

Facility Name & ID Number Fair Havens Christian Home

0018143 Report Period Beginning: July 1, 2009 Ending: June 30,2010

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	154	Skilled (SNF)	154	56,210	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	154	TOTALS	154	56,210	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	23,550	16,244	13,365	53,159	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,550	16,244	13,365	53,159	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.57%

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 11,821

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: 6/30/10 Fiscal Year: 6/30/10

* 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, 2009 Ending: June 30,2010

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	338,033	28,912	15,735	382,680		382,680	(26)	382,654		1
2	Food Purchase		384,339		384,339		384,339	(2,563)	381,776		2
3	Housekeeping	182,195	46,867		229,062		229,062		229,062		3
4	Laundry	95,797	6,307		102,104		102,104		102,104		4
5	Heat and Other Utilities			179,156	179,156		179,156	(7,083)	172,073		5
6	Maintenance	108,164	14,525	58,763	181,452		181,452	5,381	186,833		6
7	Other (specify):* Trash Removal			11,341	11,341		11,341		11,341		7
8	TOTAL General Services	724,189	480,950	264,995	1,470,134		1,470,134	(4,291)	1,465,843		8
	B. Health Care and Programs										
9	Medical Director			38,075	38,075		38,075		38,075		9
10	Nursing and Medical Records	3,273,707	680,454	27,544	3,981,705	(367,321)	3,614,384		3,614,384		10
10a	Therapy		46	1,356,577	1,356,623		1,356,623		1,356,623		10a
11	Activities	101,768	35		101,803		101,803	121	101,924		11
12	Social Services	175,302	9,417	5,155	189,874		189,874		189,874		12
13	CNA Training										13
14	Program Transportation			520	520		520		520		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,550,777	689,952	1,427,871	5,668,600	(367,321)	5,301,279	121	5,301,400		16
	C. General Administration										
17	Administrative	206,471	1,842	647,685	855,998		855,998	(557,028)	298,970		17
18	Directors Fees										18
19	Professional Services			4,857	4,857		4,857	42,388	47,245		19
20	Dues, Fees, Subscriptions & Promotions			20,193	20,193		20,193		20,193		20
21	Clerical & General Office Expenses	152,269	19,028	205,659	376,956		376,956	108,180	485,136		21
22	Employee Benefits & Payroll Taxes			828,891	828,891		828,891	40,858	869,749		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,206	18,206		18,206	19,942	38,148		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			125,931	125,931		125,931	1,612	127,543		26
27	Other (specify):* Marketing	59,259	5,521	12,821	77,601		77,601	(77,601)			27
28	TOTAL General Administration	417,999	26,391	1,864,243	2,308,633		2,308,633	(421,649)	1,886,984		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,692,965	1,197,293	3,557,109	9,447,367	(367,321)	9,080,046	(425,819)	8,654,227		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, 2009

Ending:

June 30,2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			371,536	371,536		371,536	26,749	398,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,098	71,098		71,098	(61,160)	9,938			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,117	52,117		52,117		52,117			35
36	Other (specify):* Finan. Fee/ Fines			652	652		652	(652)				36
37	TOTAL Ownership			495,403	495,403		495,403	(35,063)	460,340			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			121,517	121,517	367,321	488,838		488,838			39
40	Barber and Beauty Shops	7,491	360	33,998	41,849		41,849		41,849			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,885	83,885		83,885		83,885			42
43	Other (specify):* Apt/ Congregate			58,630	58,630		58,630	(58,630)				43
44	TOTAL Special Cost Centers	7,491	360	298,030	305,881	367,321	673,202	(58,630)	614,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,700,456	1,197,653	4,350,542	10,248,651		10,248,651	(519,512)	9,729,139			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	(2,563)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,429)	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	(71,098)	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	(128,280)	21		24
25	Fund Raising, Advertising and Promotional	(77,601)	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	(60,154)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (357,125)		\$	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)	(162,387)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (162,387)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (519,512)		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		367,321	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 367,321	47

BHF USE ONLY							
48		49		50		51	52

Fair Havens Christian HomeID# 0018143Report Period Beginning: July 1, 2009Ending: June 30,2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Apartment/Congregate	\$ (58,630)	43	1
2	Vending Revenue	(26)	1	2
3	Activity Revenue	121	11	3
4	Increase in Cash Value of Life Insurance	(337)	17	4
5	Charity Care	(581)	21	5
6	Late Fee	(49)	6	6
7	Fines & Penalties	(652)	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(60,154)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home# 0018143

