

		FOR BHF USE					

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

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

<p>I. IDPH Facility ID Number: <u>0008524</u></p> <p>Facility Name: <u>Fairview Haven</u></p> <p>Address: <u>605-609 North 4th St, PO Box 20</u> <u>Fairbury</u> <u>61739</u>  <small>Number City Zip Code</small></p> <p>County: <u>Livingston</u></p> <p>Telephone Number: <u>(815) 692-2572</u> Fax # <u>(815) 692-4257</u></p> <p>HFS ID Number: <u>37-0814781001</u></p> <p>Date of Initial License for Current Owners: <u>1962</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact:        Name: <u>Rick Plattner</u> Telephone Number: <u>(815) 692-2572</u></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"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2005</u> to <u>6/30/2006</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Rick Plattner</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Administrator</u></td> </tr> </table> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name &amp; Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>( )</u></td> <td style="border: none;">Fax # ( )</td> </tr> </table> <p align="right">       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>Rick Plattner</u>			(Title) <u>Administrator</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>( )</u>	Fax # ( )
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Facility Name & ID Number Fairview Haven, Inc.# 0008524 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>607</u>	<u>332</u>	<u>939</u>	8
9	SNF/PED					9
10	ICF	<u>7,483</u>	<u>13,590</u>		<u>21,073</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,483</u>	<u>14,197</u>	<u>332</u>	<u>22,012</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.73%

D. How many bed-hold days during this year were paid by the Department?

\_\_\_\_\_  
(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)

Apartment & Condominium Rental for ElderlyF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 10/28/62

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 10/28/62 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 21 and days of care provided 332Medicare Intermediary Administar

## IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

Facility Name &amp; ID Number

Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	257,645	19,164	7,953	284,762	-	284,762	-	284,762		1
2	Food Purchase		180,757		180,757	-	180,757	(10,494)	170,263		2
3	Housekeeping	88,409	22,655	-	111,064	-	111,064	-	111,064		3
4	Laundry	71,019	15,149	-	86,168	-	86,168	-	86,168		4
5	Heat and Other Utilities			108,180	108,180	-	108,180	(34,734)	73,446		5
6	Maintenance	152,777	83,215	9,882	245,874	-	245,874	(14,482)	231,392		6
7	Other (specify):*				-		-		-		7
8	TOTAL General Services	569,850	320,940	126,015	1,016,805	-	1,016,805	(59,710)	957,095		8
	B. Health Care and Programs										
9	Medical Director	-	-	4,800	4,800	-	4,800	-	4,800		9
10	Nursing and Medical Records	1,420,522	47,497	8,546	1,476,565	-	1,476,565	-	1,476,565		10
10a	Therapy	79,258	-	6,577	85,835	-	85,835	-	85,835		10a
11	Activities	64,248	11,870	8,435	84,553	-	84,553	-	84,553		11
12	Social Services	41,207	-	1,110	42,317	-	42,317	-	42,317		12
13	CNA Training	-	-	65	65	-	65	-	65		13
14	Program Transportation	-	-	3,273	3,273	-	3,273	-	3,273		14
15	Other (specify):*				-		-		-		15
16	TOTAL Health Care and Programs	1,605,235	59,367	32,806	1,697,408	-	1,697,408	-	1,697,408		16
	C. General Administration										
17	Administrative	64,830	-	-	64,830	-	64,830	-	64,830		17
18	Directors Fees				-		-		-		18
19	Professional Services			8,215	8,215	-	8,215	-	8,215		19
20	Dues, Fees, Subscriptions & Promotions			7,100	7,100	(488)	6,612	(274)	6,338		20
21	Clerical & General Office Expenses	111,025	4,619	34,559	150,203	(658)	149,545	(2,297)	147,248		21
22	Employee Benefits & Payroll Taxes			430,439	430,439	56,953	487,392	-	487,392		22
23	Inservice Training & Education			1,437	1,437	-	1,437	-	1,437		23
24	Travel and Seminar			14,396	14,396	1,523	15,919	(2,114)	13,805		24
25	Other Admin. Staff Transportation		-	-	-		-		-		25
26	Insurance-Prop.Liab.Malpractice			131,142	131,142	(56,953)	74,189	-	74,189		26
27	Other (specify):*				-		-		-		27
28	TOTAL General Administration	175,855	4,619	627,288	807,762	377	808,139	(4,685)	803,454		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,350,940	384,926	786,109	3,521,975	377	3,522,352	(64,395)	3,457,957		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 &amp; ID Number Fairview Haven, Inc.

