

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0027987

Facility Name: FAIRHAVEN CHRISTIAN RETIREMENT CENTER

Address: 3470 NORTH ALPINE ROAD ROCKFORD 61114
 Number City Zip Code

County: WINNEBAGO

Telephone Number: (815)877-1441 Fax # (815)877-2040

HFS ID Number: 36-2606227001

Date of Initial License for Current Owners: 03/01/1968

Type of Ownership:

<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>501(C)(3)</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 _____	

In the event there are further questions about this report, please contact:
Name: JEFF REIERSON **Telephone Number:** (815)877-1441 X305

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	<u>04/28/2007</u>
	(Type or Print Name) <u>THOMAS T. BLEED</u>	(Date)
	(Title) <u>EXECUTIVE DIRECTOR</u>	
Paid Preparer	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987 Report Period Beginning: 1/01/2006 Ending: 12/31/2006

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	96	Intermediate (ICF)	96	35,040	3
4		Intermediate/DD			4
5	135	Sheltered Care (SC)	135	49,275	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,757	15,997		26,754	10
11	ICF/DD					11
12	SC	3,285	24,708		27,993	12
13	DD 16 OR LESS					13
14	TOTALS	14,042	40,705		54,747	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.93%

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 03/01/1968

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

STATE OF ILLINOIS

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT # 0027987 Report Period Beginning: 1/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	635,657	66,549	14,153	716,359		716,359		716,359		1
2	Food Purchase		472,635		472,635	(13,275)	459,360	(14,764)	444,596		2
3	Housekeeping	293,386	47,657		341,043		341,043		341,043		3
4	Laundry	154,014	25,201		179,215		179,215		179,215		4
5	Heat and Other Utilities			331,892	331,892	(6,000)	325,892	(22,433)	303,459		5
6	Maintenance	205,354	50,619	256,819	512,792		512,792	(6,272)	506,520		6
7	Other (specify):*			156,011	156,011		156,011		156,011		7
8	TOTAL General Services	1,288,411	662,661	758,875	2,709,947	(19,275)	2,690,672	(43,469)	2,647,203		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	2,564,775	132,982	46,486	2,744,243		2,744,243		2,744,243		10
10a	Therapy										10a
11	Activities	128,601	10,386		138,987		138,987		138,987		11
12	Social Services	41,611		1,068	42,679		42,679		42,679		12
13	CNA Training										13
14	Program Transportation			7,255	7,255		7,255	(1,036)	6,219		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,734,987	143,368	71,609	2,949,964		2,949,964	(1,036)	2,948,928		16
	C. General Administration										
17	Administrative	272,393			272,393		272,393		272,393		17
18	Directors Fees										18
19	Professional Services			170,820	170,820	(12,691)	158,129	(15,902)	142,227		19
20	Dues, Fees, Subscriptions & Promotions			34,377	34,377	3,090	37,467	(16,172)	21,295		20
21	Clerical & General Office Expenses	178,763	29,502	15,412	223,677		223,677		223,677		21
22	Employee Benefits & Payroll Taxes			1,124,763	1,124,763	22,876	1,147,639		1,147,639		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,082	13,082		13,082	(11,799)	1,283		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			126,879	126,879	(27,500)	99,379	(988)	98,391		26
27	Other (specify):*			6,723	6,723		6,723	(4,912)	1,811		27
28	TOTAL General Administration	451,156	29,502	1,492,056	1,972,714	(14,225)	1,958,489	(49,773)	1,908,716		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,474,554	835,531	2,322,540	7,632,625	(33,500)	7,599,125	(94,278)	7,504,847		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			582,093	582,093	12,236	594,329	(108,111)	486,218			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,376	66,376		66,376	(55,818)	10,558			32
33	Real Estate Taxes			95,531	95,531		95,531	(95,531)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,340	3,340		3,340		3,340			35
36	Other (specify):*			12,448	12,448		12,448		12,448			36
37	TOTAL Ownership			759,788	759,788	12,236	772,024	(259,460)	512,564			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					6,000	6,000		6,000			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*			706,652	706,652	15,264	721,916		721,916			43
44	TOTAL Special Cost Centers			759,212	759,212	21,264	780,476		780,476			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,474,554	835,531	3,841,540	9,151,625		9,151,625	(353,738)	8,797,887			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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,764)	Line2		4
5	Telephone, TV & Radio in Resident Rooms	(22,433)	Line5		5
6	Rented Facility Space	(6,272)	Line6		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	(13,011)	Line32		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	(42,807)	Line32		14
15	Non-Care Related Owner's Transactions	(108,111)	Line30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(11,799)	Line24		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	(3,000)	Line27		24
25	Fund Raising, Advertising and Promotional	(14,016)	Line20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,156)	Line20		28
29	Other-Attach Schedule	(115,369)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (353,738)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (353,738)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		6,000	Line5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Dupl Insur</u>	X		27,500	Line26	45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 33,500		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
FAIRHAVEN CHRISTIAN RETIREMENT CENTER

