

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 License ID Number: 0027987

Facility Name: Fairhaven Christian Ret Ctr

Address: 3470 North Alpine Rd Rockford 61114

County: Winnebago

Telephone Number: 815-877-1441 Fax # 815-282-4217

HFS ID Number:

Date of Initial License for Current Owners: 3/1/1968

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Patrick Carroll

Telephone Number: +1(414) 259-6792

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 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)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Patrick Carroll Senior Manager

(Firm Name & Address) Wipfli Advisory LLC 10000 innovation drive, Suite 250, Milwaukee WI 53226

(Telephone) 414-431-9335 Fax # 414-431-9303

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number Fairhaven Christian Ret Ctr # 0027987 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	90	Sheltered Care (SC)	90	32,850	5
6		ICF/DD 16 or Less			6
7	186	TOTALS	186	67,890	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF	10,591				14,541			25,132	10
11	ICF/DD									11
12	SC					13,052			13,052	12
13	DD 16 OR LESS									13
14	TOTALS	10,591				27,593			38,184	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 56.24%

D. How many bed reserve days during this year were paid by the Department? 148 (Do not include bed reserve 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 03/01/68

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 certified beds. number of certified beds _____

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairhaven Christian Ret Ctr # 0027987 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,339,965	101,319	16,975	1,458,259		1,458,259		1,458,259			1
2	Food Purchase		983,588		983,588	(600)	982,988	(10,023)	972,965			2
3	Housekeeping	672,816	93,661	545	767,022		767,022		767,022			3
4	Laundry	223,084	37,978		261,062		261,062		261,062			4
5	Heat and Other Utilities			602,995	602,995	(12,444)	590,551	(23,754)	566,797			5
6	Maintenance	442,233	15,043	459,821	917,097	7,771	924,868	(9,944)	914,924			6
7	Other (specify):* security			176,645	176,645	81,734	258,379		258,379			7
8	TOTAL General Services	2,678,098	1,231,589	1,256,981	5,166,668	76,461	5,243,129	(43,721)	5,199,408			8
	B. Health Care and Programs											
9	Medical Director					20,400	20,400		20,400			9
10	Nursing and Medical Records	5,251,728	136,668	248,505	5,636,901	(103,334)	5,533,567		5,533,567			10
10a	Therapy											10a
11	Activities	222,878	15,780		238,658		238,658		238,658			11
12	Social Services					1,200	1,200		1,200			12
13	CNA Training											13
14	Program Transportation			7,977	7,977		7,977		7,977			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,474,606	152,448	256,482	5,883,536	(81,734)	5,801,802		5,801,802			16
	C. General Administration											
17	Administrative	284,910			284,910		284,910		284,910			17
18	Directors Fees											18
19	Professional Services			199,707	199,707	(26,284)	173,423		173,423			19
20	Dues, Fees, Subscriptions & Promotions			226,541	226,541	1,469	228,010	(61,359)	166,651			20
21	Clerical & General Office Expenses	762,999	28,403	277,644	1,069,046	(9,143)	1,059,903		1,059,903			21
22	Employee Benefits & Payroll Taxes			1,950,578	1,950,578	26,187	1,976,765		1,976,765			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,682	28,682		28,682	(28,682)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			440,937	440,937	(36,779)	404,158		404,158			26
27	Other (specify):* bad debt, misc, flower			(491)	(491)		(491)	(4,678)	(5,169)			27
28	TOTAL General Administration	1,047,909	28,403	3,123,598	4,199,910	(44,550)	4,155,360	(94,719)	4,060,641			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,200,613	1,412,440	4,637,061	15,250,114	(49,822)	15,200,292	(138,440)	15,061,851			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,871,573	1,871,573	(753,468)	1,118,105	(4,966)	1,113,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			117,262	117,262		117,262	(117,262)				32
33	Real Estate Taxes			301,703	301,703		301,703	(301,703)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,404	2,404		2,404		2,404			35
36	Other (specify):*											36
37	TOTAL Ownership			2,292,942	2,292,942	(753,468)	1,539,474	(423,931)	1,115,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					12,444	12,444		12,444			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			346,540	346,540		346,540		346,540			42
43	Other (specify):*			613,461	613,461	790,247	1,403,708		1,403,708			43
44	TOTAL Special Cost Centers			960,001	960,001	802,690	1,762,691		1,762,691			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,200,613	1,412,440	7,890,004	18,503,057	(600)	18,502,457	(562,371)	17,940,086			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,023)	2		4
5	Telephone, TV & Radio in Resident Rooms	(23,754)	5		5
6	Rented Facility Space	(9,944)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,966)	30		9
10	Interest and Other Investment Income	(117,262)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(28,682)	24		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				24
25	Fund Raising, Advertising and Promotional	(56,101)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(310,649)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (561,381)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (561,381)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (990)	20	1
2	Other Expenses Related to Lobbying Activities	0	0	2
3	Dues & Publications	(4,268)	20	3
4	Real estate taxes	(301,703)	33	4
5	Flowers & Decorations	(4,678)	27	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	(311,639)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Schlueter, Chuck	BOD						1
2	Johnson, Greg	BOD						2
3	Sjogren, Steve	BOD						3
4	Nyberg, Dan	BOD						4
5	Wiles, David	BOD						5
6	Voorhies, Randy	BOD						6
7	Norberg, David	BOD						7
8	Ewing, Tom	BOD						8
9	Versendaal, Rita	BOD						9
10	Buzzard, Brenda	BOD						10
11	Joiner, Terry	BOD						11
12	Swanson, Dwight	BOD						12
13	Doherty, Linda	BOD						13
14	Joe Clinton III	BOD						14
15	Bob Opperman	BOD						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

