrator	1,806	1,950	166,749	85.51	20
21	Assistant Administrator					21
22	Other Administrative	1,667	1,800	37,344	20.75	22
23	Office Manager	1,781	1,950	33,875	17.37	23
24	Clerical	5,457	6,019	81,283	13.50	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 C: Ward Clerd, Dir o	7,450	7,947	128,132	16.12	32
33	Other(specify) Comm Liason, MI	7,918	8,885	191,078	21.51	33
34	TOTAL (lines 1 - 33)	275,861	303,614	\$ 4,444,064 *	\$ 14.64	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	354	\$ 18,533	3.1.3	35
36	Medical Director	416	34,500	3.9.3	36
37	Medical Records Consultant	24	1,783	3.10.3	37
38	Nurse Consultant	16	240	3.10.3	38
39	Pharmacist Consultant	192	4,778	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	86	4,814	3.12.3	45
46	Other(specify) Dental	12	1,400	3.10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,099	\$ 66,048		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

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Report Period Beginning: July 1, 2008 Ending: June 30, 2008

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. Life Service Network 8,614.70
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,499 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. 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. \$ 4,971
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? NONE
- d. Have vehicle usage logs been maintained? On the bus, not the van
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: LarsonAllen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.