ID# 0027987

Report Period Beginning: 1/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Gas for non-care vehicles	\$ (1,036)	Line 14	1
2	Insurance for non-care vehicles	(988)	Line 26	2
3	Flowers & decorations, miscellaneous	(1,912)	Line 27	3
4	Bond trustee costs	(15,902)	Line 19	4
5	Real estate taxes - main building	(95,531)	Line 33	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(115,369)		49

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
NONE						

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT # 0027987 Report Period Beginning: 1/01/2006 Ending: 12/31/2006

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	NONE								\$		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 FAIRHAVEN CHRISTIAN RETIREMENT CENTER # 0027987 Report Period Beginning: 1/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	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					\$	\$		\$	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

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	Name of Lender	2		3	4	5	6		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	Alpine Bank-Line of Credit	X		Construction-Phase 1	None	9/1/2005	\$ 1,500,000	\$ 1,500,000	9/1/2008	0.0649	\$	1					
2	Alpine Bank-Line of Credit	X		Construction-Phase 1	None	2/1/2006	1,700,000	682,814	2/1/2009	0.0699		2					
3												3					
4												4					
5												5					
Working Capital																	
6	Alpine Bank-Line of Credit	X		Operating Expenses	None	7/12/2006	500,000	25,000	7/12/2007	0.0825	10,558	6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 3,700,000	\$ 2,207,814			\$ 10,558	9					
B. Non-Facility Related*																	
10	City of Rockford Bonds		X	Construction	None	2/22/2000	2,500,000	1,510,000	2/1/2013	0.0368	55,818	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$ 2,500,000	\$ 1,510,000			\$ 55,818	14					
15	TOTALS (line 9+line14)						\$ 6,200,000	\$ 3,717,814			\$ 66,376	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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 2005 report.	\$	200,000	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.)	\$	134,539	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(65,461)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	141,300	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.	\$	* 0.00	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	398,084	8
	2002	417,845	9
	2003	366,515	10
	2004	292,672	11
	2005	134,539	12

* Since the nursing home portion of our facility is exempt from real estate taxes, all other tax related to the main building would not be allowable and is therefore, adjusted out of the total costs on this report.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRHAVEN CHRISTIAN RETIREMENT CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0027987

CONTACT PERSON REGARDING THIS REPORT Jeff Reiersen

TELEPHONE (815) 877-1441 FAX #: (815) 877-2040

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>152B028B</u>	<u>Main Building</u>	<u>\$ 131,851.00</u>	<u>\$ none</u>
2. <u>152B030B</u>	<u>3488 N. Alpine</u>	<u>\$ 8,438.00</u>	<u>\$ none</u>
3. <u>152B051</u>	<u>Land by Alpine</u>	<u>\$ 72.00</u>	<u>\$ none</u>
4. <u>149C081B</u>	<u>Verde Lane</u>	<u>\$ 98.00</u>	<u>\$ none</u>
5. <u>149C052,053,054</u>	<u>Rolling Meadow/Terrace View Dup.</u>	<u>\$ 157,399.00</u>	<u>\$ none</u>
6. <u>152B031</u>	<u>Garden Lane Duplexes</u>	<u>\$ 21,311.00</u>	<u>\$ none</u>
7. <u>152B152,153,154,155,156</u>	<u>Garden Lane Duplexes</u>	<u>\$ 13,659.00</u>	<u>\$ none</u>
8. <u>152B157,158,159,161,162</u>	<u>Garden Lane Duplexes</u>	<u>\$ 15,578.00</u>	<u>\$ none</u>
9. _____	_____	\$ _____	\$ _____
10. <u>SEE ATTACHED PAGE 10B FOR EXPLANATION</u>	_____	\$ _____	\$ _____
TOTALS		<u>\$ 348,406.00</u>	<u>\$ none</u>

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

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

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 159,494 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

