

Facility Name & ID Number Fairview Haven, Inc.

0008524 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	63	Skilled (SNF)	63	23,058	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	63	TOTALS	63	23,058	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		437	1,100	1,537	8
9	SNF/PED					9
10	ICF	6,576	13,416		19,992	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,576	13,853	1,100	21,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.37%

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

101 (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)

Meals on Wheels; Independent & Assisted Living

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 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 63 and days of care provided 1,100

Medicare Intermediary Government National Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	251,047	20,268	80,837	352,152		352,152		352,152		1
2	Food Purchase		175,873		175,873		175,873	(22,988)	152,885		2
3	Housekeeping	136,282	29,151		165,433		165,433		165,433		3
4	Laundry	64,018	17,267		81,285		81,285	(968)	80,317		4
5	Heat and Other Utilities			145,492	145,492		145,492	(48,531)	96,961		5
6	Maintenance	163,295	45,707	53,686	262,688		262,688		262,688		6
7	Other (specify):*										7
8	TOTAL General Services	614,642	288,266	280,015	1,182,923		1,182,923	(72,487)	1,110,436		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,550,235	71,274	25,236	1,646,745	(1,199)	1,645,546		1,645,546		10
10a	Therapy	36,899	227	13,257	50,383		50,383		50,383		10a
11	Activities	76,854	9,994	2,940	89,788		89,788		89,788		11
12	Social Services	56,161		1,136	57,297		57,297		57,297		12
13	CNA Training			1,069	1,069	250	1,319		1,319		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,720,149	81,495	48,438	1,850,082	(949)	1,849,133		1,849,133		16
	C. General Administration										
17	Administrative	127,667			127,667		127,667		127,667		17
18	Directors Fees										18
19	Professional Services			13,110	13,110	(1,211)	11,899		11,899		19
20	Dues, Fees, Subscriptions & Promotions			17,345	17,345	(250)	17,095	(3,377)	13,718		20
21	Clerical & General Office Expenses	55,173	5,781	123,097	184,051	569	184,620	(23,557)	161,063		21
22	Employee Benefits & Payroll Taxes			519,675	519,675		519,675		519,675		22
23	Inservice Training & Education					1,918	1,918		1,918		23
24	Travel and Seminar			15,293	15,293	(2,948)	12,345		12,345		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,985	62,985		62,985		62,985		26
27	Other (specify):*										27
28	TOTAL General Administration	182,840	5,781	751,505	940,126	(1,922)	938,204	(26,934)	911,270		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,517,631	375,542	1,079,958	3,973,131	(2,871)	3,970,260	(99,421)	3,870,839		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.

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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			150,673	150,673		150,673	(55,085)	95,588		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			3,899	3,899		3,899	(3,899)			32
33	Real Estate Taxes					672	672	(672)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			7,575	7,575		7,575		7,575		35
36	Other (specify):*										36
37	TOTAL Ownership			162,147	162,147	672	162,819	(59,656)	103,163		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		60,175	6,914	67,089	2,199	69,288		69,288		39
40	Barber and Beauty Shops			14,869	14,869		14,869		14,869		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			34,588	34,588		34,588	(1)	34,587		42
43	Other (specify):*			2,765	2,765		2,765	(2,765)			43
44	TOTAL Special Cost Centers		60,175	59,136	119,311	2,199	121,510	(2,766)	118,744		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,517,631	435,717	1,301,241	4,254,589		4,254,589	(161,843)	4,092,746		45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,607)	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	7,399	30.3		9
10	Interest and Other Investment Income	(3,899)	32.3		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	(2,765)	43.3		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	(140,971)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,843)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (161,843)		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	Medical Supplies	x		2,199	10.2	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			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 2,199		47

BHF USE ONLY							
48		49		50		51	

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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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

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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.

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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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	A.C. Church Hail Assistance	x		Building Addition	\$ 4,231.67	11/30/01	\$ 335,572	\$ 6,045	8/15/08	0.0225	\$ 748	1					
2					-							2					
3					-							3					
4					-							4					
5					-							5					
Working Capital																	
6	Bluestem National Bank		x	Operating	-	7/13/07	100,000		1/1/08	0.0635	391	6					
7	Citizen's State Bank of Cropsey		x	Operating	-	4/28/08	58,000		4/28/09	0.0500	318	7					
8	Bluestem National Bank		x	Operating	-	1/1/08	95,000		1/1/11	0.0635	539	8					
9	TOTAL Facility Related				\$4,231.67		\$ 588,572	\$ 6,045			\$ 1,996	9					
B. Non-Facility Related*																	
10	A.C. Church Hail Assistance	x		Building Addition	10,768.33	11/30/01	853,928	15,382	8/15/08	0.0225	1,903	10					
11					-							11					
12					-							12					
13					-							13					
14	TOTAL Non-Facility Related				\$10,768.33		\$ 853,928	\$ 15,382			\$ 1,903	14					
15	TOTALS (line 9+line14)						\$ 1,442,500	\$ 21,427			\$ 3,899	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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