Report Period Beginning:

July 1, 2009

Ending:

June 30,2010

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	(26)	0	0	0	0	0	0	0	0	0	0	(26)	1
2	Food Purchase	(2,563)	0	0	0	0	0	0	0	0	0	0	(2,563)	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	(17,429)	10,346	0	0	0	0	0	0	0	0	0	(7,083)	5
6	Maintenance	(49)	5,430	0	0	0	0	0	0	0	0	0	5,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,067)	15,776	0	(4,291)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	121	0	0	0	0	0	0	0	0	0	0	121	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	121	0	0	0	0	0	0	0	0	0	0	121	16
	C. General Administration													
17	Administrative	(337)	(556,691)	0	0	0	0	0	0	0	0	0	(557,028)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	42,388	0	0	0	0	0	0	0	0	0	42,388	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(128,861)	237,041	0	0	0	0	0	0	0	0	0	108,180	21
22	Employee Benefits & Payroll Taxes	0	40,858	0	0	0	0	0	0	0	0	0	40,858	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	19,942	0	0	0	0	0	0	0	0	0	19,942	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	1,612	0	0	0	0	0	0	0	0	0	1,612	26
27	Other (specify):*	(77,601)	0	0	0	0	0	0	0	0	0	0	(77,601)	27
28	TOTAL General Administration	(206,799)	(214,850)	0	(421,649)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(226,745)	(199,074)	0	(425,819)	29								

STATE OF ILLINOIS

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2009 Ending:

Summary B

June 30,2010

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	26,749	0	0	0	0	0	0	0	0	0	26,749	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71,098)	9,938	0	0	0	0	0	0	0	0	0	(61,160)	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):*	(652)	0	0	0	0	0	0	0	0	0	0	(652)	36
37	TOTAL Ownership	(71,750)	36,687	0	(35,063)	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):*	(58,630)	0	0	0	0	0	0	0	0	0	0	(58,630)	43
44	TOTAL Special Cost Centers	(58,630)	0	0	0	0	0	0	0	0	0	0	(58,630)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(357,125)	(162,387)	0	(519,512)	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	\$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	\$ 10,346	\$ 10,346	1
2	V	6 Maintenance				5,430	5,430	2
3	V	17 Administrative	647,685			90,994	(556,691)	3
4	V	19 Professional Services				42,388	42,388	4
5	V	21 Clerical				237,041	237,041	5
6	V	22 Employee Benefits				40,858	40,858	6
7	V	24 Travel and Seminars				19,942	19,942	7
8	V	26 Insurance				1,612	1,612	8
9	V	30 Depreciation				26,749	26,749	9
10	V	32 Interest				9,938	9,938	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 647,685			\$ 485,298	\$ * (162,387)	14

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

Facility Name & ID Number

Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2009

Ending:

June 30,2010

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, 2009

Ending: ne 30,2010

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, 2009 Ending:

June 30,2010

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	Illinois Finance Authority		X	Refinance Old Debt		6/30/2007	\$ 1,070,306	\$ 1,070,306	6/30/2031	0.0567	\$ 55,928	1							
2	Bond Fund	X		Refinance Debt	\$1,192.00	*	256,682	256,682	6/30/2032	0.0572	15,170	2							
3												3							
4	* This is an allocation of the total GO bond debt which includes several different series with several different rates of interest.										4								
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$1,192.00		\$ 1,326,988	\$ 1,326,988			\$ 71,098	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,326,988	\$ 1,326,988			\$ 71,098	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.)

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 2009 report.			\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2005	_____	8	FOR BHF USE ONLY		
	2006	_____	9			
	2007	_____	10			
	2008	_____	11			
	2009	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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>See attached</u>	\$ <u>844.00</u>	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>844.00</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? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2009 Ending:

June 30,2010

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:

A. Land.

	1	2	3	4	
	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>7,406</u>	<u>2</u>
3	TOTALS	56,500		\$ 62,044	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		\$ 1,768,309	4
5				384,841		20				5
6	6	1983	1983	109,815	2,745	35	2,745		72,752	6
7	Home Office Allocation			76,383	5,675		5,675		152,274	7
8										8
Improvement Type**										
9	Wall Guards		1979	485		15			485	9
10	Garage		1979	4,167		30			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		2,475	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		2,284	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		106,421	24
25	Electric Door		1984	10,229		10			10,229	25
26	Floor Covering		1985	3,457		10			3,457	26
27										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, 2009 Ending: June 30,2010