FAIRHAVEN CHRISTIAN RETIREMENT CENTER, RETIREMENT LIVING, DUPLEXES (114 UNITS TOTAL)

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>Main Building</u>	<u>871,200</u>	<u>1965</u>	<u>\$ 62,304</u>	1
2					2
3	TOTALS	871,200		\$ 62,304	3

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

1/01/2006

Ending:

12/31/2006

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	94		1967	1967	\$ 1,115,078	\$ 27,041	40	\$ 27,041	\$	\$ 1,074,325	4
5	76		1973	1973	1,051,996	26,186	40	26,186		881,766	5
6	20		1975	1975	255,191	5,843	20-40	5,843		205,514	6
7	41		1979	1979	1,323,223	31,213	40	31,213		935,987	7
8											8
	Improvement Type**										
9		Land improvements		1968	36,138	27	20-40	27		36,069	9
10		Install computers, call light system		1985	29,244	2	12-20	2		29,244	10
11		Carpet, Health Center call light system, boiler repair		1986	16,918	70	5-20	70		16,918	11
12		Expansion tank, carpet, light fixt., closet door, windows		1987	14,030	158	5-20	158		13,967	12
13		Fire alarm system, new laundry doors		1988	30,856	738	5-20	738		29,758	13
14		Sliding doors-front entry, water softener		1989	25,488	1,132	10-20	1,132		22,661	14
15		Hot water heater, boiler repair, air condit., exam room		1990	24,368	195	10-20	195		23,699	15
16		Air condit.-2 kitchens, HC computer cab., burner/boiler		1991	44,311	1,118	15-20	1,118		42,269	16
17		Chapel speaker system, burner/boiler, carpeting		1992	27,646	317	10-15	317		27,646	17
18		Remodel dietary off., a/c coff shop, carpeting,smoke det.		1993	35,136	258	10-20	258		33,463	18
19		Air condit.-laundry, new kitchen/apt, fire alarm		1994	11,134	225	10-20	225		9,446	19
20		Remodel of 6 rooms		1996	33,302	1,643	5-20	1,643		17,693	20
21		Remodeling of nurses station		1996	8,438	422	20	422		4,431	21
22		Boiler repair and new boiler		1996	5,363	267	10	267		5,359	22
23		Heaters		1996	1,630	81	10	81		1,630	23
24		New lights		1996	7,499	375	20	375		3,938	24
25		New windows		1996	1,762	88	20	88		924	25
26		Mixing valve and cartridge		1996	6,459	235	5-10	235		6,457	26
27		Rehab & conversion of rooms		1997	119,116	4,765	25	4,765		45,266	27
28		Remodel of Rehab dept., identicard door system		1997	37,374	1,937	10-25	1,937		18,402	28
29		Wall heaters,doors & wind.,water heater,chill water sys		1997	18,338	810	10-25	810		7,695	29
30		Roof work, office remodel,clock wiring,shelving,boiler		1997	33,616	1,728	10-25	1,728		17,850	30
31		Fence along Alpine Road		1998	84,198	4,210	20	4,210		35,785	31
32		Blacktop		1998	12,538	627	20	627		5,330	32
33		Remodel of Rehab Dept & Breakroom		1998	42,423	1,697	25	1,697		14,425	33
34		Rehab resident rooms		1998	92,743	3,710	25	3,710		31,535	34
35		Rehab offices-Ex dir.,ADON, Maint., Activities		1998	36,208	1,448	25	1,448		12,307	35
36		Rear entrance door, fire protection system		1998	6,051	242	25	242		2,057	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