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									\$		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 Ret Ctr # 0027987 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	City of Rockford Bonds	x		Construction Phase I and II			\$ 800,000	\$ 3,260,041	6/15/2034	0.0319	\$ 111,134	1	
2	Property Loans	x		Purchase of Land and Building			500,000		3/15/2025	0.0375	1,542	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Midwest Bank - LOC	x		Operating Expenses		N/A	500,000		9/19/2025	0.0800		6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,800,000	\$ 3,260,041			\$ 112,676	9	
	B. Non-Facility Related*												
10									interest expenses adjust		(112,676)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (112,676)	14	
15	TOTALS (line 9+line14)						\$ 1,800,000	\$ 3,260,041			\$ 0	15	

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	375,000	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.)				\$	301,703	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(73,297)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	375,000	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.				\$	301,703	7
Assessed Value from Real Estate Tax Bill: 2024 8						
Real Estate Tax Bill for Calendar Year: 2020 206,966 9						
2021 255,056 10						
2022 289,056 11						
2023 295,172 12						
2024 345,000 13						
* 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 costs on this report.						
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Fairhaven Christian Ret Ctr

COUNTY

Winnebago

FACILITY IDPH LICENSE NUMBER

0027987

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 12-08-126-031	main building	\$ 173,032.82	\$
2. 12-05-355-008	main building	\$ 67.84	\$
3. 12-05-376-013	main building	\$ 14,578.16	\$
4. 12-05-377-001	duplexes	\$ 75,601.40	\$
5. 12-05-376-009	duplexes	\$ 75,972.56	\$
6. 12-05-378-004	duplexes	\$ 62,113.62	\$
7. 12-05-351-004		\$ 9,726.44	\$
8. 12-05-351-009		\$ 4,815.54	\$
9. 12-05-351-011 and 12-05-351.003		\$ 9,168.64	\$
10. adjust to trial balance		\$ (123,374.02)	\$
TOTALS		\$ 301,703.00	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 183,865 B. General Construction Type: Exterior brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [x] (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? [x] (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 (112 units total)

F. List the bed capacity for the building if it differs from the licensed total. n/a
G. Have you properly capitalized all major repairs and equipment purchases? yes
H. Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? no
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
n/a