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	137	20	137		4,708	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		7,880	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		10,593	56
57	Nurses Station Desks	1994		853	20	853			57
58	Alarm/Auto Door	1994	4,257		10			4,257	58
59	Cabinets	1994	1,480		15			1,480	59
60	Carpeting in Office	1993	979		5			979	60
61	Gas Rooftop Piping	1994	4,905	245	20	245		3,862	61
62	Heating & A/C Unit	1994	5,565	278	20	278		4,382	62
63	Remodel Garage	1995	3,704		10			3,704	63
64		1995			10				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	3,178	15	3,178		52,000	67
68	Service Sink	1995	1,003		10			1,003	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,209,110	\$ 71,870		\$ 71,870	\$	\$ 2,388,515	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, 2009 Ending: June 30,2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,209,110	\$ 71,870		\$ 71,870	\$	\$ 2,388,515	1
2									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		589	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		1996							15
16									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		9,270	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)		\$ 3,322,871	\$ 72,642		\$ 72,642	\$	\$ 2,496,899	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, 2009 Ending: June 30,2010

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		\$ 3,322,871	\$ 72,642		\$ 72,642	\$	\$ 2,496,899	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		10			2,256	7
8	Install Grab Bars	1999	2,401		10			2,401	8
9	Install 24V Door Closer	1999	1,189		5			1,189	9
10									10
11	Remodel Station 4	1999	26,585	1,772	15	1,772		19,938	11
12	Back Door Alarm Pad	1999	2,874		10			2,874	12
13	Front Countertop	1999	881	59	15	59		656	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		10			553	16
17	Carrier Rooftop Unit	1999	6,779		10			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	24	10	24		947	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	636	10	636		7,637	27
28	Ceiling Grid Covers	2000	1,418		8			1,418	28
29	Compressor Room 101	2000	1,131	75	15	75		760	29
30	REMODELING FHCH	2000	6,395	640	10	640		6,342	30
31	REMODELING PROJECT	2000	7,075	708	10	708		6,781	31
32	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001		1,922		1,922			32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,489,038	\$ 78,478		\$ 78,478	\$	\$ 2,655,477	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, 2009 Ending: June 30,2010

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		\$ 3,489,038	\$ 78,478		\$ 78,478		\$ 2,655,477	1
2	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		1,166	2
3	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001		72		72			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		1,839	6
7	Locks (3) for Fire Doors	6/15/2002	4,077	408	10	408		3,296	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		2,209	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		27,789	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		1,042	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		5,758	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		1,828	17
18	Fire Alarm Door Closure/Holder	6/24/2003	895	90	10	90		634	18
19	Roof Top A/C Unit	6/30/2003	5,090	509	10	509		3,605	19
20	Data/Phone Lines - Cabling	7/17/2003	12,404	1,240	10	1,240		8,682	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		988	22
23	Additional Smoke Alarms on Fire System	9/11/2003		123		123			23
24	New Partitions in Front Restrooms	10/29/2003	2,794	279	10	279		1,886	24
25	Electrical Updates - Breakers/Panel	11/14/2003	31,417	1,571	20	1,571		10,472	25
26	Plans & Specs-Delaved Egress Locks	11/25/2003	2,571	257	10	257		1,671	26
27	Installation Panic Bar on Front Door	9/19/2003	735		5			735	27
28	High Efficiency Ballasts and Lights	12/11/2003	49,970	4,997	10	4,997		32,897	28
29	Replace Breakers	1/12/2004	5,962	298	20	298		1,938	29
30	10x12 Canopy Bldg	1/28/2004		138	10	138			30
31	Delayed Egress Locking System	1/21/2004	10,945	1,095	10	1,095		7,115	31
32	Resurface Dishwashing Area w/Gritty Floor	2/6/2004	2,150		5			2,150	32
33	(12) YLLW Generator Powered Emergency	5/4/2004	518	52	10	52		320	33
34	TOTAL (lines 1 thru 33)		\$ 3,681,324	\$ 95,233		\$ 95,233		\$ 2,784,352	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, 2009 Ending: June 30,2010