1/01/2006 Ending: 12/31/2006

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	Rehab Health Ctr., Halls, Storage, Conference room	1998	\$ 24,693	\$ 988	25	\$ 988	\$	\$ 8,399	37
38	Rehab coffee shop & gift shop	1998	4,374	175	25	175		1,488	38
39	Health Ctr. sound system,	1998	4,308	287	15	287		2,440	39
40	Electrical work, heating & air condit.	1998	5,180	207	25	207		1,760	40
41	Fence and grading	1999	13,566	678	20	678		5,085	41
42	Blacktop, patching, speed bumps	1999	18,220	951	10-20	951		7,132	42
43	Rehab resident rooms	1999	84,948	3,398	25	3,398		25,485	43
44	Rehab maint off., shop, laund room, housekeeping off.	1999	44,768	1,791	25	1,791		13,433	44
45	Health Ctr. Elevator conversion, emerg. Lights	1999	9,806	931	10-20	931		6,983	45
46	Windows, storm doors, boiler room electrical	1999	12,196	518	20-25	518		3,885	46
47	Rehab Health Ctr.-lighting,heat,ceiling panels,flooring	1999	33,716	1,349	25	1,349		10,118	47
48	Rehab Health Ctr.-conf room,util room,activ,air cond	1999	17,993	864	15-25	864		6,479	48
49	Rehab Health Ctr.-soc serv off., 1st floor restroom	1999	4,077	163	25	163		1,222	49
50	Wanderguard door alarm	1999	530	53	10	53		398	50
51	Remodel-Main office,coffee shop,gift shop	2000	1,110,762	27,769	40	27,769		180,499	51
52	Employee parking lot	2000	96,253	4,813	20	4,813		31,284	52
53	Irrigation system	2000	18,761	938	20	938		6,097	53
54	Beauty shops-1st & 3rd	2000	49,403	1,235	40	1,235		8,028	54
55	Remodel-Maint., Acctg, Activ.,& 2nd fl HC kitchen off.	2000	38,198	1,910	20	1,910		12,415	55
56	Rehab resident rooms	2000	64,544	3,588	10-20	3,588		23,322	56
57	Main entrance doors	2000	10,535	527	20	527		3,425	57
58	Roof repairs,elevator room repairs,electric,phone,comp.	2000	35,305	2,299	10-20	2,299		14,943	58
59	Back flow system	2000	65,706	3,285	20	3,285		21,353	59
60	Smoke barrier upgrade	2000	68,105	1,703	40	1,703		11,069	60
61	Vanity/Tops/Faucets	2001	8,998	600	15	600		3,300	61
62	Recaulk-main entrance/main dining/S&W wings perimeters	2001	15,040	1,504	10	1,504		8,272	62
63	Signage, OSHA modifications,HVAC modifications	2001	16,911	873	15-25	873		4,802	63
64	2nd floor remodeling-ceiling,sprinkler,lighting,duct work	2001	48,885	2,375	20-25	2,375		13,063	64
65	Rehab resident rooms,countertop,locks	2001	30,992	1,550	20	1,550		8,525	65
66	Miscell plants,pots,trees,mulch,sprinkler system supplies	2001	8,496	618	5-15	618		2,301	66
67	Miscell boiler room doors/frames,castings-main,a/c install	2001	4,578	374	10-25	374		2,057	67
68	Rehab dietary office-elect,fan coil ductwork,door	2001	7,190	360	20	360		1,980	68
69	Redo wall,hallway,rear stairway coping stone reset	2002	2,104	105	20	105		473	69
70	TOTAL (lines 4 thru 69)		\$ 6,566,956	\$ 187,587		\$ 187,587	\$	\$ 4,065,331	70

