

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0027987</u></p> <p>Facility Name: <u>FAIRHAVEN CHRISTIAN RETIREMENT CENTER</u></p> <p>Address: <u>3470 NORTH ALPINE ROAD</u> <u>ROCKFORD</u> <u>61114</u> Number City Zip Code</p> <p>County: <u>WINNEBAGO</u></p> <p>Telephone Number: <u>(815)877-1441</u> Fax # <u>(815)282-4217</u></p> <p>HFS ID Number: <u>36-2606227001</u></p> <p>Date of Initial License for Current Owners: <u>03/01/1968</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(C)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> _____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JEFF REIERSON</u> Telephone Number: <u>(815)877-1441 X305</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(C)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> _____		<input type="checkbox"/> Limited Liability Co.	<input type="checkbox"/> _____		<input type="checkbox"/> Trust	<input type="checkbox"/> _____		<input type="checkbox"/> Other	<input type="checkbox"/> _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>THOMAS T. BLEED</u> (Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>THOMAS T. BLEED</u> (Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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	(Telephone) (____) _____ Fax # (____) _____																																

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	35,136	3
4		Intermediate/DD			4
5	135	Sheltered Care (SC)	135	49,410	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,546	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	12,264	18,619		30,883	10
11	ICF/DD					11
12	SC	2,378	26,460		28,838	12
13	DD 16 OR LESS					13
14	TOTALS	14,642	45,079		59,721	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.64%

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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number

FAIRHAVEN CHRISTIAN RETIREMENT

0027987

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	743,828	60,453	17,542	821,823		821,823		821,823		1
2	Food Purchase		563,989		563,989	(15,517)	548,472	(18,977)	529,495		2
3	Housekeeping	295,867	46,942	711	343,520		343,520		343,520		3
4	Laundry	135,715	36,715		172,430		172,430		172,430		4
5	Heat and Other Utilities			466,055	466,055	(7,260)	458,795	(7,777)	451,018		5
6	Maintenance	245,891	56,341	303,335	605,567		605,567	(7,600)	597,967		6
7	Other (specify):*			175,263	175,263		175,263		175,263		7
8	TOTAL General Services	1,421,301	764,440	962,906	3,148,647	(22,777)	3,125,870	(34,354)	3,091,516		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,625,451	129,146	207,486	2,962,083		2,962,083		2,962,083		10
10a	Therapy										10a
11	Activities	142,042	13,910	569	156,521		156,521		156,521		11
12	Social Services	43,900			43,900		43,900		43,900		12
13	CNA Training										13
14	Program Transportation			11,172	11,172		11,172	(1,397)	9,775		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,811,393	143,056	237,227	3,191,676		3,191,676	(1,397)	3,190,279		16
	C. General Administration										
17	Administrative	298,983			298,983		298,983		298,983		17
18	Directors Fees										18
19	Professional Services			100,292	100,292	(13,499)	86,793	(20,670)	66,123		19
20	Dues, Fees, Subscriptions & Promotions			64,550	64,550	1,580	66,130	(46,590)	19,540		20
21	Clerical & General Office Expenses	217,128	31,705	20,580	269,413		269,413		269,413		21
22	Employee Benefits & Payroll Taxes			1,253,676	1,253,676	27,436	1,281,112		1,281,112		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,628	13,628		13,628	(10,598)	3,030		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			114,567	114,567	(27,500)	87,067	(859)	86,208		26
27	Other (specify):*			8,649	8,649		8,649	(6,693)	1,956		27
28	TOTAL General Administration	516,111	31,705	1,575,942	2,123,758	(11,983)	2,111,775	(85,410)	2,026,365		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,748,805	939,201	2,776,075	8,464,081	(34,760)	8,429,321	(121,161)	8,308,160		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 **FAIRHAVEN CHRISTIAN RETIREMENT CENTER #0027987** Report Period Beginning: **1/1/2008** Ending: **12/31/2008**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			664,020	664,020	489	664,509	(115,000)	549,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			245,588	245,588		245,588	(32,679)	212,909			32
33	Real Estate Taxes			171,001	171,001		171,001	(171,001)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,581	2,581		2,581		2,581			35
36	Other (specify):*			12,448	12,448		12,448		12,448			36
37	TOTAL Ownership			1,095,638	1,095,638	489	1,096,127	(318,680)	777,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					7,260	7,260		7,260			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*			837,435	837,435	27,011	864,446		864,446			43
44	TOTAL Special Cost Centers			890,139	890,139	34,271	924,410		924,410			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,748,805	939,201	4,761,852	10,449,858		10,449,858	(439,841)	10,010,017			45