#0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			150,507	150,507		150,507	(46,606)	103,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,317	11,317	(377)	10,940	(10,940)				32
33	Real Estate Taxes			639	639		639	(639)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,518	3,518		3,518		3,518			35
36	Other (specify):*											36
37	TOTAL Ownership			165,981	165,981	(377)	165,604	(58,185)	107,419			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,277		13,277		13,277		13,277			39
40	Barber and Beauty Shops			11,857	11,857		11,857		11,857			40
41	Coffee and Gift Shops			4,067	4,067		4,067		4,067			41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):*			8,451	8,451		8,451	(8,451)				43
44	TOTAL Special Cost Centers		13,277	58,868	72,145		72,145	(8,451)	63,694			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,350,940	398,203	1,010,958	3,760,101		3,760,101	(131,031)	3,629,070			45

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

Facility Name & ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,627)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(274)	20.3		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	(121,130)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,031)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(0)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (0)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (131,031)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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

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		
	V		\$			\$	\$	1
	V		0				(0)	2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$ 0			\$	\$ *	(0) 14

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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 Fairview Haven, Inc.

# 0008524 Report Period Beginning: 7/1/2005

Ending: 6/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	
						Amount of Note	Reporting Period Interest Expense					
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
	YES	NO										
A. Directly Facility Related												
Long-Term												
1	A.C. Church Hail Assistance	x		Building Addition	\$4,231.67	Nov-01	\$ 335,572	\$ 104,997	Aug-08	0.0225	\$ 2,948	1
2												2
3												3
4												4
5												5
Working Capital												
6	Bluestem National Bank		x	Operating		Jan-06	95,000		Jan-07	0.0650	492	6
7												7
8												8
9	TOTAL Facility Related				\$4,231.67		\$ 430,572	\$ 104,997			\$ 3,440	9
B. Non-Facility Related*												
10	A.C. Church Hail Assistance	x		Building Addition	\$10,768.33	Nov-01	853,928	267,186	Aug-08	0.0225	7,500	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				\$10,768.33		\$ 853,928	\$ 267,186			\$ 7,500	14
15	TOTALS (line 9+line14)						\$ 1,284,500	\$ 372,183			\$ 10,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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:** 2005 REAL ESTATE TAX COST DOCUMENTATION

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

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

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Fairview Haven, Inc. COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Rick Plattner

TELEPHONE (815) 692-2572 FAX #: (815) 692-4257

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

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

**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        x NO

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

**C. Tax Bills**

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

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

Facility Name & ID Number Fairview Haven, Inc.

# 0008524 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Home</u>	<u>90,000</u>	<u>1962</u>	<u>\$ 6,422</u>	1
2					2
3	TOTALS	90,000		\$ 6,422	3