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

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

1/01/2006 Ending: 12/31/2006

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		\$ 6,566,956	\$ 187,587		\$ 187,587	\$	\$ 4,065,331	1
2	Vanity/Tops/Faucets	2002	8,106	540	15	540		2,430	2
3	Keys,locks,windows	2002	6,335	351	15-20	351		1,579	3
4	East entrance doors-structural changes	2002	7,684	384	20	384		1,728	4
5	Recaulk-HC wing perimeter	2002	12,695	1,270	10	1,270		5,715	5
6	Doors	2002	7,581	505	15	505		2,273	6
7	Laundry,south lounge,water serv valve,roof,trash chute changes	2002	9,256	1,054	5-15	1,054		4,743	7
8	Main office,conference room,training room changes	2002	4,097	205	20	205		922	8
9	Room number signs	2002	6,070	304	20	304		1,368	9
10	Landscaping, front entrance and east drainage	2003	6,332	555	10-15	555		1,942	10
11	Back parking lot-coat and seal	2003	8,175	1,362	3	1,362		8,175	11
12	Modify patient toilet rooms and showers	2003	36,996	1,480	25	1,480		5,180	12
13	Garages-crown molding	2003	3,601	180	20	180		630	13
14	Screen,glass,wall,door,latches,locks replacement	2003	15,747	1,063	5-20	1,063		3,720	14
15	Lighting	2003	24,236	1,307	5-20	1,307		4,575	15
16	Vanity/Tops/Faucets	2003	4,908	327	15	327		1,145	16
17	Boiler room rework	2003	3,795	190	20	190		665	17
18	South wing roof	2003	66,135	3,307	20	3,307		11,574	18
19	Smoke barrier upgrade	2003	28,657	1,433	20	1,433		5,015	19
20	Employee parking lot, sidewalks	2004	14,283	952	15	952		2,380	20
21	Landscaping drainage	2004	12,100	807	15	807		2,017	21
22	Employee patio, residents veranda	2004	42,639	2,139	15-20	2,139		5,347	22
23	Vanities/tops	2004	7,657	510	15	510		1,275	23
24	Emergency lighting, kitchen feeds, sink	2004	16,344	1,057	15-20	1,057		2,642	24
25	Library	2004	11,520	576	20	576		1,440	25
26	3rd floor renovation	2004	53,708	2,685	20	2,685		6,713	26
27	Thermostats, heaters, heat lamps	2004	7,888	526	15	526		1,315	27
28	Building equipment, mixing valve, wire fence	2004	14,689	1,043	15	1,043		2,608	28
29	HC room doors	2004	8,783	586	15	586		1,465	29
30	Room refurbishment- 302/304	2004	8,782	439	20	439		1,098	30
31	HVAC controls, a/c units	2004	24,793	1,653	15	1,653		4,132	31
32	Curve improvement and walkway	2005	43,285	2,886	15	2,886		4,329	32
33	Recreational path - veranda	2005	10,099	673	15	673		1,010	33
34	TOTAL (lines 1 thru 33)		\$ 7,103,932	\$ 219,936		\$ 219,936	\$	\$ 4,166,481	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 12B, Carried Forward		\$ 7,103,932	\$ 219,936		\$ 219,936	\$	\$ 4,166,481	1
2	Blacktop - HC entrance and kitchen parking lot	2005	8,225	548	15	548		822	2
3	Globe fixtures at front entrance and signage	2005	2,856	190	15	190		285	3
4	Boiler room floor drains, rebrick boiler #2	2005	11,544	577	20	577		865	4
5	Vanities/tops	2005	2,581	172	15	172		258	5
6	East wing mixing value	2005	6,422	428	15	428		642	6
7	Roof exhaust fans, repairs & HC tuckpointing	2005	11,525	714	15-20	714		1,071	7
8	Upgrade elevator door-left side center building	2005	15,754	788	20	788		1,182	8
9	Window replacement and painting	2005	22,075	1,104	20	1,104		1,656	9
10	Remove/replace HC canopy	2005	46,471	1,859	25	1,859		2,788	10
11	Garage door-Kabota storage	2005	1,264	63	20	63		95	11
12	Storage room cages	2005	753	50	15	50		75	12
13	Boiler room walkway	2006	19,603	490	20	490		490	13
14	Signage	2006	5,011	167	15	167		167	14
15	Storage room cages	2006	16,254	406	20	406		406	15
16	Upgrade elevator doors	2006	58,240	1,456	20	1,456		1,456	16
17	Curb & gutter, irrigation system	2006	18,415	614	15	614		614	17
18	Repipe softners	2006	5,700	143	20	143		143	18
19	Vanities/tops	2006	4,530	151	15	151		151	19
20	Exhaust fans-roofs	2006	16,456	549	15	549		549	20
21	Window replacement and painting	2006	11,817	277	20	277		277	21
22	Bathtub conversions	2006	4,265	107	20	107		107	22
23	Lighting and electrical work	2006	1,615	40	20	40		40	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,395,308	\$ 230,829		\$ 230,829	\$	\$ 4,180,620	34

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

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTE# 0027987 Report Period Beginning: 1/01/2006 Ending: 12/31/2006

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	\$ 3,407,489	\$ 243,646	\$ 243,646	\$	5-20 yrs.	\$ 1,994,340	71
72	Current Year Purchases	115,164	6,108	6,108		5-20 yrs.	6,108	72
73	Fully Depreciated Assets	(998,676)				5-20 yrs.	(998,676)	73
74								74
75	TOTALS	\$ 2,523,977	\$ 249,754	\$ 249,754	\$		\$ 1,001,772	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	Bus	Ford Turtle Top-2003	2003	\$ 56,345	\$ 5,635	\$ 5,635	\$	10 yrs.	\$ 19,721	76
77										77
78										78
79										79
80	TOTALS			\$ 56,345	\$ 5,635	\$ 5,635	\$		\$ 19,721	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)	\$ 10,037,934	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 486,218	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 486,218	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,202,113	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	Garages 1968-92, Vehicles 1989-2006	\$ 69,375	\$ 3,069	\$ 55,319	86
87	Landscaping equipment-1968-2006	49,439		49,439	87
88	Duplexes & Land Improv.1990-2006	13,183,903	430,444	5,913,065	88
89	E-wing furn.&land improv1990-2006	3,482,300	93,385	1,680,603	89
90	Land-Duplexes	411,576			90
91	TOTALS	\$ 17,196,593	\$ 526,898	\$ 7,698,426	91