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

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven, Inc. COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Dave Blunier

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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

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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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		1962	1962	\$ 145,220	\$ 2,904	50	\$ 2,904	\$	\$ 132,898	4
5	8		1999	1999	354,656		39	9,094	9,094	84,263	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			1962	258	5	50	5		219	9
10	Additions 66-67			1962	2,116	42	50	42		1,772	10
11	Additions 67-68			1967	13,436	269	50	269		11,023	11
12	Additions 69-70			1962	1,893	38	50	38		1,479	12
13	Additions 71-72			1971	26,066	521	50	521		19,284	13
14	Additions 72-73			1972	6,314	126	50	126		4,542	14
15	Additions 77-78			1978	4,507	90	50	90		2,747	15
16	Sprinkler System			1979	42,306	846	50	846		24,677	16
17	Generator Room			1979	8,460	169	50	169		4,932	17
18	Additions 78-79			1979	1,578	32	50	32		937	18
19	Driveway Asphalt			1978	1,475		10			1,475	19
20	Generator			1979	19,921		25			19,921	20
21	Smoke Detector			1980	6,529		25			6,529	21
22	Lights			1980	4,260	142	30	142		3,987	22
23	Additions 79-80			1979	3,516	70	50	70		2,035	23
24	Smoke Detector			1980	1,575		15			1,575	24
25	Additions 80-81			1981	16,207	324	50	324		8,912	25
26	Porch Enclosure			1981	9,453	189	50	189		5,072	26
27	Dining Room Lighting			1981	2,838	95	30	95		2,544	27
28	Lobby Lighting			1981	763	25	30	25		670	28
29	Linen Exhaust Fan			1982	376		10			376	29
30	Sprinkler System			1982	1,977	40	50	40		1,051	30
31	Room D2 Addition			1982	432	9	50	9		233	31
32	Room B14 Addition			1982	2,380	48	50	48		1,251	32
33	Exhaust Fan			1982	322		10			322	33
34	New Roof			1982	3,582		10			3,582	34
35	New Air Conditioner			1982	2,590		10			2,590	35
36	Remodel Kitchen & Dining Room			1983	8,205	164	50	164		4,156	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

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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	1983	\$ 994	\$	10	\$	\$	\$ 994	37
38 Landscape	1983	1,455	49	30	49		1,220	38
39 Attic Fan	1983	1,381		10			1,381	39
40 Kitchen Cabinets & Fixtures	1983	619		20			619	40
41 Social Service Office	1986	227	5	50	5		117	41
42 Outside Light Fixture	1986	437		10			437	42
43 Blacktop Drive & Trees	1962	2,750		10			2,750	43
44 Laundry Room	1978	14,944	299	50	299		9,016	44
45 Trees	1986	920		10			920	45
46 Concrete Drive	1986	4,199		10			4,199	46
47 Remodeling Activity Rm & D-Wing	1986	167,304		20			167,304	47
48 Remodeling C-Wing Bath, Restroom Pilot Lights, D-Wing	1987	8,585	271	30	286	15	6,305	48
49 Courtyard--Original Set-up	1987	19,000	633	30	633		13,348	49
50 Remodel Linen Rm, Exit Lights, Utility, Wardrobe Shelves, Nursing S	1988	21,731	610	17		(610)	21,731	50
51 Courtyard	1988	1,827	61	30	61		1,235	51
52 Patio Roof	1989	2,576	129	20	126	(3)	2,576	52
53 Attic Ceiling	1991	452		10			452	53
54 New Roof	1991	21,664	867	25	867		14,738	54
55 Plumbing-New Faucets-Resident Rooms	1992	6,148		10			6,148	55
56 Carport-Entryway Cover	1992	15,403		15			15,403	56
57 Kitchen Remodeling	1992	173,371	7,274	25	6,935	(339)	107,538	57
58 Office Remodel	1994	20,943	838	25	838		11,941	58
59 Kitchen Remodeling & Cabinets	1993	14,811	721	10		(721)	14,811	59
60 Kitchen Door, Trees, Carpet	1994	2,855	190	15	190		2,746	60
61 Sewer Extension	1995	2,697	180	15	180		2,400	61
62 Room B-1 & Drug Room Remodel	1995	833	33	25	33		440	62
63 Replace Main Sprinkler System	1995	2,550	170	15	170		2,243	63
64 Repair Dining Room Ice Machine Wall	1996	948	38	25	38		467	64
65 Front Parking Lot & Sidewalk	1995	20,675	1,378	15	1,378		17,450	65
66 Door Alarm System	1995	6,226		7			6,226	66
67 Ceiling Mount Smoke Detectors-Resident Rms	1995	183		7			183	67
68 Nurse Call System	1995	27,948		7			27,948	68
69 Ceiling Mount Smoke Detectors-Resident Rms	1996	3,211		7			3,211	69
70 TOTAL (lines 4 thru 69)		\$ 1,263,078	\$ 19,894		\$ 27,330	\$ 7,436	\$ 823,551	70