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

STATE OF ILLINOIS
FAIRHAVEN CHRISTIAN RETIREMENT CENTER

ID# 0027987

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Line
1	Gas for non-care vehicles	\$ (1,397)	Line 14	1
2	Insurance for non-care vehicles	(859)	Line 26	2
3	Flowers & decorations, miscellaneous	(1,893)	Line 27	3
4	Bond trustee costs	(20,670)	Line 19	4
5	Real estate taxes - main building	(171,001)	Line 33	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				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	(195,820)		49

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT CENTER**

0027987

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

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: 1/1/2008 Ending: 12/31/2008

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: 1/1/2008 Ending: 2/31/2008

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					\$	\$		\$	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 FAIRHAVEN CHRISTIAN RETIREMENT (# 0027987 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Alpine Bank-Line of Credit	X		Construction - Phase 1 & 2	NONE	4/30/2008	\$ 5,150,000	\$ 3,799,048	7/30/2009	0.0575	\$ 212,909	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alpine Bank-Line of Credit	X		Operating Expenses	NONE	8/11/2008	500,000		8/10/2009	0.0325		6
7												7
8												8
9	TOTAL Facility Related						\$ 5,650,000	\$ 3,799,048			\$ 212,909	9
	B. Non-Facility Related*											
10	City of Rockford Bonds		X	Construction	NONE	2/22/2000	2,500,000	1,100,000	2/1/2013	0.0293	32,679	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 2,500,000	\$ 1,100,000			\$ 32,679	14
15	TOTALS (line 9+line14)						\$ 8,150,000	\$ 4,899,048			\$ 245,588	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>\$ 156,241.00</u>	<u>\$ none</u>
2. <u>152B030B</u>	<u>3488 N. Alpine</u>	<u>\$ 11,142.00</u>	<u>\$ none</u>
3. <u>152B051</u>	<u>Land by Alpine</u>	<u>\$ 73.00</u>	<u>\$ none</u>
4. <u>149C081B</u>	<u>Verde Lane</u>	<u>\$ 108.00</u>	<u>\$ none</u>
5. <u>149C052,053,054</u>	<u>Rolling Meadow/Terrace View Dup.</u>	<u>\$ 159,687.00</u>	<u>\$ none</u>
6. <u>152B031</u>	<u>Garden Lane Duplexes</u>	<u>\$ 21,614.00</u>	<u>\$ none</u>
7. <u>152B152,153,154,155,156</u>	<u>Garden Lane Duplexes</u>	<u>\$ 18,374.00</u>	<u>\$ none</u>
8. <u>152B157,158,159,161,162</u>	<u>Garden Lane Duplexes</u>	<u>\$ 20,983.00</u>	<u>\$ none</u>
9. _____	_____	\$ _____	\$ _____
10. <u>SEE ATTACHED PAGE 10B FOR</u>	<u>EXPLANATION</u>	\$ _____	\$ _____
TOTALS		<u>\$ 388,222.00</u>	<u>\$ none</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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

A. Land.

	1	2	3	4	
	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:

1/1/2008

Ending:

12/31/2008

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	\$ 13,568	40	\$ 13,568	\$	\$ 1,114,934	4
5	76	1973	1973	1,051,996	26,186	40	26,186		934,138	5
6	20	1975	1975	255,191	5,843	20-40	5,843		217,200	6
7	41	1979	1979	1,323,223	31,213	40	31,213		998,413	7
8										8
	Improvement Type**									
9	Land improvements		1968	36,138	19	20-40	19		36,115	9
10	Fire alarm system, new laundry doors		1988	30,856	360	5-20	360		30,856	10
11	Sliding doors-front entry, water softener		1989	25,488	1,132	10-20	1,132		24,925	11
12	Hot water heater, boiler repair, air condit., exam room		1990	24,368	192	10-20	192		24,083	12
13	Air condit.-2 kitchens, HC computer cab., burner/boiler		1991	44,311	372	15-20	372		43,019	13
14	Remodel dietary off., a/c coff shop, carpeting,smoke det.		1993	35,136	258	10-20	258		33,979	14
15	Air condit.-laundry, new kitchen/apt, fire alarm		1994	11,134	225	10-20	225		9,896	15
16	Remodel of 6 rooms		1996	33,302	1,643	5-20	1,643		20,979	16
17	Remodeling of nurses station		1996	8,438	422	20	422		5,275	17
18	New lights		1996	7,499	375	20	375		4,688	18
19	New windows		1996	1,762	88	20	88		1,100	19
20	Rehab & conversion of rooms		1997	119,116	4,765	25	4,765		54,796	20
21	Remodel of Rehab dept., identicard door system		1997	37,374	1,201	10-25	1,201		21,172	21
22	Wall heaters,doors & wind.,water heater,chill water sys		1997	18,338	715	10-25	715		9,173	22
23	Roof work, office remodel,clock wiring,shelving,boiler		1997	33,616	1,445	10-25	1,445		20,882	23
24	Fence along Alpine Road		1998	84,198	4,210	20	4,210		44,205	24
25	Blacktop		1998	12,538	627	20	627		6,584	25
26	Remodel of Rehab Dept & Breakroom		1998	42,423	1,697	25	1,697		17,819	26
27	Rehab resident rooms		1998	92,743	3,710	25	3,710		38,955	27
28	Rehab offices-Ex dir.,ADON, Maint., Activities		1998	36,208	1,448	25	1,448		15,203	28
29	Rear entrance door, fire protection system		1998	6,051	242	25	242		2,541	29
30	Rehab Health Ctr., Halls, Storage, Conference room		1998	24,693	988	25	988		10,375	30
31	Rehab coffee shop & gift shop		1998	4,374	175	25	175		1,838	31
32	Health Ctr. sound system,		1998	4,308	287	15	287		3,014	32
33	Electrical work, heating & air condit.		1998	5,180	207	25	207		2,174	33
34	Fence and grading		1999	13,566	678	20	678		6,441	34
35	Blacktop, patching, speed bumps		1999	18,220	951	10-20	951		9,034	35
36	Rehab resident rooms		1999	84,948	3,398	25	3,398		32,281	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 FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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 maint off., shop, laund room, housekeeping off.	1999	\$ 44,768	\$ 1,791	25	\$ 1,791	\$	\$ 17,015	37
38	Health Ctr. Elevator conversion, emerg. Lights	1999	9,806	931	10-20	931		8,845	38
39	Windows, storm doors, boiler room electrical	1999	12,196	518	20-25	518		4,921	39
40	Rehab Health Ctr.-lighting,heat,ceiling panels,flooring	1999	33,716	1,349	25	1,349		12,816	40
41	Rehab Health Ctr.-conf room,util room,activ,air cond	1999	17,993	864	15-25	864		8,207	41
42	Rehab Health Ctr.-soc serv off., 1st floor restroom	1999	4,077	163	25	163		1,548	42
43	Wanderguard door alarm	1999	530	53	10	53		504	43
44	Remodel-Main office,coffee shop,gift shop	2000	1,110,762	27,769	40	27,769		236,037	44
45	Employee parking lot	2000	96,253	4,813	20	4,813		40,910	45
46	Irrigation system	2000	18,761	938	20	938		7,973	46
47	Beauty shops-1st & 3rd	2000	49,403	1,235	40	1,235		10,498	47
48	Remodel-Maint., Acctg, Activ.,& 2nd fl HC kitchen off.	2000	38,198	1,910	20	1,910		16,235	48
49	Rehab resident rooms	2000	64,544	3,588	10-20	3,588		30,498	49
50	Main entrance doors	2000	10,535	527	20	527		4,479	50
51	Roof repairs,elevator room repairs,electric,phone,comp.	2000	35,305	2,299	10-20	2,299		19,541	51
52	Back flow system	2000	65,706	3,285	20	3,285		27,923	52
53	Smoke barrier upgrade	2000	68,105	1,703	40	1,703		14,475	53
54	Vanity/Tops/Faucets	2001	8,998	600	15	600		4,500	54
55	Recaulk-main entrance/main dining/S&W wings perimeters	2001	15,040	1,504	10	1,504		11,280	55
56	Signage, OSHA modifications,HVAC modifications	2001	16,911	873	15-25	873		6,548	56
57	2nd floor remodeling-ceiling,sprinkler,lighting,duct work	2001	48,885	2,375	20-25	2,375		17,813	57
58	Rehab resident rooms,countertop,locks	2001	30,992	1,550	20	1,550		11,625	58
59	Miscell plants,pots,trees,mulch,sprinkler system supplies	2001	8,496	568	5-15	568		3,437	59
60	Miscell boiler room doors/frames,castings-main,a/c install	2001	4,578	374	10-25	374		2,805	60
61	Rehab dietary office-elect,fan coil ductwork,door	2001	7,190	360	20	360		2,700	61
62	Redo wall,hallway,rear stairway coping stone reset	2002	2,104	105	20	105		683	62
63	Vanity/Tops/Faucets	2002	8,106	540	15	540		3,510	63
64	Keys,locks,windows	2002	6,335	351	15-20	351		2,281	64
65	East entrance doors-structural changes	2002	7,684	384	20	384		2,496	65
66	Recaulk-HC wing perimeter	2002	12,695	1,270	10	1,270		8,255	66
67	Doors	2002	7,581	505	15	505		3,283	67
68	Laundry,south lounge,water serv valve,roof,trash chute changes	2002	9,256	399	5-15	399		5,868	68
69	Main office,conference room,training room changes	2002	4,097	205	20	205		1,332	69
70	TOTAL (lines 4 thru 69)		\$ 6,521,420	\$ 174,339		\$ 174,339	\$	\$ 4,346,928	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:

1/1/2008

Ending:

12/31/2008

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,521,420	\$ 174,339		\$ 174,339	\$	\$ 4,346,928	1
2	Room number signs	2002	6,070	304	20	304		1,976	2
3	Landscaping, front entrance and east drainage	2003	6,332	555	10-15	555		3,052	3
4	Modify patient toilet rooms and showers	2003	36,996	1,480	25	1,480		8,140	4
5	Garages-crown molding	2003	3,601	180	20	180		990	5
6	Screen,glass,wall,door,latches,locks replacement	2003	15,747	997	5-20	997		5,780	6
7	Lighting	2003	24,236	1,266	5-20	1,266		7,148	7
8	Vanity/Tops/Faucets	2003	4,908	327	15	327		1,799	8
9	Boiler room rework	2003	3,795	190	20	190		1,045	9
10	South wing roof	2003	66,135	3,307	20	3,307		18,188	10
11	Smoke barrier upgrade	2003	28,657	1,433	20	1,433		7,881	11
12	Employee parking lot, sidewalks	2004	14,283	952	15	952		4,284	12
13	Landscaping drainage	2004	12,100	807	15	807		3,631	13
14	Employee patio, residents veranda	2004	42,639	2,139	15-20	2,139		9,625	14
15	Vanities/tops	2004	7,657	510	15	510		2,295	15
16	Emergency lighting, kitchen feeds, sink	2004	16,344	1,057	15-20	1,057		4,756	16
17	Library	2004	11,520	576	20	576		2,592	17
18	3rd floor renovation	2004	53,708	2,685	20	2,685		12,083	18
19	Thermostats, heaters, heat lamps	2004	7,888	526	15	526		2,367	19
20	Building equipment, mixing valve, wire fence	2004	14,689	1,043	15	1,043		4,694	20
21	HC room doors	2004	8,783	586	15	586		2,637	21
22	Room refurbishment- 302/304	2004	8,782	439	20	439		1,976	22
23	HVAC controls, a/c units	2004	24,793	1,653	15	1,653		7,438	23
24	Curve improvement and walkway	2005	43,285	2,886	15	2,886		10,101	24
25	Recreational path - veranda	2005	10,099	673	15	673		2,356	25
26	Blacktop - HC entrance and kitchen parking lot	2005	8,225	548	15	548		1,918	26
27	Globe fixtures at front entrance and signage	2005	2,856	190	15	190		665	27
28	Boiler room floor drains, rebrick boiler #2	2005	11,544	577	20	577		2,019	28
29	Vanities/tops	2005	2,581	172	15	172		602	29
30	East wing mixing valve	2005	6,422	428	15	428		1,498	30
31	Roof exhaust fans, repairs & HC tuckpointing	2005	11,525	714	15-20	714		2,499	31
32	Upgrade elevator door-left side center building	2005	15,754	788	20	788		2,758	32
33	Window replacement and painting	2005	22,075	1,104	20	1,104		3,864	33
34	TOTAL (lines 1 thru 33)		\$ 7,075,449	\$ 205,431		\$ 205,431	\$	\$ 4,489,585	34

**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:

1/1/2008

Ending:

12/31/2008

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		\$ 7,075,449	\$ 205,431		\$ 205,431	\$	\$ 4,489,585	1
2	Remove/replace HC canopy	2005	46,471	1,859	25	1,859		6,506	2
3	Garage door-Kabota storage	2005	1,264	63	20	63		221	3
4	Storage room cages	2005	753	50	15	50		175	4