Facility Name &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		Jan-62	Jan-62	\$ 145,220	\$ 2,904	50	\$ 2,904	\$	\$ 127,090	4
5	8		Mar-99	Mar-99	354,656		39	9,094	9,094	66,075	5
6											6
7											7
8											8
		Improvement Type**									
9		Additions 65-66		Jan-62	258	5	50	5		209	9
10		Additions 66-67		Jan-62	2,116	42	50	42		1,688	10
11		Additions 67-68		Jul-67	13,436	269	50	269		10,485	11
12		Additions 69-70		Jan-62	1,893	38	50	38		1,403	12
13		Additions 71-72		Jul-71	26,066	521	50	521		18,242	13
14		Additions 72-73		Jul-72	6,314	126	50	126		4,290	14
15		Additions 77-78		Jan-78	4,507	90	50	90		2,567	15
16		Sprinkler System		May-79	42,306	846	50	846		22,985	16
17		Generator Room		May-79	8,460	169	50	169		4,594	17
18		Additions 78-79		Jan-79	1,578	32	50	32		873	18
19		Driveway Asphalt		Aug-78	1,475		10			1,475	19
20		Generator		Sep-79	19,921		25			19,921	20
21		Smoke Detector		May-80	6,529		25			6,529	21
22		Lights		Jun-80	4,260	142	30	142		3,703	22
23		Additions 79-80		Jul-79	3,516	70	50	70		1,895	23
24		Smoke Detector		Aug-80	1,575		15			1,575	24
25		Additions 80-81		Jan-81	16,207	324	50	324		8,264	25
26		Porch Enclosure		Sep-81	9,453	189	50	189		4,694	26
27		Dining Room Lighting		Sep-81	2,838	95	30	95		2,354	27
28		Lobby Lighting		Dec-81	763	25	30	25		620	28
29		Linen Exhaust Fan		Jan-82	376		10			376	29
30		Sprinkler System		Feb-82	1,977	40	50	40		971	30
31		Room D2 Addition		Feb-82	432	9	50	9		215	31
32		Room B14 Addition		May-82	2,380	48	50	48		1,155	32
33		Exhaust Fan		Jun-82	322		10			322	33
34		New Roof		Jul-82	3,582		10			3,582	34
35		New Air Conditioner		Jul-82	2,590		10			2,590	35
36		Remodel Kitchen & Dining Room		Mar-83	8,205	164	50	164		3,828	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 &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	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	New Sign	Jun-83	\$ 994	\$	10	\$	\$	\$ 994	37
38	Landscape	Jul-83	1,455	49	30	49		1,122	38
39	Attic Fan	Dec-83	1,381		10			1,381	39
40	Kitchen Cabinets & Fixtures	Dec-83	619		20			619	40
41	Social Service Office	Jan-86	227	5	50	5		107	41
42	Outside Light Fixture	Jan-86	437		10			437	42
43	Blacktop Drive & Trees	Jan-62	2,750		10			2,750	43
44	Laundry Room	Jan-78	14,944	299	50	299		8,418	44
45	Trees	Jan-86	920		10			920	45
46	Concrete Drive	Jan-86	4,199		10			4,199	46
47	Remodeling Activity Rm & D-Wing	Jan-86	167,304	5,575	20	5,578	3	167,304	47
48	Remodeling C-Wing Bath, Restroom Pilot Lights, D-Wing	Jan-87	8,585	287	30	286	(1)	5,733	48
49	Courtyard--Original Set-up	Jun-87	19,000	633	30	633		12,082	49
50	Remodel Linen Rm, Exit Lights, Utility, Wardrobe Shelves, Nursing Sta	Jan-88	21,731	764	17		(764)	21,731	50
51	Courtyard	Apr-88	1,827	61	30	61		1,113	51
52	Patio Roof	Jul-89	2,576	129	20	129		2,321	52
53	Attic Ceiling	Jun-91	452		10			452	53
54	New Roof	Jun-91	21,664	867	25	867		13,004	54
55	Plumbing-New Faucets-Resident Rooms	Mar-92	6,148		10			6,148	55
56	Carport-Entryway Cover	Dec-92	15,403	1,027	15	1,027		14,977	56
57	Kitchen Remodeling	Apr-92	173,371	7,274	25	6,935	(339)	93,668	57
58	Office Remodel	Apr-94	20,943	838	25	838		10,265	58
59	Kitchen Remodeling & Cabinets	Oct-93	14,811	721	10		(721)	14,811	59
60	Kitchen Door, Trees, Carpet	Jan-94	2,855	190	15	190		2,366	60
61	Sewer Extension	Feb-95	2,697	180	15	180		2,040	61
62	Room B-1 & Drug Room Remodel	Feb-95	833	33	25	33		374	62
63	Replace Main Sprinkler System	Apr-95	2,550	170	15	170		1,903	63
64	Repair Dining Room Ice Machine Wall	Mar-96	948	38	25	38		391	64
65	Front Parking Lot & Sidewalk	Nov-95	20,675	1,378	15	1,378		14,694	65
66	Door Alarm System	May-95	6,226		7			6,226	66
67	Ceiling Mount Smoke Detectors-Resident Rms	Sep-95	183		7			183	67
68	Nurse Call System	Apr-95	27,948		7			27,948	68
69	Ceiling Mount Smoke Detectors-Resident Rms	Jun-96	3,211		7			3,211	69
70	TOTAL (lines 4 thru 69)		\$ 1,263,078	\$ 26,666		\$ 33,938	\$ 7,272	\$ 768,462	70