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		\$ 3,681,324	\$ 95,233		\$ 95,233	\$	\$ 2,784,352	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		7,527	3
4	Remodel Therapy Room w/Nurse Station	6/22/2004	8,101	810	10	810		4,928	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	7,790		10			7,790	7
8	Concrete work	5/30/2003	4,230	423	10	423		3,020	8
9	Fence - Garbage Area	7/3/2003	1,596	160	10	160		1,118	9
10	Consult/Replace Sidewalks - NH to Parking Lot	5/20/2004	11,455	1,146	10	1,146		7,066	10
11	In Sink Erator - Disposal	8/24/2004	1,399	140	10	140		828	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		1,121	13
14	Install Steel Full View Hinged Patio Door	9/13/2004	1,085	109	3	109		633	14
15	Engineering Services - Door Systems Design	9/27/2004	810	27	10	27		810	15
16					10				16
17	(45) GE Zonelight Units	1/14/2005	49,747	6,219	5	6,219		34,202	17
18	Engin/Arch SVC-Potential Lighting	1/17/2005	5,507	551	3	551		3,029	18
19	Installation of 20 New A/C	8/22/2005	21,841	4,368	5	4,368		21,477	19
20	Painting 400 Wing Labor & mat	12/31/2005	28,576	2,858	10	2,858		13,098	20
21	400 Wing Remodeling Project	12/31/2005	3,559	356	10	356		1,631	21
22	Painting Kitchen & Storeroom	12/31/2005	1,806	361	5	361		1,655	22
23	Addtl Painting Supplies 400 Wing	2/1/2006	1,375	138	10	138		608	23
24	(13) Floor Mounted Toilets & 1.6 G	6/15/2006	5,254	525	10	525		2,145	24
25	Installation of (23) P-TAC Units	6/23/2006	4,300	860	5	860		3,512	25
26	Carrier 10 Ton Unit W/Gas Heat W/O	5/18/2006	11,998	1,200	10	1,200		4,999	26
27	(25) GE Heat/Cool Wall Units 28	6/27/2006	15,174	3,035	5	3,035		12,392	27
28	Install 2 New Sidewalks W/Railings	5/4/2006	4,184	418	10	418		1,744	28
29	16X32 Garage With Brown Roof	8/23/2005	3,092	309	15	309		1,014	29
30	HPCV Club House Desig	1/24/2001	7,800	195	40	195		1,853	30
31	12X12 Liquid Oxygen Bu	6/2/2003	1,995	200	10	200		1,414	31
32	Ridge Vent/Wall Vent	8/29/2003	1,936	194	10	194		1,339	32
33	Painting - Front Office, Admin., Admissions & Dietary	7/27/2006	776	155	5	155		621	33
34	TOTAL (lines 1 thru 33)		\$ 3,996,574	\$ 121,419		\$ 121,419	\$	\$ 3,021,494	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, 2009 Ending: June 30,2010