5	Boiler room walkway	2006	19,603	980	20	980		2,450	5
6	Signage	2006	5,011	334	15	334		835	6
7	Storage room cages	2006	16,254	813	20	813		2,032	7
8	Upgrade elevator doors	2006	58,240	2,912	20	2,912		7,280	8
9	Curb & gutter, irrigation system	2006	18,415	1,228	15	1,228		3,070	9
10	Repipe softners	2006	5,700	285	20	285		713	10
11	Vanities/tops	2006	4,530	302	15	302		755	11
12	Exhaust fans-roofs	2006	16,456	1,097	15	1,097		2,743	12
13	Window replacement and painting	2006	11,817	554	20	554		1,385	13
14	Bathtub conversions	2006	4,265	213	20	213		533	14
15	Lighting and electrical work	2006	1,615	81	20	81		202	15
16	Landscaping-veranda and health center	2007	5,764	276	15	276		414	16
17	Health center hydrant extension, air infiltration	2007	10,003	500	20	500		750	17
18	Front parking lot-coat and seal, grading and core out	2007	5,557	811	5-15	811		1,216	18
19	Signage	2007	2,192	146	15	146		219	19
20	Lighting	2007	6,143	347	15-20	347		521	20
21	Vanities/tops/air conditioner units	2007	11,404	760	15	760		1,140	21
22	Exhaust fans-roofs	2007	8,322	555	15	555		832	22
23	Bathtub conversions	2007	12,338	617	20	617		925	23
24	Health center soffit work, wrap-around, saniglaze	2007	21,849	1,142	15-20	1,142		1,713	24
25	Fire alarm system	2007	8,263	413	20	413		620	25
26	Condenser unit	2007	8,146	407	20	407		611	26
27	Veranda aluminum screen	2007	4,880	244	20	244		366	27
28	Windows and locks	2007	1,733	87	20	87		130	28
29	Modular nurses stations	2007	11,618	581	20	581		871	29
30	Building - phase 1 - air make-up, fire suppression, SC dining	2007	2,930,779	73,269	40	73,269		109,904	30
31	Roofs - phase 1 - main building and health center	2007	209,834	8,393	25	8,393		12,590	31
32	Health center canopy - phase 1	2007	11,115	278	40	278		417	32
33	Move telephone pole to widen curve	2008	2,267	57	20	57		57	33
34	TOTAL (lines 1 thru 33)		\$ 10,558,050	\$ 305,085		\$ 305,085	\$	\$ 4,651,781	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 12C, Carried Forward		\$ 10,558,050	\$ 305,085		\$ 305,085	\$	\$ 4,651,781	1
2	Lighting, new bollards	2008	10,902	282	15-20	282		282	2
3	Vanities, tops, faucets	2008	4,707	157	15	157		157	3
4	Signage	2008	1,193	40	15	40		40	4
5	Doors, door closers, windows	2008	5,623	172	15-20	172		172	5
6	Fire alarm system	2008	5,601	140	20	140		140	6
7	Roof top exhausters, maint garage roof	2008	11,059	352	15-40	352		352	7
8	Ceiling tile-hallways and laundry room	2008	17,556	439	20	439		439	8
9	Key switches for elevators	2008	1,300	32	20	32		32	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,615,991	\$ 306,699		\$ 306,699	\$	\$ 4,653,395	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: 1/1/2008