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

Facility Name &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,263,078	\$ 26,666		\$ 33,938	\$ 7,272	\$ 768,462	1
2	Draperies	Jan-97	1,086		7			1,086	2
3	Phone System	May-97	12,981	1,298	10	1,298		11,895	3
4	Fire Alarm System	Mar-97	324		7			324	4
5	Door Alarm System	Mar-97	439		7			439	5
6	Ceiling Mount Smoke Detectors-Resident Rms	Jan-97	191		7			191	6
7	Door Alarm System	Dec-96	724		7			724	7
8	Courtyard Landscaping	Aug-96	649	43	15	43		426	8
9	Window Coverings	Feb-98	1,798		7			1,798	9
10	Intercom System	Apr-98	15,310		7			15,310	10
11	Nurse Call System	Nov-97	2,148		7			2,148	11
12	Fire Alarm System	Apr-98	744		7			744	12
13	Telephone System	Oct-97	461		7			461	13
14	Smoke Detectors	Jan-99	108	8	7	10	2	108	14
15	Bathroom Sprinkler System	May-00	1,873	125	15	125		760	15
16	Sink	Jan-00	746	107	7	107		695	16
17	Water Heater	Aug-99	6,669	667	10	667		4,612	17
18	Water Heater	Mar-01	3,647	365	10	365		1,935	18
19	B Wing Air Conditioner	Sep-00	1,623	232	7	232		1,352	19
20	Dry Pendants - Shower room	Aug-00	2,762	276	10	276		1,621	20
21	Nurses Station Carpet	Sep-00	1,151	115	10	115		666	21
22	Large Capacity Water Heater	May-01	5,290	529	10	529		2,732	22
23	Telephone System	Mar-02	853	122	7	122		526	23
24	Air Conditioning Unit	May-02	1,730	173	10	173		714	24
25	Nurse Call System	Jan-02	64,740	6,474	10	6,474		28,574	25
26	Draperies	Feb-03	1,243	124	10	124		422	26
27	Phone System Wiring	Aug-02	1,496	214	7	214		836	27
28	Water Cooler	May-03	526	75	7	75		231	28
29	Lightning Arrestors	Nov-02	1,175	117	10	118	1	432	29
30	Eyewash Station	Dec-02	884	88	10	88		315	30
31	Firecode Updates	Dec-02	4,850	323	15	323		1,156	31
32	Activity Draperies	May-03	662	66	10	66		203	32
33	Concrete Improvements	Jun-03	4,566	304	15	304		936	33
34	TOTAL (lines 1 thru 33)		\$ 1,406,527	\$ 38,511		\$ 45,786	\$ 7,275	\$ 852,834	34