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		\$ 3,996,574	\$ 121,419		\$ 121,419	\$	\$ 3,021,494	1
2	Painting - Resident rooms and Doors	8/9/2006	2,061	412	5	412		1,614	2
3	Painting and Wallpaper - resident rooms and baths	9/27/2006	11,440	2,288	5	2,288		8,771	3
4	31 Door gaurds and kick plates	10/23/2006	2,289	229	10	229		858	4
5	Install Cabling for reclaim unit	10/24/2006	8,506	1,701	5	1,701		6,380	5
6	Install new Pass-through window in front office	10/18/2006	551	55	10	55		206	6
7	34 Braille room signs	11/3/2006	1,161	116	10	116		425	7
8	Paint, wallpaper and misc. supplies	11/8/2006	6,253	1,251	5	1,251		4,586	8
9	Paint, wallpaper and supplies	12/31/2006	1,235	247	5	247		885	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		679	11
12	Floor covering and Adhesives	5/1/2007	31,423	3,142	10	3,142		9,950	12
13									13
14	Painting - PT, Office, Chapel, and ice cream parlor	6/27/2007	6,875	1,375	5	1,375		4,240	14
15	Concrete pad in shaded area	2/5/2007	275	18	15	18		63	15
16	Labor & Materials- stain wood trim in PT	7/18/2007	725	73	10	73		218	16
17	Ceiling- painting main DR hallway in PT	7/25/2007	1,760	352	5	352		1,056	17
18	Installed 4 additional cablephone lines	8/20/2007	702	70	10	70		205	18
19	Installed drain in kitchen	9/15/2007	3,190	319	10	319		904	19
20	Installation of new flooring in dining room	9/1/2007	5,917	592	10	592		1,677	20
21	Paint & wallpaper for modeling project	9/17/2007	2,575	258	10	258		730	21
22	LTC series- 2 slot room signs with braille	9/14/2007	3,215	322	10	322		911	22
23	Blinds	5/12/2009	896	104		104		104	23
24	Front sidewalk entrance canopy	7/1/2007	7,167	478	15	478		1,434	24
25	Relocate remote annunciator for generator	11/16/2007	753	75	10	75		201	25
26	Install battery Backup emergency lights	11/16/2007	1,625	163	10	163		434	26
27	Install new ceiling tiles and screens	12/18/2007	950	190	5	190		491	27
28	Rubber tile & express tile flooring	7/1/2007	4,674	935	5	935		2,804	28
29	Therapy Gym	12/1/2007	156,174	15,612	10	15,612		40,244	29
30	Install handrails for safety	12/1/2007	2,055	206	10	206		531	30
31	Install new medal door fronts	12/1/2007	4,817	482	10	482		1,245	31
32	Vinyl plank flooring in dining room	12/1/2007	16,978	1,698	10	1,698		4,386	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,285,707	\$ 154,603		\$ 154,603	\$	\$ 3,118,630	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		\$ 4,285,707	\$ 154,603		\$ 154,603	\$	\$ 3,118,630	1
2	Design and Install new fire alarm system	12/28/2007	6,750	675	10	675		1,714	2
3	Design and install sprinkler system	12/20/2007	6,154	615	10	615		1,589	3
4	Door Wander guard system- 50% down payment	12/26/2007	25,847	2,585	10	2,585		6,677	4
5	Install hand rail and fencing	12/26/2007	2,987	299	10	299		772	5
6	Install hardware on new door assembly	12/7/2007	1,520	152	10	152		393	6
7	Therapy Gym Architectural services	12/1/2007	11,439	1,144	10	1,144		2,955	7
8	Install new floor in activity room	12/6/2007	2,174	435	5	435		1,123	8
9	Install wall covering in Main dining room	12/7/2007	500	100	5	100		258	9
10	Install 8x10 front entry door	12/18/2007	1,500	150	10	150		388	10
11	Wallpaper remodel	1/9/2008	569	57	10	57		142	11
12	Wallpaper remodel	1/16/2008	10,000	1,000	10	1,000		2,500	12
13	Wallpaper remodel	1/16/2008	770	77	10	77		193	13
14	Painting station #4	1/30/2008	2,950	295	10	295		738	14
15	Frame guards	1/16/2008	5,589	559	10	559		1,397	15
16	Door protectors	1/3/2008	3,652	365	10	365		913	16
17	Therapy Gym remodeling	1/1/2008	17,308	1,731	10	1,731		4,327	17
18	Install 4 wall-mount battery back up	1/28/2008	512	51	10	51		128	18
19	Retainage fee for wallpaper remodel project	2/18/2008	7,049	705	10	705		1,704	19
20	Painting walls- Units 1,2,3	2/29/2008	144,450	14,445	10	14,445		34,909	20
21	Wallpaper remodel	3/12/2008	710	71	10	71		166	21
22	Nurse Call system	3/19/2008	61,541	6,154	10	6,154		14,360	22
23	Installation of hallway lights	3/26/2008	14,524	1,452	10	1,452		3,389	23
24	Paint/Wallpaper remodel	3/31/2008	1,669	334	5	334		779	24
25	Door Wander guard system	5/20/2008	26,523	2,652	5	2,652		5,746	25
26	Wallpaper remodel	5/1/2008	2,368	474	5	474		1,027	26
27	Counter tops for offices	5/1/2008	1,411	141	10	141		306	27
28	Trane Evaporator coil	6/27/2008	7,210	1,442	5	1,442		3,004	28
29	LTC series 2 slot room slides	9/14/2007	1,611	161	10	161		456	29
30	Armstrong Vinyl flooring for dining room	12/20/2007	1,048	105	10	105		271	30
31	Part of wallpaper remodel	1/1/2008	805	80	10	80		201	31
32	Landscaping	6/4/2010	5,090	42	10	42		42	32
33	New Signage	5/31/2010	10,520	175	10	175		175	33
34	TOTAL (lines 1 thru 33)		\$ 4,672,457	\$ 193,327		\$ 193,327	\$	\$ 3,211,369	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, 2009 Ending: June 30,2010

