

Facility Name & ID Number Fairview Haven

0008524 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	22,995	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	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF		367	603	970	8	
9	SNF/PED					9	
10	ICF	7,294	14,050		21,344	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	7,294	14,417	603	22,314	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.04%

D. How many bed-hold days during this year were paid by the Department? 141 (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 and 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 603

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

* 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	251,639	16,923	85,674	354,236		354,236		354,236		1
2	Food Purchase		174,258		174,258		174,258	(29,380)	144,878		2
3	Housekeeping	122,301	28,614		150,915		150,915		150,915		3
4	Laundry	79,782	26,811	1,192	107,785		107,785	(1,192)	106,593		4
5	Heat and Other Utilities			174,408	174,408		174,408	(60,461)	113,947		5
6	Maintenance	170,408	47,975	24,820	243,203		243,203		243,203		6
7	Other (specify):*										7
8	TOTAL General Services	624,130	294,581	286,094	1,204,805		1,204,805	(91,033)	1,113,772		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,635,786	106,181	30,065	1,772,032		1,772,032		1,772,032		10
10a	Therapy	90,359		13,331	103,690		103,690		103,690		10a
11	Activities	79,295	15,133	4,122	98,550		98,550		98,550		11
12	Social Services	54,690		798	55,488		55,488		55,488		12
13	CNA Training			5,235	5,235		5,235		5,235		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,860,130	121,314	58,351	2,039,795		2,039,795		2,039,795		16
	C. General Administration										
17	Administrative	130,395			130,395		130,395		130,395		17
18	Directors Fees										18
19	Professional Services			7,935	7,935		7,935		7,935		19
20	Dues, Fees, Subscriptions & Promotions			7,747	7,747		7,747		7,747		20
21	Clerical & General Office Expenses	49,687	16,569	99,634	165,890		165,890	(23,411)	142,479		21
22	Employee Benefits & Payroll Taxes			588,016	588,016		588,016		588,016		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,023	16,023		16,023		16,023		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,400	64,400		64,400		64,400		26
27	Other (specify):*										27
28	TOTAL General Administration	180,082	16,569	783,755	980,406		980,406	(23,411)	956,995		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,664,342	432,464	1,128,200	4,225,006		4,225,006	(114,444)	4,110,562		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Fairview Haven

#0008524

Report Period Beginning:

7/1/08

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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			155,895	155,895		155,895	(55,216)	100,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,252	3,252		3,252	(3,252)				32
33	Real Estate Taxes			1,374	1,374		1,374	(1,374)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,204	8,204		8,204		8,204			35
36	Other (specify):*											36
37	TOTAL Ownership			168,725	168,725		168,725	(59,842)	108,883			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,302		37,302		37,302		37,302			39
40	Barber and Beauty Shops			14,399	14,399		14,399		14,399			40
41	Coffee and Gift Shops			177	177		177		177			41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):*			10,725	10,725		10,725	(10,725)				43
44	TOTAL Special Cost Centers		37,302	59,794	97,096		97,096	(10,725)	86,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,664,342	469,766	1,356,719	4,490,827		4,490,827	(185,011)	4,305,816			45

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

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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	(27,345)	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	7,599	30		9
10	Interest and Other Investment Income	(3,252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(10,725)	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	(151,288)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,011)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (185,011)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Fundraising Expense	\$ (10,725)	43	1
2	Non Patient Meals	(27,345)	2	2
3	Miscellaneous Revenue	(1,630)	21	3
4	Vending Revenue	(2,035)	2	4
5	Non Care Related Real Estate Tax	(1,374)	33	5
6	Non Care Expenses	(20,369)	21	6
7	Non Care Utilities	(60,461)	5	7
8	Non Care Depreciation	(62,815)	30	8
9	Non Care Laundry	(1,192)	4	9
10	Other Promotional Exp	(1,412)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(189,358)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(29,380)	0	0	0	0	0	0	0	0	0	0	(29,380)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,192)	0	0	0	0	0	0	0	0	0	0	(1,192)	4
5	Heat and Other Utilities	(60,461)	0	0	0	0	0	0	0	0	0	0	(60,461)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(91,033)	0	(91,033)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(23,411)	0	0	0	0	0	0	0	0	0	0	(23,411)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(23,411)	0	(23,411)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(114,444)	0	(114,444)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Haven

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Report Period Beginning:

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(55,216)	0	0	0	0	0	0	0	0	0	0	(55,216)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,252)	0	0	0	0	0	0	0	0	0	0	(3,252)	32
33	Real Estate Taxes	(1,374)	0	0	0	0	0	0	0	0	0	0	(1,374)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(59,842)	0	0	0	0	0	0	0	0	0	0	(59,842)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,725)	0	0	0	0	0	0	0	0	0	0	(10,725)	43
44	TOTAL Special Cost Centers	(10,725)	0	0	0	0	0	0	0	0	0	0	(10,725)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(185,011)	0	0	0	0	0	0	0	0	0	0	(185,011)	45

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

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

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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	2	3	4	5	6	7	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	\$	8/15/08	0.0225	\$ 15	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Bluestem National Bank		x	Operating		1/31/08	95,000	15,000	1/31/11	0.0545	1,624	6							
7	Citizen's State Bank of Cropsey		x	Operating		5/8/09	116,500		5/8/10	0.0350	1,576	7							
8												8							
9	TOTAL Facility Related				\$4,231.67		\$ 547,072	\$ 15,000			\$ 3,215	9							
B. Non-Facility Related*																			
10	A.C. Church Hail Assistance	x		Building Addition	\$10,768.33	11/30/01	853,928		8/15/08	0.0225	37	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related				\$10,768.33		\$ 853,928	\$			\$ 37	14							
15	TOTALS (line 9+line14)						\$ 1,401,000	\$ 15,000			\$ 3,252	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.)

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

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:

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		1962	1962	\$ 145,220	\$ 2,904	50	\$ 2,904	\$	\$ 135,802	4
5	8		1999	1999	354,656		39	9,094	9,094	93,357	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66		1965		258	5	50	5		224	9
10	Additions 66-67		1966		2,116	42	50	42		1,814	10
11	Additions 67-68		1967		13,436	269	50	269		11,292	11
12	Additions 69-70		1969		1,893	38	50	38		1,517	12
13	Additions 71-72		1971		26,066	521	50	521		19,805	13
14	Additions 72-73		1972		6,314	126	50	126		4,668	14
15	Additions 77-78		1978		4,507	90	50	90		2,837	15
16	Sprinkler System		1979		42,306	846	50	846		25,523	16
17	Generator Room		1979		8,460	169	50	169		5,101	17
18	Additions 79-80		1979		1,578	32	50	32		969	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		4,129	22
23	Additions 79-80		1979		3,516	70	50	70		2,105	23
24	Smoke Detector		1980		1,575		15			1,575	24
25	Additions 80-81		1981		16,207	324	50	324		9,236	25
26	Porch Enclosure		1981		9,453	189	50	189		5,261	26
27	Dining Room Lighting		1981		2,838	95	30	95		2,639	27
28	Lobby Lighting		1981		763	25	30	25		695	28
29	Linen Exhaust Fan		1982		376		10			376	29
30	Sprinkler System Imp		1982		1,977	40	50	40		1,091	30
31	Room D2 Addition		1982		432	9	50	9		242	31
32	Room B14 Addition		1982		2,380	48	50	48		1,299	32
33	Exhaust Fan		1982		322		10			322	33
34	New Roof		1982		3,582		10			3,582	34
35	New Air Conditioning		1982		2,590		10			2,590	35
36	Remodel Kitchen and D.R.		1983		8,205	164	50	164		4,320	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	New Sign	1983	\$ 994	\$	10	\$	\$	\$ 994	37
38	Landscape	1983	1,455	49	30	49		1,269	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		122	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		9,315	44
45	Trees	1986	920		10			920	45
46	Concrete Drive	1986	4,199		10			4,199	46
47	Remodeling Activity Rm	1986	167,304		20			167,304	47
48	Remodeling C-Wing	1987	8,585	271	30	286	15	6,591	48
49	Courtyard	1987	19,000	633	30	633		13,981	49
50	Remodel Linen Room	1988	21,731	610	17		(610)	21,731	50
51	Courtyard	1988	1,827	61	30	61		1,296	51
52	Patio Roof	1989	2,576		20			2,576	52
53	Attic Ceiling	1991	452		10			452	53
54	New Roof	1991	21,664	867	25	867		15,605	54
55	Plumbing -New faucet	1992	6,148		10			6,148	55
56	Carport-Entryway	1992	15,403		15			15,403	56
57	Kitchen Remodeling	1992	173,371	7,274	25	6,935	(339)	114,473	57
58	Office Remodel	1994	20,943	838	25	838		12,779	58
59	Kitchen Remodeling	1993	14,811	721	10		(721)	14,811	59
60	Kitchen Door, trees, carpet	1994	2,855	109	15	109		2,855	60
61	Sewer Extension	1995	2,697	180	15	180		2,580	61
62	Room B-1	1995	833	33	25	33		473	62
63	Replace Main sprinkler system	1995	2,550	170	15	170		2,413	63
64	Repair dining room ice machine wall	1996	948	38	25	38		505	64
65	Front parking lot and sidewalk	1995	20,675	1,378	15	1,378		18,828	65
66	Door alarm system	1995	6,226		7			6,226	66
67	Ceiling Mount smoke detectors	1995	183		7			183	67
68	Nurse Call system	1995	27,948		7			27,948	68
69	Ceiling Mount smoke detectors	1996	3,211		7			3,211	69
70	TOTAL (lines 4 thru 69)		\$ 1,263,078	\$ 19,683		\$ 27,122	\$ 7,439	\$ 850,674	70