Ending: 12/31/2008

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	\$ 3,869,826	\$ 227,342	\$ 227,342	\$	5-20 yrs.	\$ 2,493,868	71
72	Current Year Purchases	184,041	9,834	9,834		5-20 yrs.	9,834	72
73	Fully Depreciated Assets	(1,498,731)				5-20 yrs.	(1,498,731)	73
74								74
75	TOTALS	\$ 2,555,136	\$ 237,176	\$ 237,176	\$		\$ 1,004,971	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	\$ 5,634	\$ 5,634	\$	10 yrs.	\$ 30,989	76
77										77
78										78
79										79
80	TOTALS			\$ 56,345	\$ 5,634	\$ 5,634	\$		\$ 30,989	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)	\$ 13,289,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 549,509	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 549,509	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)	\$ 5,689,355	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 1989-2008	\$ 66,149	\$ 2,566	\$ 54,845	86
87	Landscaping equipment-1968-2008	49,439		49,439	87
88	Duplexes & Land Improv.1990-2008	14,182,239	503,302	6,883,506	88
89	E-wing furn.&land improv1990-2008	3,482,300	92,757	1,866,413	89
90	Land-Duplexes	411,576			90
91	TOTALS	\$ 18,191,703	\$ 598,625	\$ 8,854,203	91

G. Construction-in-Progress

	Description	Cost	
92	Construction-in-progress	\$ 491,216	92
93			93
94			94
95		\$ 491,216	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	Other (specify): _____															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: **1/1/2008** Ending: **12/31/2008**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2008** (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	\$ 199,068	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,200)	598,958		3
4	Supply Inventory (priced at Lwr Cst or Mk)	47,130		4
5	Short-Term Investments	507,228		5
6	Prepaid Insurance	50,248		6
7	Other Prepaid Expenses	52,517		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Limited Use Assets	742,892		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,198,041	\$	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	27,846,043		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,125,012		16
17	Accumulated Depreciation (book methods)	(16,845,757)		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 (spec Bond Clsg Cost(Net))	50,826		22
23	Other(specify): Vehicles,CIP	728,579		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,378,583	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,576,624	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 331,390	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	220,000		29
30	Accrued Salaries Payable	231,726		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	162,000		32
33	Accrued Interest Payable	17,687		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Property Tax Credits Due Residents	315,000		36
37	Accrued Retirement- 403-B	12,660		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,290,463	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,799,048		39
40	Mortgage Payable			40
41	Bonds Payable	880,000		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Advance Deposits on Founder's Fees	173,615		43
44	Founder's Fees	5,376,729		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,229,392	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,519,855	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,056,769	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,576,624	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,663,684	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,663,684	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	334,062	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	153,860	11
12	Expenditures for Specific Purposes	(23,289)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Unrealized losses on investments	(71,548)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 393,085	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,056,769	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CEN1 # 0027987 Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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	\$ 8,575,284	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,575,284	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	6,600	13
14	Non-Patient Meals	35,143	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,600	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	144,495	21
22	Laundry	5,394	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 199,232	23
D. Non-Operating Revenue			
24	Contributions	116,843	24
25	Interest and Other Investment Income***	28,288	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 145,131	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Duplex Income	1,789,263	28
28a	Equipment Rental & Other Income	75,010	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,864,273	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,783,920	30