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		\$ 4,672,457	\$ 193,327		\$ 193,327	\$	\$ 3,211,369	1
2	Install new storm sewers and drains	9/24/2007	4,577	458	10	458		1,297	2
3									3
4	Station #4 Remodeling Project	7/1/2008	14,000	1,399	10	1,399		2,798	4
5	Fire Alarm System	7/8/2008	1,350	135	10	135		270	5
6									6
7	Fire Alarm Equipment	8/1/2008	30,993	3,099	10	3,099		5,940	7
8	Fire Alarm Equipment	8/1/2008	13,836	1,268	10	1,268		2,615	8
9	Toilet Seats - Resident Bathrooms	8/18/2008	5,625	1,125	5	1,125		2,156	9
10	Fire Alarm Equipment	8/1/2008	3,346	334	10	334		641	10
11	Fire Alarm System	10/16/2008	11,649	1,164	10	1,164		2,038	11
12	Fire Alarm System	11/1/2008	16,101	1,610	10	1,610		2,683	12
13	Tile Flooring - Front Lobby	11/14/2008	17,602	1,760	10	1,760		2,933	13
14	Exterior Lighting	12/17/2008	2,750	275	10	275		436	14
15	Oxygen Room - Instal Fan	12/12/2008	1,629	163	10	163		258	15
16	Oxygen Storage Room	12/31/2008	6,627	663	10	663		1,050	16
17									17
18	Fire Alarm System	1/19/2009	1,151	115	10	115		173	18
19	Fire Alarm System	3/1/2009	14,396	1,440	10	1,440		1,920	19
20	2 Side Entry Tub	5/14/2009	17,547	1,755	10	1,755		2,047	20
21	Artwork	6/23/2009	21,044	2,104	10	2,104		2,279	21
22	Window Treatments	6/26/2009	15,688	1,569	10	1,569		1,700	22
23	Vinyl Flooring	6/5/2009	9,766	1,953	5	1,953		2,116	23
24	Locks	6/1/2009	8,320	69	10	69		138	24
25	Cabinets - Nurses Station and Office	6/23/2009	15,750	1,575	10	1,575		1,706	25
26	Mixing Valve	6/30/2009	966	97	10	97		105	26
27	Water Closets	6/24/2009	8,540	854	10	854		925	27
28	Wheelchair Accessible Curb	10/22/2008	1,050	105	10	105		184	28
29	Designer Services	7/17/2009	1,200	120	10	120		120	29
30	Shower room tile replacement	9/16/2009	1,182	99	10	99		99	30
31	New roof	8/21/2009	372,567	34,151	10	34,151		34,151	31
32	Shower room repairs	8/5/2009	1,630	149	10	149		149	32
33	Ceramic tile	8/31/2009	1,233	113	10	113		113	33
34	TOTAL (lines 1 thru 33)		\$ 5,294,569	\$ 253,048		\$ 253,048	\$	\$ 3,284,410	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, 2009 Ending: June 30,2010