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

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0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,263,078	\$ 19,683		\$ 27,122	\$ 7,439	\$ 850,674	1
2	Draperies	1997	1,086		7			1,086	2
3	Phone System	1997	12,981		10			12,981	3
4	Fire alarm system	1997	324		7			324	4
5	Door alarm system	1997	439		7			439	5
6	Ceiling Mount smoke detectors	1997	191		7			191	6
7	Door alarm system	1996	724		7			724	7
8	Courtyard landscaping	1996	649	43	15	43		555	8
9	Window coverings	1998	1,798		7			1,798	9
10	Intercom system	1998	15,310		7			15,310	10
11	Nurse call system	1997	2,148		7			2,148	11
12	Fire alarm system	1998	744		7			744	12
13	Telephone system	1997	461		7			461	13
14	Smoke detectors	1999	108		7			108	14
15	Bathroom sprinkler system	2000	1,873	125	15	125		1,135	15
16	Sink	2000	746		7			746	16
17	Water heater	1999	6,669	667	10	667		6,613	17
18	Water heater	2001	3,647	365	10	365		3,030	18
19	B Wing air conditioner	2000	1,623		7			1,623	19
20	Dry pendants	2000	2,762	276	10	276		2,449	20
21	Nurses station carpet	2000	1,151	115	10	115		1,011	21
22	Large capacity water heater	2001	5,290	529	10	529		4,319	22
23	Telephone system	2002	853	83	7	83		853	23
24	Air conditioning unit	2002	1,730	173	10	173		1,233	24
25	Nurse call system	2002	64,740	6,474	10	6,474		47,996	25
26	Draperies	2003	1,243	124	10	124		794	26
27	Phone system wiring	2002	1,496	214	7	214		1,478	27
28	Water cooler	2003	526	75	7	75		456	28
29	Lightning arrestors	2002	1,175	117	10	118	1	786	29
30	Eyewash station	2002	884	88	10	88		579	30
31	Firecode updates	2002	4,850	323	15	323		2,125	31
32	Activity draperies	2003	662	66	10	66		401	32
33	Concrete improvements	2003	4,566	304	15	304		1,848	33
34	TOTAL (lines 1 thru 33)		\$ 1,406,527	\$ 29,846		\$ 37,285	\$ 7,440	\$ 967,018	34

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,406,527	\$ 29,846		\$ 37,285	\$ 7,440	\$ 967,018	1
2	Plumbing rough in	2004	955	95	10	96	1	504	2
3	Window blinds	2004	643	92	7	92		499	3
4	Kitchen grease trap	2003	738	74	10	74		440	4
5	Driveway	2004	4,504	300	15	300		1,524	5
6	Sprinkler system	2004	1,090	109	10	109		559	6
7	Kitchen grease trap	2003	2,561	171	15	171		980	7
8	Bath tub	2003	12,232	1,223	10	1,223		6,789	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		115	10
11	Light fixtures	2003	595	60	10	60		333	11
12	Air conditioning units	2003	4,222	281	15	281		1,610	12
13	Dining draperies	2004	1,300	186	7	186		901	13
14	Front parking lot	2005	5,912	394	15	394		1,592	14
15	Generator Heater	2005	770	110	7	110		469	15
16	Door monitors	2004	1,980	283	7	283		1,310	16
17	Sprinkler rehab	2004	26,592	2,659	10	2,659		12,108	17
18	5T Air conditioning	2005	2,150	307	7	307		1,268	18
19	C Wing ductwork	2005	3,013	201	15	201		805	19
20	13 bathroom remodeling	2005	4,979	332	15	332		1,188	20
21	Bathroom steel door frames	2006	1,353	90	15	90		290	21
22	5 ton condensor	2005	8,697	870	10	870		3,330	22
23	Fire system engineering	2005	2,787	186	15	186		656	23
24	North basement office remodel	2006	2,460	164	15	164		557	24
25	Foam roofing	2006	2,292	153	15	153		531	25
26	Door alarm and keypad	2005	2,592	259	10	259		918	26
27	Fire door closures and shutters	2005	3,383	338	10	338		1,210	27
28	B hall shower tile	2006	935	62	15	62		212	28
29	Bathtub	2006	10,264	1,026	10	1,026		3,483	29
30	Generator upgrade	2006	15,624	2,474	7	2,232	(242)	7,252	30
31	Intercom replacement	2006	2,500		7	357	357	1,131	31
32	Generator upgrade	2005	1,697		7	242	242	968	32
33	Front door automatic opener	2006	3,610	361	10	361		1,086	33
34	TOTAL (lines 1 thru 33)		\$ 1,539,378	\$ 42,727		\$ 50,525	\$ 7,798	\$ 1,021,636	34