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [x] 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	main building	871,200	1965	\$ 62,304	1
2					2
3	TOTALS	871,200		\$ 62,304	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	49			1967	\$ 1,115,078	\$	40	\$	\$	1,115,078	4	
5	76			1973	1,051,996		40			1,051,996	5	
6	20			1975	255,191		20-40			255,191	6	
7	41			1979	1,323,223		40			1,323,223	7	
8											8	
	Improvement Type**											
9	improvements			1996	51,001					51,001	9	
10	improvements			1997	208,444					208,444	10	
11	improvements			1998	308,408					308,408	11	
12	improvements			1999	239,290					239,290	12	
13	improvements			2000	1,557,572	45,047		45,047		1,191,213	13	
14	improvements			2001	121,472					121,472	14	
15	improvements			2002	51,233					51,233	15	
16	improvements			2003	190,407					190,272	16	
17	improvements			2004	223,186					223,186	17	
18	improvements			2005	86,848	4,212		4,212		86,346	18	
19	improvements			2006	161,906					161,906	19	
20	improvements			2007	3,242,381	87,465		87,465		1,618,103	20	
21	improvements			2008	60,208	3,341		3,341		58,468	21	
22	improvements			2009	2,179,741	65,865		65,865		1,095,517	22	
23	improvements			2010	877,282	32,486		32,486		503,535	23	
24	improvements			2011	395,167	11,924		11,924		175,793	24	
25	improvements			2012	2,533,852	67,310		67,310		785,972	25	
26	improvements			2013	454,333	24,389		24,389		305,936	26	
27	improvements			2014	293,198	18,635		18,635		214,033	27	
28	improvements			2015	1,094,733	17,870		17,870		196,570	28	
29	improvements			2016	608,774	12,164		12,164		121,640	29	
30	improvements			2017	1,372,824	41,548		41,548		353,158	30	
31	improvements			2018	128,809	7,809		7,809		58,567	31	
32	improvements			2019	217,810	15,119		15,119		101,414	32	
33	improvements			2020	77,519	7,160		7,160		39,379	33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairhaven Christian Ret Ctr

0027987

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Grading/Install drainage box	2021	\$ 2,335	\$ 156	15	\$ 156	\$	\$ 702	37
38	Remove and replace damaged steps/sidewalks	2021	19,610	1,307	15	1,307		5,882	38
39	Landscaping - replace trees	2021	1,435	96	15	96		432	39
40	Black vinyl fence - Alpine South	2021	5,250	350	15	350		1,575	40
41	Sealcoat Tar seal front parking lot	2021	14,326	955	15	955		4,298	41
42									42
43	8x4 sidewalk - campus	2022	475	48	10	48		172	43
44	New light poles exterior	2022	10,830	542	20	542		1,761	44
45	Pavement Sealing	2022	18,460	1,231	15	1,231		4,103	45
46	4468 TV Concrete work	2022	9,050	603	15	603		1,960	46
47	new windows 3rd floor hc 45, 47, 49, 53, 55,57	2022	24,456	2,446	10	2,446		8,765	47
48									48
49	Sealcoat parking lot	2023	20,600	2,060	10	2,060		5,837	49
50	Front entrance landscaping	2023	10,010	1,001	10	1,001		2,502	50
51	New Courtyard pavillion	2023	181,256	18,126	10	18,126	(0)	36,252	51
52									52
53	Main Building - Concrete Patio	2024	3,750	63	10	63		438	53
54	Resealing parking lot, main lot	2024	18,638	1,553	10	1,553		3,417	54
55	replace 11 squares of sidewalk	2024	3,850	80	10	80		465	55
56	pavement repaint/patching	2024	540	18	10	18		72	56
57	new courtyard pavillion completion	2024	6,850	190	10	190		875	57
58	roof inspection requirements	2024	100,697	839	10	839		10,909	58
59									59
60	Landscaping Around Campus - GAG	2025	30,907	3,091	10	3,091		3,091	60
61	Sealcoating Aux, GL, HC lot, Chapel	2025	23,604	2,360	10	2,360		2,360	61
62	Repairs to Fence and Signage from Car Accident	2025	10,960	731	15	731		731	62
63	Outdoor (3) Light Poles Replaced	2025	1,037	69	15	69		69	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 21,000,812	\$ 500,257		\$ 500,257	\$ (0)	\$ 12,303,012	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$5,577,165	\$567,311	\$	\$(567,311)		\$3,491,056	71
72	Current Year Purchases	258,900	42,231		(42,231)		42,231	72
73	Fully Depreciated Assets	5,451,306						73
74								74
75	TOTALS	\$11,287,371	\$609,542	\$	\$(609,542)		\$3,533,287	75