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 12H, Carried Forward		\$ 5,294,569	\$ 253,048		\$ 253,048	\$	\$ 3,284,410	1
2	Ceramic tile	8/28/2009	143	13		13		13	2
3	Ceramic tile	8/28/2009	2,152	197		197		197	3
4	Tapered Rod Pocket Valance	9/21/2009	202	17		17		17	4
5	Ceramic tile for shower rooms	9/18/2009	5,707	476		476		476	5
6	Completion of shower rooms	9/25/2009	1,211	101		101		101	6
7	New water heaters	10/1/2009	57,980	4,349		4,349		4,349	7
8	Ceramic tile Trane heat Pump/ Air handler	9/30/2009	5,520	460		460		460	8
9	Ceramic tile for shower rooms	10/19/2009	2,631	197		197		197	9
10	Install trane air handler	9/30/2009	307	26		26		26	10
11	Glass replacement	10/23/2009	2,631	197		197		197	11
12	Water replacement	8/26/2009	142	13		13		13	12
13	Water replacement project	10/16/2009	1,469	110		110		110	13
14	Installation of Trane	10/30/2009	2,631	197		197		197	14
15	Prayer decals for windows	8/10/2009	968	88		88		88	15
16	shower remodel	10/28/2009	1,376	103		103		103	16
17	Area Rugs	11/2/2009	310	21		21		21	17
18	Shower room remodel	10/28/2009	5,889	442		442		442	18
19	Shower room remodel	10/28/2009	2,176	163		163		163	19
20	Shower room remodel	10/28/2009	75	6		6		6	20
21	Shower room remodel	10/30/2009	509	38		38		38	21
22	Painting of shower rooms	1/2/2010	923	69		69		69	22
23	Light Fixtures	12/30/2009	610	30		30		30	23
24	Shower room remodel	3/13/2010	408	24		24		24	24
25	Shower room updateds	6/30/2010	265	9		9		9	25
26	Shower room remodel	6/30/2010	19,208	160		160		160	26
27	Electric Panael & Circuitry for Generator	6/29/2010	22,765	190		190		190	27
28	Roof Top A/C for Dining Room	6/29/2010	13,403	112		112		112	28
29	Dryer Vents	6/29/2010	651	6		6		6	29
30	A/C for Therapy Room	6/29/2010	4,295	36		36		36	30
31	Landscape deposit	9/22/2009	19,000	1,583		1,583		1,583	31
32	Landscaping- 2009	11/5/2009	18,256	1,217		1,217		1,217	32
33	Asphalt Paving of Parking lot	6/10/2010	32,989	275		275		274	33
34	TOTAL (lines 1 thru 33)		\$ 5,521,371	\$ 263,973		\$ 263,973	\$	\$ 3,295,334	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	\$ 649,952	\$ 86,638	\$ 86,638	\$		\$ 301,223	71
72	Current Year Purchases	136,863	9,946	9,946			9,946	72
73	Fully Depreciated Assets	902,898	5,891	5,891			902,898	73
74	Home Office Allocation	244,879	18,192	18,192			37,260	74
75	TOTALS	\$ 1,934,592	\$ 120,667	\$ 120,667	\$		\$ 1,251,327	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	7,657	7,657			52,505	77
78										78
79	Home Office Allocation			38,800	2,882	2,882			13,701	79
80	TOTALS			\$ 94,622	\$ 10,539	\$ 10,539	\$		\$ 69,523	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,612,629	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 395,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 395,179	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)	\$ 4,616,184	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$ 47,237	\$	\$	86
87	Duplex Building and Equipment	951,433	27,848	617,601	87
88					88
89					89
90					90
91	TOTALS	\$ 998,670	\$ 27,848	\$ 617,601	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 50,004	92
93	Home Office Allocation	55,997	93
94			94
95		\$ 106,001	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: \$ 52,117 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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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? Fair Havens only hires certified CNAs</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		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	10A-3	hrs	\$	8,000	\$ 491,079	\$	8,000	\$ 491,079	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,274	276,808		3,274	276,808	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		9,756	588,690		9,756	588,690	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			\$	21,030	\$ 1,356,577	\$	21,030	\$ 1,356,577	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, 2009

Ending:

June 30,2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30,2010 (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	\$ 5,706,802	\$	1
2	Cash-Patient Deposits	33,916		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>60,837</u>)	1,224,687		3
4	Supply Inventory (priced at)	23,559		4
5	Short-Term Investments	1,304,955		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,263		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/ Other A/R</u>	17,137		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,323,319	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,875		13
14	Buildings, at Historical Cost	6,098,954		14
15	Leasehold Improvements, at Historical Cost	246,927		15
16	Equipment, at Historical Cost	1,816,345		16
17	Accumulated Depreciation (book methods)	(5,036,511)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	785,454		21
22	Other Long-Term Assets (spe CIP)	50,004		22
23	Other(specify): <u>Other Assets</u>	7,550		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,070,598	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,393,917	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 336,380	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,916		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,794		30
31	Accrued Taxes Payable (excluding real estate taxes)	422		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,633		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Liabilities</u>	100,069		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 793,214	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,326,988		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Entrance Fees</u>	151,835		43
44	<u>Due life right residents</u>	118,907		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,597,730	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,390,944	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,002,973	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,393,917	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,687,470	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,687,470	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,315,503	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)	\$ 1,315,503	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)	\$ 10,002,973	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