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

Facility Name &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,406,527	\$ 38,511		\$ 45,786	\$ 7,275	\$ 852,834	1
2	Plumbing rough-in for tub	Apr-04	955	95	10	96	1	216	2
3	Window Blinds	Jan-04	643	92	7	92		223	3
4	Kitchen Grease Trap	Jul-03	738	74	10	74		218	4
5	Driveway	Jun-04	4,504	300	15	300		624	5
6	Sprinkler System Air Compressor	May-04	1,090	109	10	109		232	6
7	Kitchen Grease Trap	Oct-03	2,561	171	15	171		467	7
8	Bath Tub	Dec-03	12,232	1,223	10	1,223		3,120	8
9	Time Clock System-Remove per Audit	Jun-04							9
10	D-Wing Fire Safety Drywall	Dec-03	421	21	20	21		52	10
11	Light Fixtures	Dec-03	595	60	10	60		153	11
12	Air Conditioning Units - Laundry & C-Wing	Oct-03	4,222	281	15	281		767	12
13	Dining Draperies	Aug-04	1,300	186	7	186		343	13
14	Front Parking Lot Cemented	Jun-05	5,912	394	15	394		410	14
15	Generator Heater	Mar-05	770	110	7	110		139	15
16	Door Monitors	Nov-04	1,980	283	7	283		461	16
17	Sprinkler Rehab	Dec-04	26,592	2,659	10	2,659		4,131	17
18	5T Air Conditioning Fan Coil Unit	May-05	2,150	307	7	307		347	18
19	C-Wing Ductwork	Jun-05	3,013	201	15	201		202	19
20	13 Bathroom Remodeling	Dec-05	4,979	194	15	192	(2)	192	20
21	Bathroom Steel Door Frames & Birch Doors	Apr-06	1,353	17	15	20	3	20	21
22	5 Ton Condensor Unit	Sep-05	8,697	725	10	720	(5)	720	22
23	Fire System Engineering	Dec-05	2,787	93	15	98	5	98	23
24	North Basement Office Remodel	Feb-06	2,460	68	15	65	(3)	65	24
25	Foam Roofing	Jan-06	2,292	76	15	72	(4)	72	25
26	Door Alarm & Key Pad	Dec-05	2,592	151	10	141	(10)	141	26
27	Fire Door Closures & Shutters	Dec-05	3,383	197	10	196	(1)	196	27
28	B-Hall Shower Tile	Jan-06	935	26	15	26		26	28
29	Bathtub	Feb-06	10,264	428	10	405	(23)	405	29
30	Generator Upgrade	Mar-06	15,624	619	7	556	(63)	556	30
31	Intercom Replacement	Apr-06	2,500		7	60	60	60	31
32	Generator Upgrade	Mar-05	1,697		7	242	242	242	32
33	Front Door Automatic Opener	Jun-06	3,610		10	3	3	3	33
34	TOTAL (lines 1 thru 33)		\$ 1,539,378	\$ 47,671		\$ 55,149	\$ 7,478	\$ 867,735	34

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 325,784	\$ 37,077	\$ 37,077	\$	various	\$ 169,574	71
72	Current Year Purchases	14,323	676	676		various	676	72
73	Fully Depreciated Assets	435,201				various	435,201	73
74								74
75	TOTALS	\$ 775,308	\$ 37,753	\$ 37,753	\$		\$ 605,451	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Ford Clubvan Triton V-10 '98	May-98	\$ 46,290	\$	\$	\$	5	\$ 46,290	76
77	Patient Transport	Paint Clubvan	Apr-03	1,147	229	229		5	745	77
78	Bus Tie Downs	03 Ford Bus	Mar-06	2,184	146	130	(16)	5	130	78
79	Patient Transport	03 Ford Bus	Feb-04	42,561	10,640	10,640		4	24,827	79
80	TOTALS			\$ 92,182	\$ 11,015	\$ 10,999	\$ (16)		\$ 71,992	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)	\$ 2,413,290	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,439	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,901	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,462	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,545,178	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		\$	\$	\$	86
87	Non-Care Assets	2,215,364	54,068	737,405	87
88	Buffet Line	18,500	440	440	88
89					89
90					90
91	TOTALS	\$ 2,233,864	\$ 54,508	\$ 737,845	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: \$ 3,518

Description: \$3,518.00-Copy System

(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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

\* 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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		65		65
9	TOTALS	\$	\$ 65	\$	\$ 65
10	SUM OF line 9, col. 1 and 2 (e)	\$	65		

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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

- (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.