D. Vehicle Costs. (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	van	ford starcraft - 2015	2016	\$33,398	\$3,340	\$3,340	\$	10	\$31,729	76
77										77
78										78
79										79
80	TOTALS			\$33,398	\$3,340	\$3,340	\$		\$31,729	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)	\$32,383,885	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,113,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$503,597	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(609,542)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$15,868,028	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	land-duplexes, new land, 2019-2025	\$1,604,707	\$	\$1,604,707	86
87	Garages 1968-92 Vehicles 1989-2025	105,286		105,286	87
88	Landscaping equipment 1968-2025	18,909		18,909	88
89	duplexes & land improv 1990-2025	18,342,033	683,408	12,213,146	89
90	e-wing furn & land imp 1990-2025	2,930,169	70,060	2,614,088	90
91	TOTALS	\$23,001,104	\$753,468	\$16,556,136	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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

* 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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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 prescrpts							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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 522,856	\$	1
2	Cash-Patient Deposits	13,022		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	607,597		3
4	Supply Inventory (priced at)	231,136		4
5	Short-Term Investments	717,058		5
6	Prepaid Insurance	58,927		6
7	Other Prepaid Expenses	73,717		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,825,684		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,049,997	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,604,707		13
14	Buildings, at Historical Cost	44,525,530		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,909,585		16
17	Accumulated Depreciation (book methods)	(36,416,122)		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 (specify):			22
23	Other(specify): Vehicles, CIP	540,740		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,164,440	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 27,214,437	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 496,484	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,022		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,273		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	455,000		32
33	Accrued Interest Payable	4,333		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Acc RE Credit, Settlnent Payable	706,481		36
37	accrued retirement	24,621		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,999,214	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,212,718		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	advance deposits, lease obligation	4,428,695		43
44	founders fee/potential refund	4,218,385		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,859,798	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,859,012	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,355,425	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 27,214,437	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,898,145	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,898,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(435,561)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	892,841	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 457,280	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)	\$ 13,355,425	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairhaven Christian Ret Ctr

0027987

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,520,228	1
2	Discounts and Allowances for all Levels	(1,413,994)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,106,234	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	8,400	13
14	Non-Patient Meals	18,562	14
15	Telephone, Television and Radio	30,294	15
16	Rental of Facility Space	9,944	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	169,600	21
22	Laundry	10,882	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 247,682	23
	D. Non-Operating Revenue		
24	Contributions	304,322	24
25	Interest and Other Investment Income***	274,321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 578,643	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	duplex income	2,638,709	28
28a	other, equip, activity, fitness, transport, maint, rentals	496,228	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,134,937	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,067,496	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	5,166,668	31
32	Health Care	5,883,536	32
33	General Administration	4,199,910	33
	B. Capital Expense		
34	Ownership	2,292,942	34
	C. Ancillary Expense		
35	Special Cost Centers	613,461	35
36	Provider Participation Fee	346,540	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,503,057	40
41	Income before Income Taxes (line 30 minus line 40)**	(435,561)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (435,561)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,404,841.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	5,159,364.00	48
49	Medicare Part A		49
50	Other-(specify) resident income	3,112,105.00	50
51	Other-(specify) founders fee	547,833.00	51
52	Other-(specify) support income		52
53	Other-(specify) supportive care	3,285,751.00	53
54	Other-(specify) nursing care equipment	10,335.00	54
55	Other-(specify) contractual adjs	-1,413,994.00	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,106,235	56