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	\$ 9,327,892	1
2	Discounts and Allowances for all Levels	(2,798,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,529,307	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,533,635	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,533,635	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	53,930	13
14	Non-Patient Meals	2,563	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,326	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,772	19
20	Radiology and X-Ray	37,610	20
21	Other Medical Services	47,055	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 272,256	23
D. Non-Operating Revenue			
24	Contributions	48,131	24
25	Interest and Other Investment Income***	86,442	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 134,573	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/ Duplex)	87,172	28
28a	Gain/Loss on Investments and Miscellaneous	7,211	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 94,383	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,564,154	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,470,134	31
32	Health Care	5,668,600	32
33	General Administration	2,308,633	33
B. Capital Expense			
34	Ownership	495,403	34
C. Ancillary Expense			
35	Special Cost Centers	221,996	35
36	Provider Participation Fee	83,885	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,248,651	40
41	Income before Income Taxes (line 30 minus line 40)**	1,315,503	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,315,503	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, 2009

Ending:

June 30,2010

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	1,549	1,549	\$ 82,250	\$ 53.10	1
2	Assistant Director of Nursing	2,921	2,921	71,891	24.61	2
3	Registered Nurses	12,023	13,317	332,820	24.99	3
4	Licensed Practical Nurses	33,930	37,004	788,063	21.30	4
5	CNAs & Orderlies	127,709	137,530	1,679,972	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,853	7,853	92,276	11.75	8
9	Activity Director	9,373	9,373	101,768	10.86	9
10	Activity Assistants					10
11	Social Service Workers	1,175	2,314	22,621	9.78	11
12	Dietician					12
13	Food Service Supervisor	2,524	2,524	58,323	23.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,265	31,134	279,710	8.98	15
16	Dishwashers					16
17	Maintenance Workers	5,472	5,813	108,164	18.61	17
18	Housekeepers	16,403	17,593	182,195	10.36	18
19	Laundry	9,519	10,398	95,797	9.21	19
20	Administrator	3,393	3,393	206,471	60.85	20
21	Assistant Administrator					21
22	Other Administrative	1,527	1,527	33,974	22.25	22
23	Office Manager	1,858	1,858	32,240	17.35	23
24	Clerical	5,498	6,460	86,055	13.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	5,510	5,510	107,180	19.45	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,225	5,225	68,849	13.18	31
32	Other Health Care: Managing Nurse, a	6,682	6,682	157,586	23.58	32
33	Other(specify) Marketing, Beauty	4,429	4,455	112,251	25.20	33
34	TOTAL (lines 1 - 33)	293,838	314,433	\$ 4,700,456 *	\$ 14.95	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	318	\$ 15,735	3.1.3	35
36	Medical Director	384	38,075	3.9.3	36
37	Medical Records Consultant	35	2,674	3.10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	4,890	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	82	5,065	3.12.3	45
46	Other(specify) Dental	11	1,100	3.10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,022	\$ 67,539		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laurie Brown	Executive Director	0	\$ 172,006	Workers' Compensation Insurance	\$ 93,732	IDPH License Fee	\$	
Ricky Goveia	Administration Assistant	0	34,435	Unemployment Compensation Insurance	59,913	Advertising: Employee Recruitment	8,960	
Diana Gilbert	Business Office Manager	0	30	FICA Taxes	341,102	Health Care Worker Background Check		
				Employee Health Insurance	296,758	(Indicate # of checks performed _____)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		License	140	
				Employee Physicals	3,688	Dues	9,249	
				Employee Expense	19,741	Subscriptions	1,844	
				457 Plan Expense	11,625			
				Employee Uniforms	2,332			
				Home Office Allocation	40,858	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 206,471	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 869,749		\$ 20,193		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 647,685			\$	Out-of-State Travel	\$
							In-State Travel	12,161
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 647,685				Seminar Expense	6,045
							Home Office Allocation	19,942
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 38,148
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount	\$				
Davis & Campbell L.L.C.	Legal		\$ 2,861					
My Innerview	Employee Survey		1,426					
Ferry and Associates	Evacuation Plan		570					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,857					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2009 Ending: June 30, 201

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 8,529.33
- (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. \$ 93,154 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,885
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. \$ 2,563
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.