Facility Name & ID Number Fairview Haven, Inc.# 0008524 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	35	\$ 2,086	\$	35	\$ 2,086	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		9	472		9	472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2					13,277		13,277	13
14	TOTAL			\$	44	\$ 2,558	\$ 13,277	44	\$ 15,835	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 &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 194,979	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	488,806		3
4	Supply Inventory (priced at FIFO )	17,000		4
5	Short-Term Investments	187,099		5
6	Prepaid Insurance	59,610		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 947,494	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,814		13
14	Buildings, at Historical Cost	3,294,451		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	907,841		16
17	Accumulated Depreciation (book methods)	(2,181,962)		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):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,055,144	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,002,638	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ (80,416)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(150,442)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(32,495)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Unearned Income	(227,620)		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ (490,973)	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	(372,183)		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ (372,183)	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ (863,156)	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (2,139,482)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ (3,002,638)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,942,567	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,942,567	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	196,915	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 196,915	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,139,482	24 *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

## 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		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,191,931	1
2	Discounts and Allowances for all Levels	(262,473)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,929,458	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	32,430	6
7	Oxygen	8,068	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 40,498	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	4,555	12
13	Barber and Beauty Care	11,528	13
14	Non-Patient Meals	9,627	14
15	Telephone, Television and Radio	9,170	15
16	Rental of Facility Space		16
17	Sale of Drugs	(3,787)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73	19
20	Radiology and X-Ray	144	20
21	Other Medical Services	46,393	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,703	23
	D. Non-Operating Revenue		
24	Contributions	398,857	24
25	Interest and Other Investment Income***	13,633	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 412,490	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	493,897	28
28a	Other Income	2,970	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 496,867	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,957,016	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,016,805	31
32	Health Care	1,697,408	32
33	General Administration	807,762	33
	B. Capital Expense		
34	Ownership	165,981	34
	C. Ancillary Expense		
35	Special Cost Centers	37,652	35
36	Provider Participation Fee	34,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,760,101	40
41	Income before Income Taxes (line 30 minus line 40)**	196,915	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 196,915	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 Fairview Haven, Inc.

# 0008524

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,083	2,083	\$ 53,344	\$ 25.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,456	12,259	270,360	22.05	3
4	Licensed Practical Nurses	17,267	18,925	368,444	19.47	4
5	CNAs & Orderlies	56,511	60,805	698,787	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,886	5,293	79,258	14.97	8
9	Activity Director	1,914	1,914	23,957	12.52	9
10	Activity Assistants	3,647	4,100	40,291	9.83	10
11	Social Service Workers	3,101	3,337	41,207	12.35	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,891	14.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,565	19,713	226,754	11.50	15
16	Dishwashers					16
17	Maintenance Workers	6,753	7,425	152,777	20.58	17
18	Housekeepers	7,567	8,175	88,409	10.81	18
19	Laundry	6,368	6,876	71,019	10.33	19
20	Administrator	1,764	1,764	64,830	36.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,960	6,173	111,025	17.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	2,523	2,798	29,587	10.57	33
34	TOTAL (lines 1 - 33)	152,445	163,720	\$ 2,350,940 *	\$ 14.36	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	136	\$ 7,953	1.3	35
36	Medical Director	48	4,800	9.3	36
37	Medical Records Consultant	36	1,530	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	24	1,680	10.3	39
40	Physical Therapy Consultant	26	1,543	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,954	11.3	44
45	Social Service Consultant	17	1,110	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	330	\$ 21,569		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides			10.3/10a.3	52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name &amp; ID Number Fairview Haven, Inc.

# 0008524

Report Period Beginning: 7/1/2005

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## 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 of IL 3,877
- (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? 6.6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,898 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,493  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,627
- (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% of Program  
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? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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 \$2500, 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.