G. Construction-in-Progress

	Description	Cost	
92	Construction-in-progress	\$ 2,858,787	92
93			93
94			94
95		\$ 2,858,787	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: NONE

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. 2007 \$ _____
13. 2008 \$ _____
14. 2009 \$ _____

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

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

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER # 0027987 Report Period Beginning: 1/01/2006 Ending: 12/31/2006

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>All nurses aides come to Fairhaven having already completed C.N.A. classes prior to employment. 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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	NONE	hrs	\$		\$		\$									1
2	Licensed Speech and Language Development Therapist		hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist		hrs														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	Exceptional Care Program																12
13	Other (specify):																13
14	TOTAL			\$		\$		\$		\$		\$		\$			14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT CENTER** # **0027987** Report Period Beginning: **1/01/2006** Ending: **12/31/2006**

XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2006** (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	\$ 29,219	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 3,200)	466,785		3
4	Supply Inventory (priced at Lwr Cst or Mk)	46,267		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,851		6
7	Other Prepaid Expenses	40,158		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Limited Use Assets</u>	395,396		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 993,676	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	473,880		13
14	Buildings, at Historical Cost	23,734,394		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,367,910		16
17	Accumulated Depreciation (book methods)	(14,615,122)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Bond Clsg Cost(Net)</u>)	75,721		22
23	Other(specify): <u>Vehicles, CIP</u>	3,061,732		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,098,515	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,092,191	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 984,055	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	225,000		29
30	Accrued Salaries Payable	148,786		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	141,300		32
33	Accrued Interest Payable	5,165		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Property Tax Credits Due Residents</u>	300,000		36
37	<u>Accrued Retirement - 403-B</u>	20,997		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,825,303	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,182,814		39
40	Mortgage Payable			40
41	Bonds Payable	1,310,000		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Advance deposits on Founder's Fees</u>	159,150		43
44	<u>Founder's Fees</u>	5,231,387		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,883,351	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,708,654	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,383,537	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,092,191	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,081,077	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,081,077	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	292,649	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	(44)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Unrealized gains on investments	9,855	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 302,460	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)	\$ 7,383,537	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,010,651	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,010,651	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	6,000	13
14	Non-Patient Meals	27,341	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,272	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	134,405	21
22	Laundry	4,928	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 178,946	23
D. Non-Operating Revenue			
24	Contributions	197,217	24
25	Interest and Other Investment Income***	13,011	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 210,228	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Duplex Income	1,806,167	28
28a	Equipment Rental & Other Income	238,282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,044,449	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,444,274	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,709,947	31
32	Health Care	2,949,964	32
33	General Administration	1,972,714	33
B. Capital Expense			
34	Ownership	759,788	34
C. Ancillary Expense			
35	Special Cost Centers	706,652	35
36	Provider Participation Fee	52,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,151,625	40
41	Income before Income Taxes (line 30 minus line 40)**	292,649	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 292,649	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 **FAIRHAVEN CHRISTIAN RETIREMENT CENTER**

0027987

Report Period Beginning:

1/01/2006

Ending:

12/31/2006

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	1,864	2,080	\$ 71,363	\$ 34.31	1
2	Assistant Director of Nursing	1,864	2,080	49,647	23.87	2
3	Registered Nurses	22,043	24,835	519,075	20.90	3
4	Licensed Practical Nurses	30,677	32,148	606,404	18.86	4
5	CNAs & Orderlies	90,160	99,029	1,158,854	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,737	9,723	113,332	11.66	8
9	Activity Director	4,864	5,116	72,206	14.11	9
10	Activity Assistants	5,774	5,975	56,395	9.44	10
11	Social Service Workers	1,944	2,080	41,611	20.01	11
12	Dietician					12
13	Food Service Supervisor	3,902	4,366	76,103	17.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,776	29,148	300,260	10.30	15
16	Dishwashers	31,821	33,559	259,294	7.73	16
17	Maintenance Workers	12,219	13,134	205,354	15.64	17
18	Housekeepers	30,455	32,591	293,386	9.00	18
19	Laundry	13,474	14,580	154,014	10.56	19
20	Administrator	1,864	2,080	114,453	55.03	20
21	Assistant Administrator	1,864	2,080	89,571	43.06	21
22	Other Administrative	1,896	2,080	68,369	32.87	22
23	Office Manager	1,864	2,080	35,902	17.26	23
24	Clerical	10,024	10,773	142,861	13.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,945	2,241	46,100	20.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	306,031	331,778	\$ 4,474,554 *	\$ 13.49	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	377	\$ 14,153	1-3	35
36	Medical Director	36	16,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	1,375	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	18	1,068	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	529	\$ 33,396		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	98	\$ 4,469	10-3	50
51	Licensed Practical Nurses	1,126	36,973	10-3	51
52	Certified Nurse Assistants/Aides	240	3,669	10-3	52
53	TOTAL (lines 50 - 52)	1,464	\$ 45,111		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	
Tom Bleed	Exec. Director	0	\$ 114,453	Workers' Compensation Insurance	\$ 157,024	IDPH License Fee	\$ 0	
Jeff Reiersen	Asst. Administrator	0	89,571	Unemployment Compensation Insurance	21,179	Advertising: Employee Recruitment	5,087	
Steve Hemenway	Dir. Of Resid & Human Serv.	0	68,369	FICA Taxes	323,219	Health Care Worker Background Check		
				Employee Health Insurance	519,439	(Indicate # of checks performed <u>67</u>)	670	
				Employee Meals	13,275	Patient Background Checks <u>242</u>	2,420	
				Illinois Municipal Retirement Fund (IMRF)*		LSN Membership Fees	10,891	
				403-B Annuity Expense-company match	79,041	Required Minority Advertising	430	
				403-B Annuity Expense-administration	5,841	Profess & Business Related Subscript.	1,337	
				Company Appreciation Events	19,998	State Licenses & IL CPA Society Dues	460	
				Employee Benefits Corp-Flex Spending admin	2,249	Promotional & Advertising Fees	14,016	
				Employee-Physicals	3,760	Less: Public Relations Expense	(1,720)	
				Employee Assistance Program	2,614	Non-allowable advertising	(10,826)	
						Yellow page advertising	(1,470)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 272,393	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,295
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$	
C. Professional Services								
Vendor/Payee	Type		Amount					
Achieve Healthcare Tech	Acctg/Med Record Support		\$ 8,707				Out-of-State Travel	
ADP	Payroll Services		15,740				\$ 0	
Amcore Bank	3rd Party Admin-403-B		5,841					
Chase Bank	Trustee Serv Bond Issue		15,902				In-State Travel	
Guyer & Enichen	Attorney - Tax Appeals		88,989				738	
John P. Hill & Associates	Real Estate Appraisers		7,500					
Illinois State Police	Background Checks		3,090				Seminar Expense	
Williams McCarthy	Attorney - 403-B issues		250				545	
McGladrey & Pullen	Annual Audit & Acctg Serv.		14,450					
Mygait	Residents Computer Serv.		4,500				Entertainment Expense	
Physicians Immed Care	Employee Physicals		3,760				()	
Schlueter Eklund	Attorney- General issues		2,091					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 170,820				\$			\$ 1,283	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning: 1/01/2006

Ending: 12/31/2006

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 Services Network(LSN) \$10,891
- (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? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,420 Line 10 (Col.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. \$ 52,560
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? NONE
- (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. \$ 13,275 Has any meal income been offset against related costs? YES Indicate the amount. \$ 14,764
- (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? 100%
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? YES
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: McGladrey & Pullen CPA'S The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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.

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/06 - 12/31/06

RECLASSIFICATIONS:

LINE 2	Food purchase	<u>\$ (13,275)</u>	Take out cost of meals provided to employees
LINE 5	Heat & other utilities	<u>\$ (6,000)</u>	Take out utilities allocable to beauty shop
LINE 19	Professional services	\$ (3,090)	Take out background checks
		\$ (3,760)	Take out employee exams
		<u>\$ (5,841)</u>	Take out 403-B administration function
		<u>\$ (12,691)</u>	
LINE 20	Fees, subscriptions, & promotions	<u>\$ 3,090</u>	Add in background checks from line 19
LINE 22	Employee benefits & payroll taxes	\$ 13,275	Add in cost of meals from line 2
		\$ 3,760	Add in employee exams from line 19
		\$ 5,841	Add in 403-B administration function from line 19
		<u>\$ 22,876</u>	
LINE 26	Insurance-Property & Liability	<u>\$ (27,500)</u>	Take out insurance-property for Duplexes
LINE 30	Depreciation	<u>\$ 12,236</u>	Add in additional depreciation relating to Duplexes
LINE 40	Barber & Beauty Shops	<u>\$ 6,000</u>	Add in utilities taken out of line 5
LINE 43	Other-Duplexes	\$ 27,500	Add in insurance-property from line 26
		<u>\$ (12,236)</u>	Take out depreciation from line 30
		<u>\$ 15,264</u>	
TOTAL		<u>\$ -</u>	