**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:

07/01/07

Ending: 06/30/08

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	
1		\$ 1,263,078	\$ 19,894		\$ 27,330	\$ 7,436	\$ 823,551	1
2	1997	1,086		7			1,086	2
3	1997	12,981		10			12,981	3
4	1997	324		7			324	4
5	1997	439		7			439	5
6	1997	191		7			191	6
7	1996	724		7			724	7
8	1996	649	43	15	43		512	8
9	1998	1,798		7			1,798	9
10	1998	15,310		7			15,310	10
11	1997	2,148		7			2,148	11
12	1998	744		7			744	12
13	1997	461		7			461	13
14	1999	108		7			108	14
15	2000	1,873	125	15	125		1,010	15
16	2000	746		7			746	16
17	1999	6,669	667	10	667		5,946	17
18	2001	3,647	365	10	365		2,665	18
19	2000	1,623	39	7	39		1,623	19
20	2000	2,762	276	10	276		2,173	20
21	2000	1,151	115	10	115		896	21
22	2001	5,290	529	10	529		3,790	22
23	2002	853	122	7	122		770	23
24	2002	1,730	173	10	173		1,060	24
25	2002	64,740	6,474	10	6,474		41,522	25
26	2003	1,243	124	10	124		670	26
27	2002	1,496	214	7	214		1,264	27
28	2003	526	75	7	75		381	28
29	2002	1,175	117	10	118	1	668	29
30	2002	884	88	10	88		491	30
31	2002	4,850	323	15	323		1,802	31
32	2003	662	66	10	66		335	32
33	2003	4,566	304	15	304		1,544	33
34		\$ 1,406,527	\$ 30,133		\$ 37,570	\$ 7,437	\$ 929,733	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:

07/01/07

Ending: 06/30/08

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	
1		\$ 1,406,527	\$ 30,133		\$ 37,570	\$ 7,437	\$ 929,733	1
2	2004	955	95	10	96	1	408	2
3	2004	643	92	7	92		407	3
4	2003	738	74	10	74		366	4
5	2004	4,504	300	15	300		1,224	5
6	2004	1,090	109	10	109		450	6
7	2003	2,561	171	15	171		809	7
8	2003	12,232	1,223	10	1,223		5,566	8
9	2004							9
10	2003	421	21	20	21		94	10
11	2003	595	60	10	60		273	11
12	2003	4,222	281	15	281		1,329	12
13	2004	1,300	186	7	186		715	13
14	2005	5,912	394	15	394		1,198	14
15	2005	770	110	7	110		359	15
16	2004	1,980	283	7	283		1,027	16
17	2004	26,592	2,659	10	2,659		9,449	17
18	2005	2,150	307	7	307		961	18
19	2005	3,013	201	15	201		604	19
20	2005	4,979	332	15	332		856	20
21	2006	1,353	90	15	90		200	21
22	2005	8,697	870	10	870		2,460	22
23	2005	2,787	186	15	186		470	23
24	2006	2,460	164	15	164		393	24
25	2006	2,292	153	15	153		378	25
26	2005	2,592	259	10	259		659	26
27	2005	3,383	338	10	338		872	27
28	2006	935	62	15	62		150	28
29	2006	10,264	1,026	10	1,026		2,457	29
30	2006	15,624	2,474	7	2,232	(242)	5,020	30
31	2006	2,500		7	357	357	774	31
32	2005	1,697		7	242	242	726	32
33	2006	3,610	361	10	361		725	33
34		\$ 1,539,378	\$ 43,014		\$ 50,809	\$ 7,795	\$ 971,112	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,539,378	\$ 43,014		\$ 50,809	\$ 7,795	\$ 971,112	1
2	2006	3,478	497	7	497		930	2
3	2006	2,059	137	15	137		256	3
4	2007	2,573	103	25	103		122	4
5	2007	7,549	503	15	503		597	5
6	2006	1,033	148	7	148		277	6
7	2007	25,605	1,823	10	1,796	(27)	1,796	7
8	2008	2,905		15				8
9	2008	404	20	10	20		20	9
10	2008	6,331	211	15	206	(5)	206	10
11	2008	937	23	10	23		23	11
12	2008	8,631	480	15	96	(384)	96	12
13	2007	16,191	900	15	905	5	905	13
14	2008	3,831	64	15	64		64	14
15	2008	4,070	242	7	242		242	15
16	2008	3,523	59	15	61	2	61	16
17	2007	29,381	1,306	15	1,304	(2)	1,304	17
18	2008	820	49	7	45	(4)	45	18
19	2008	1,819	65	7	68	3	68	19
20	2008	8,646	144	15	159	15	159	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		\$ 1,669,164	\$ 49,788		\$ 57,186	\$ 7,398	\$ 978,283	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:

07/01/07

Ending:

06/30/08

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	\$ 261,473	\$ 29,333	\$ 29,333	\$	various	\$ 176,982	71
72	Current Year Purchases	15,504	1,366	1,366		various	1,366	72
73	Fully Depreciated Assets	495,014				various	495,014	73
74								74
75	TOTALS	\$ 771,991	\$ 30,699	\$ 30,699	\$		\$ 673,362	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	1998	\$ 46,290	\$	\$	\$	5	\$ 46,290	76
77	Patient Transport	Paint Clubvan	2003	1,147	172	173	1	5	1,147	77
78	Bus Tie Downs	03 Ford Bus	2006	2,184	437	437		5	1,004	78
79	Patient Transport	03 Ford Bus	2004	42,561	7,093	7,093		4	42,560	79
80	TOTALS			\$ 92,182	\$ 7,702	\$ 7,703	\$ 1		\$ 91,001	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)	\$ 2,539,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,189	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,588	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,399	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,742,646	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	2,323,608	59,263	875,734	87
88	Buffet Line	18,500	2,643	5,726	88
89					89
90					90
91	TOTALS	\$ 2,342,108	\$ 61,906	\$ 881,460	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.

Facility Name & ID Number Fairview Haven, Inc.

0008524

Report Period Beginning: 07/01/07

06/30/08

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: \$ 7,575

Description: \$7,575.00-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. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$ 1,069	\$	\$ 1,069
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		250		250
9	TOTALS	\$	\$ 1,319	\$	\$ 1,319
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,319		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	5

- (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:

07/01/07

Ending:

06/30/08

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost			Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	89	\$ 5,348						89	\$	5,348		1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		15	824						15		824		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							60,175				60,175		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Exceptional Care</u>	39.2														12
13	Other (specify): <u>Medical Supplies</u>	39.2								2,199				2,199		13
14	TOTAL			\$	104	\$ 6,172				\$ 62,374			\$	104	\$ 68,546	14

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

Facility Name & ID Number Fairview Haven, Inc.

0008524

Report Period Beginning: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 60,651	\$
2	Cash-Patient Deposits		
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	318,444	
4	Supply Inventory (priced at FIFO)		
5	Short-Term Investments	348,536	
6	Prepaid Insurance	43,267	
7	Other Prepaid Expenses	140	
8	Accounts Receivable (owners or related parties)		
9	Other(specify):		
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 771,038	\$
B. Long-Term Assets			
11	Long-Term Notes Receivable		
12	Long-Term Investments		
13	Land	24,249	
14	Buildings, at Historical Cost	3,258,974	
15	Leasehold Improvements, at Historical Cost		
16	Equipment, at Historical Cost	1,183,015	
17	Accumulated Depreciation (book methods)	(2,487,332)	
18	Deferred Charges		
19	Organization & Pre-Operating Costs		
20	Accumulated Amortization - Organization & Pre-Operating Costs		
21	Restricted Funds		
22	Other Long-Term Assets (specify):		
23	Other(specify):		
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,978,906	\$
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,749,944	\$

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 47,751	\$
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		
30	Accrued Salaries Payable	190,574	
31	Accrued Taxes Payable (excluding real estate taxes)	5,038	
32	Accrued Real Estate Taxes(Sch.IX-B)		
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
36	Unearned Income		
37	Restricted	603	
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 243,966	\$
D. Long-Term Liabilities			
39	Long-Term Notes Payable		
40	Mortgage Payable	156,427	
41	Bonds Payable		
42	Deferred Compensation		
	Other Long-Term Liabilities(specify):		
43			
44			
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 156,427	\$
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 400,393	\$
47	TOTAL EQUITY(page 18, line 24)	\$ 2,349,551	\$
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,749,944	\$

*(See instructions.)