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	18,355	21,343	\$ 812,338	\$ 38.06	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	19,915	24,935	994,982	39.90	3
4	Licensed Practical Nurses	23,277	30,776	943,675	30.66	4
5	CNAs & Orderlies	92,182	111,333	2,298,842	20.65	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	9,677	11,534	195,641	16.96	8
9	Activity Director	11,243	12,188	222,878	18.29	9
10	Activity Assistants	2,892	3,132	0	0.00	10
11	Social Service Workers			0		11
12	Dietician	71,849	80,316	1,339,965	16.68	12
13	Food Service Supervisor			0		13
14	Head Cook			0		14
15	Cook Helpers/Assistants			0		15
16	Dishwashers			0		16
17	Maintenance Workers	15,244	17,142	442,233	25.80	17
18	Housekeepers	32,368	36,369	672,816	18.50	18
19	Laundry	12,991	14,527	223,084	15.36	19
20	Administrator	20,901	22,695	1,047,909	46.17	20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,894	386,291	\$ 9,194,363 *	\$ 23.80	34

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	315	\$ 16,975	3-1-3	35
36	Medical Director	12	20,400	3-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	163	10,595	3-10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,200	3-11-3	44
45	Social Service Consultant	16	1,200	3-11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	522	\$ 50,370		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,643	\$ 128,443	3-10-3	50
51	Licensed Practical Nurses	1,300	86,386	3-10-3	51
52	Certified Nurse Assistants/Aides	40	1,474		52
53	TOTAL (lines 50 - 52)	2,984	\$ 216,303		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID NumberFairhaven Christian Ret Ctr# 0027987Report Period Beginning:01/01/2025Ending:12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeff Reiersen	Executive Director		\$ 137,110
Christine Hintzsche	Interim Admisitrator		147,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 284,910

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Midland Wealth Management	3rd Party Admin - 403(b) Pla	\$ 10,365
Wipfli LLP	Annual Audit and Acctg. Service	38,117
ADP	Payroll Serices	24,868
Paylocity	Payroll Serices	23,193
Legal Fees	See Detail	3,198
Matrixcare/Vanillaware	Acctg./Med Record Support	60,456
Firm Systems/Accurate Biometrics	Fingerprints	1,469
Physician Immediate Care/Wellnow	Employee Physicals/Drug Screen	15,822
Illinois State Police	Background checks	990
Misc	Consulting Fees	21,231
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 199,707

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 100,357
Unemployment Compensation Insurance	5,028
FICA Taxes	669,370
Employee Health Insurance	1,006,855
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Insurance-Dental	35,435
Group Insurance-Life	12,560
Group Insurance-LTD	14,213
Retirement Expense	89,187
Company Apprec. Events	15,506
Resident Apprec. Events	2,067
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 16,500
Advertising: Employee Recruitment	125,340
Health Care Worker Background Check (Indicate # of checks performed)	1,469
Patient Background Checks	
Association Dues (total from pg 22, #4)	5,330
Professional and Business Related Subscriptio	2,342
Advertising: Employee Recruitment	141,999
Less: Public Relations Expense	(4,268)
PAC and Lobbying payments	(990)
All non-allowable advertising	(121,071)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

no
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

LEADING AGE

Amount

15,510

15,510

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE

990

990

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE

16,500

16,500

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$ 38,228

Line 10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$ 346,540

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$

Has any meal income been offset against
related costs?

yes

Indicate the amount.

\$

(12)

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.

\$

(13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: WIPFLI LLP

yes

(14)

Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V?

yes

(15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

yes

Attach invoices and a summary of services for all architect and appraisal fees.