		2	
	Expenses	Amount	
A. Operating Expenses			
31	General Services	3,148,647	31
32	Health Care	3,191,676	32
33	General Administration	2,123,758	33
B. Capital Expense			
34	Ownership	1,095,638	34
C. Ancillary Expense			
35	Special Cost Centers	837,435	35
36	Provider Participation Fee	52,704	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,449,858	40
41	Income before Income Taxes (line 30 minus line 40)**	334,062	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 334,062	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:

1/1/2008

Ending:

12/31/2008

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	1,904	2,040	\$ 78,026	\$ 38.25	1
2	Assistant Director of Nursing	1,864	2,080	54,532	26.22	2
3	Registered Nurses	20,016	21,400	517,571	24.19	3
4	Licensed Practical Nurses	25,360	27,786	540,137	19.44	4
5	CNAs & Orderlies	96,739	103,518	1,309,920	12.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,521	6,120	77,118	12.60	8
9	Activity Director	3,264	3,400	58,066	17.08	9
10	Activity Assistants	8,410	8,993	83,976	9.34	10
11	Social Service Workers	1,960	2,116	43,900	20.75	11
12	Dietician					12
13	Food Service Supervisor	4,096	4,528	86,061	19.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,171	26,714	293,568	10.99	15
16	Dishwashers	40,967	43,267	364,199	8.42	16
17	Maintenance Workers	13,714	14,562	245,891	16.89	17
18	Housekeepers	27,546	29,368	295,867	10.07	18
19	Laundry	11,640	12,928	135,715	10.50	19
20	Administrator	1,864	2,080	125,315	60.25	20
21	Assistant Administrator	1,864	2,080	98,741	47.47	21
22	Other Administrative	1,864	2,080	74,927	36.02	22
23	Office Manager	1,864	2,080	38,884	18.69	23
24	Clerical	11,834	12,524	178,244	14.23	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	2,230	2,422	48,147	19.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,692	332,086	\$ 4,748,805 *	\$ 14.30	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	416	\$ 17,542	1-3	35
36	Medical Director	36	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	104	1,510	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	8	569	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	564	\$ 37,621		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	649	\$ 25,903	10-3	50
51	Licensed Practical Nurses	4,005	143,024	10-3	51
52	Certified Nurse Assistants/Aides	1,869	37,049	10-3	52
53	TOTAL (lines 50 - 52)	6,523	\$ 205,976		53

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning: 1/1/2008 Ending: 12/31/2008

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network(LSN) \$11,265
- (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? 8-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,364 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. \$ 52,704
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. \$ 15,517 Has any meal income been offset against related costs? YES Indicate the amount. \$ 18,977
- (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

1/1/08 - 12/31/08

RECLASSIFICATIONS:

LINE 2	Food purchase	<u>\$ (15,517)</u>	Take out cost of meals provided to employees
LINE 5	Heat & other utilities	<u>\$ (7,260)</u>	Take out utilities allocable to beauty shop
LINE 19	Professional services	\$ (1,580)	Take out background checks
		\$ (5,995)	Take out employee exams
		<u>\$ (5,924)</u>	Take out 403-B administration function
		<u>\$ (13,499)</u>	
LINE 20	Fees, subscriptions, & promotions	<u>\$ 1,580</u>	Add in background checks from line 19
LINE 22	Employee benefits & payroll taxes	\$ 15,517	Add in cost of meals from line 2
		\$ 5,995	Add in employee exams from line 19
		\$ 5,924	Add in 403-B administration function from line 19
		<u>\$ 27,436</u>	
LINE 26	Insurance-Property & Liability	<u>\$ (27,500)</u>	Take out insurance-property for Duplexes
LINE 30	Depreciation	<u>\$ 489</u>	Add in additional depreciation relating to Duplexes
LINE 40	Barber & Beauty Shops	<u>\$ 7,260</u>	Add in utilities taken out of line 5
LINE 43	Other-Duplexes	\$ 27,500	Add in insurance-property from line 26
		\$ (489)	Take out depreciation from line 30
		<u>\$ 27,011</u>	
TOTAL		<u>\$ -</u>	

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/08-12/31/08

Schedule V p. 3 & 4

LINE 7

Security Services	\$ 139,742
Trash Disposal	\$ 35,521
	<u>\$ 175,263</u>

LINE 27

Flowers & Decorations-Nursing Ctr.	<u>\$ 1,956</u>
------------------------------------	-----------------

LINE 36

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

LINE 43

Duplexes: Real Estate Taxes	\$ 227,918
Depreciation	\$ 503,302
Utilities	\$ 56,623
Maintenance	\$ 49,103
Insurance	\$ 27,500
	<u>\$ 864,446</u>

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987 1/1/08 - 12/31/08

Sch VI p. 5

LINE 29

Gas for Non-Care Vehicles	\$	(1,397)
Insurance for Non-Care Vehicles	\$	(859)
Flowers & Decorations, Miscellaneous	\$	(1,893)
Bond Trustee Costs	\$	(20,670)
Real Estate Taxes - Main Building	\$	(171,001)
	\$	<u>(195,820)</u>

LINE 45

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

FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/08 - 12/31/08

Sch XVII Income Statement Page 19

E. Other Revenue

Line 28	<u>\$ 1,789,263</u>	Duplex Monthly Maintenance and Founder's Fee Income
Line 28a	\$ 7,937	Equipment Rental-Wheelchairs & Gerichairs
	<u>\$ 67,073</u>	Other Income such as Vending Machine, Monthly Cable, Activities, Gain on Sale,
	<u>\$ 75,010</u>	

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987 1/1/08-12/31/08

PAGE 10B: 2007 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 1/1/08 - 12/31/08

2008 SCHEDULE V (LINE 24)

<u>DATE</u>	<u>SEMINAR</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>ATTENDEE(S)</u>	<u>COST</u>
4/2/08-4/3/08	Life Services Network Conference 2008	Chicago, IL	LSN	Tom Bleed, Executive Director, Mary Carlson, ADON Paula Rasanen, In-Service Coordinator, Debbie Engle, Life Enrichment Director, Cindy Speece, Charge Nurse Peggy Otto, Nursing Administrator, Barb Shaver, Office Manager Kim Bender, Resident Services Manager, Bryan Noreen, Consultant	\$3,030

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987 1/1/08 - 12/31/08

2008 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		
Evans, John	Vice Secretary	Yes	Construction/Refurbishing Rooms/Duplexes	John Evans Construction Co.
Johnson, Steve	Vice President	Yes	Property/Liability/Auto/Umbrella Insurance	Williams Manny Insurance Co.
Johnson, Larry	Treasurer	No		
Kingstrom, Paul	Asst Treasurer	No		
Lindquist, Evie	Director	No		
Schlueter, Chuck	Director	Yes	Attorney - General Issues	Schlueter Ecklund
Thompson, Richard	Director	No		
Watts, Linda	Director	No		
Sjogren, Steve	Director	No		
Voorhies, Randy	Director	Yes	Building Sprinkler Installation	
Brogan, Neil	Director	No		