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/06-12/31/06

Schedule V p. 3 & 4

LINE 7

Security Services	\$ 135,594
Trash Disposal	\$ 20,417
	<u>\$ 156,011</u>

LINE 27

Flowers & Decorations-Nursing Ctr.	<u>\$ 1,811</u>
------------------------------------	-----------------

LINE 36

Amortization of Bond Closing Costs	<u>\$ 12,448</u>
------------------------------------	------------------

LINE 43

Duplexes: Real Estate Taxes	\$ 176,662
Depreciation	\$ 430,444
Utilities	\$ 44,698
Maintenance	\$ 42,612
Insurance	\$ 27,500
	<u>\$ 721,916</u>

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/06 - 12/31/06

Sch VI p. 5

LINE 29

Gas for Non-Care Vehicles	\$	(1,036)
Insurance for Non-Care Vehicles	\$	(988)
Flowers & Decorations, Miscellaneous	\$	(1,912)
Bond Trustee Costs	\$	(15,902)
Real Estate Taxes - Main Building	\$	(95,531)
	\$	<u>(115,369)</u>

LINE 45

Duplex Insurance	<u>\$27,500</u>
------------------	-----------------

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/06 - 12/31/06

Sch XVII Income Statement Page 19

E. Other Revenue

Line 28	<u>\$ 1,806,167</u>	Duplex Monthly Maintenance and Founder's Fee Income
Line 28a	\$ 6,824	Equipment Rental-Wheelchairs & Gerichairs
	<u>\$ 231,458</u>	Other Income such as Vending Machine, Monthly Cable, Activities, Gain on Sale,
	<u>\$ 238,282</u>	Real Estate Tax Refund

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/06-12/31/06

PAGE 10B: 2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

EXPLANATION REGARDING PAGE 10A PARTS B & C:

- B. Our tax bills relate to property that is not directly used for nursing home services, such as duplex living and independent living in the main building. None is allocated to the nursing home section since it is exempt from real estate taxes.

- C. No tax bills have been attached to this report since all of our company real estate tax has been adjusted out.

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/06 - 12/31/06

2006 SCHEDULE V (LINE 24)

<u>DATE</u>	<u>SEMINAR</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>ATTENDEE(S)</u>	<u>COST</u>
9/25-9/27/06	Life Services Network 2006 Senior Housing, Supportive & Assisted Living Conference	Woodridge, IL	LSN	Tom Bleed, Executive Director, Steve Hemenway, Resident & Human Services Director	\$1,283

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/06 - 12/31/06

2006 SCHEDULE VII - NON-PROFIT NURSING HOMES

<u>Board of Director</u>	<u>Officer</u>	<u>Provided services to Fairhaven?</u>	<u>Service/Product</u>	<u>Entity of Ownership</u>
Wiles, David	President	Yes	Carbon Dioxide/Nitrogen Cylinder Rentals	
Nyberg, Dan	Secretary	No		
Opperman, Kathy	Treasurer	No		
Evans, John	Asst. Secretary	Yes	Construction/Refurbishing Rooms/Duplexes	John Evans Construction Co.
Johnson, Steve	Vice-President	Yes	Property/Liability/Auto/Umbrella Insurance	Williams Manny Insurance Co.
Kingstrom, Paul	Asst. Treasurer	No		
Klaas, Palmer	Director	Yes	Investment Services- Endowment	
Sjogren, Steve	Director	No		
Lindquist, Evie	Director	No		
Meyer, Ken	Director	No		
Schlueter, Mel	Director	No		
Thompson, Richard	Director	No		
Watts, Linda	Director	No		
Johnson, Larry	Director	No		
Voorhies, Randy	Director	Yes	Building Sprinkler Installation	
Brogan, Neil	Director	No		