Facility Name & ID Number Fairview Haven, Inc.

0008524

Report Period Beginning: 07/01/07

Ending: 06/30/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,296,111	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,296,111	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,440	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)	\$ 53,440	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)	\$ 2,349,551	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairview Haven, Inc.

0008524

Report Period Beginning:

07/01/07

Ending:

06/30/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,518,206	1
2	Discounts and Allowances for all Levels	(400,114)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,118,092	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	98,970	6
7	Oxygen	2,490	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 101,460	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	1,381	12
13	Barber and Beauty Care	14,463	13
14	Non-Patient Meals	21,607	14
15	Telephone, Television and Radio	8,327	15
16	Rental of Facility Space		16
17	Sale of Drugs	53,277	17
18	Sale of Supplies to Non-Patients	3,609	18
19	Laboratory	17,257	19
20	Radiology and X-Ray		20
21	Other Medical Services	36,741	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 156,662	23
D. Non-Operating Revenue			
24	Contributions	330,950	24
25	Interest and Other Investment Income***	23,474	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 354,424	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	575,142	28
28a	Other Income	2,249	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 577,391	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,308,029	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,182,923	31
32	Health Care	1,850,082	32
33	General Administration	940,126	33
B. Capital Expense			
34	Ownership	162,147	34
C. Ancillary Expense			
35	Special Cost Centers	84,723	35
36	Provider Participation Fee	34,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,254,589	40
41	Income before Income Taxes (line 30 minus line 40)**	53,440	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 53,440	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:

07/01/07

Ending:

06/30/08

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	2,227	2,333	\$ 57,797	\$ 24.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,975	7,595	192,799	25.38	3
4	Licensed Practical Nurses	19,181	21,487	479,738	22.33	4
5	CNAs & Orderlies	53,315	57,703	771,848	13.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,686	1,811	36,899	20.37	8
9	Activity Director	1,741	1,935	25,480	13.17	9
10	Activity Assistants	4,557	4,818	51,374	10.66	10
11	Social Service Workers	4,350	4,809	56,161	11.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,685	20,831	251,047	12.05	15
16	Dishwashers					16
17	Maintenance Workers	8,369	9,112	163,295	17.92	17
18	Housekeepers	12,944	14,012	136,282	9.73	18
19	Laundry	6,262	6,633	64,018	9.65	19
20	Administrator	1,928	2,088	68,419	32.77	20
21	Assistant Administrator					21
22	Other Administrative	1,912	2,088	59,248	28.38	22
23	Office Manager					23
24	Clerical	4,579	4,833	55,173	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,771	2,943	48,053	16.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,482	165,031	\$ 2,517,631 *	\$ 15.26	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	107	\$ 5,128	1.3	35
36	Medical Director	48	4,800	9.3	36
37	Medical Records Consultant	29	1,350	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	21	1,611	10.3	39
40	Physical Therapy Consultant	66	3,970	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,940	11.3	44
45	Social Service Consultant	19	1,136	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	340	\$ 20,935		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	785	19,995	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	785	\$ 19,995		53

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

** See instructions.

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Richard Plattner	Administrator		\$ 68,419	Workers' Compensation Insurance	\$ 49,386	IDPH License Fee	\$ 1,990	
David Blunier	Dir. of HR & Fin		59,248	Unemployment Compensation Insurance		Advertising: Employee Recruitment	8,108	
				FICA Taxes	182,304	Health Care Worker Background Check	370	
				Employee Health Insurance	226,638	(Indicate # of checks performed 37)		
				Employee Meals		Patient Background Checks 29	290	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	3,925	
				Employee Pension Plan	45,897	Dues & Licenses	1,326	
				Employee Physicals, Hep. B.	615	Subscriptions & Newspapers	1,036	
				Employee Appreciation	13,984			
				Employee Uniforms	852			
						Less: Public Relations Expense ()		
						Non-allowable advertising (3,327)		
						Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 127,667	TOTAL (agree to Schedule V, line 22, col.8)	\$ 519,675	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,718	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	5,312
							Seminar Expense	7,033
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 12,345
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Westervelt, Johnson, Nicoll & Keller	Legal		\$ 1,101					
Robert Rein, CPA	Accounting		6,038					
FRR Healthcare	Consulting		2,998					
Jewel Technology	Consulting		1,762					
Reclassification			1,211					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 13,110					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
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14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Fairview Haven, Inc.

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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 3,925
- (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? 6.8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 24,771 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. \$ 34,587
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. \$ 21,607
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.