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,539,378	\$ 42,727		\$ 50,525	\$ 7,798	\$ 1,021,636	1
2	Fire alarm system	2006	3,478	497	7	497		1,427	2
3	Air conditioning	2006	2,059	137	15	137		512	3
4	Guttering system	2007	2,573	103	25	103		719	4
5	Air conditioning	2007	7,549	503	15	503		1,100	5
6	Door alarm system	2006	1,033	148	7	148		425	6
7	Landscaping	2007	25,605	1,823	10	1,796	(27)	3,592	7
8	Dock improvements	2008	2,905		15				8
9	Fornt door opener	2008	404	40	10	40		60	9
10	Blessing way upgrade	2008	6,331	422	15	422		412	10
11	Garbage disposal	2008	937	94	10	94		117	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		671	12
13	West side window replacement	2007	16,191	1,079	15	1,079		1,984	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831	255	15	255		319	14
15	Furnace	2008	4,070	581	7	581		823	15
16	Ductwork repair	2008	3,523	235	15	235		296	16
17	Landscap, sprinkler system repair	2007	29,381	1,959	15	1,959		3,263	17
18	Shower repair	2008	820	117	7	117		162	18
19	Kitchen water softener	2008	1,819	260	7	260		328	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		735	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	57		57		57	21
22	Blessing Way - Heat/Trim	2009	4,519	151		151		151	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	226		226		226	23
24	Daffodil drive - air conditioner	2009	916	11		11		11	24
25	Dock Upgrade	2008	11,078	492		492		492	25
26	Fire system upgrade	2008	2,860	143		143		143	26
27	New offices - business/nursing	2009	20,230	337		337		337	27
28	New window	2009	316	4		4		4	28
29	Resident rooms - heating/furn	2009	10,484	58		58		58	29
30	Sprinkler System upgrade	2009	18,674	622		622		622	30
31	Therapy room air conditioner	2009	1,535	110		110		110	31
32	Window	2009	2,974	33		33			32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,757,559	\$ 54,377		\$ 62,148	\$ 7,771	\$ 1,040,792	34

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 270,185	\$ 34,352	\$ 34,352	\$	various	\$ 181,435	71
72	Current Year Purchases	33,970	3,743	3,743		various	3,743	72
73	Fully Depreciated Assets	501,806				various		73
74								74
75	TOTALS	\$ 805,961	\$ 38,095	\$ 38,095	\$		\$ 185,178	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 Transportation	Ford clubvan triton v-10 '98	1998	\$ 46,290	\$	\$	\$	5	\$ 46,290	76
77	Patient Transportation	Paint Clubvan	2003	1,147	172		(172)	5	1,147	77
78	Bus Tie Downs	03 Ford bus	2006	2,184	437	437		5	1,441	78
79	Patient Transportation	03 Ford bus	2004	42,561				4	42,562	79
80	TOTALS			\$ 92,182	\$ 609	\$ 437	\$ (172)		\$ 91,440	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)	\$ 2,662,124	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,081	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,679	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,599	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,317,410	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	Non Care Assets	\$ 2,343,111	\$ 60,127	\$ 935,861	86
87	Buffet Line	18,500	2,643	8,369	87
88					88
89					89
90					90
91	TOTALS	\$ 2,361,611	\$ 62,770	\$ 944,230	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? _____

16. Rental Amount for movable equipment: \$ 8,204 Description: Copy System YES NO

(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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/08 Ending: 6/30/09
 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? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	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>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$ 4,685	\$	\$ 4,685
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		550		550
9	TOTALS	\$	\$ 5,235	\$	\$ 5,235
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,235		

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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	\$	79	\$ 4,734	\$	79	\$ 4,734	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		12	648		12	648	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		63	3,775		63	3,775	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				21,763		21,763	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Physical Therapy Asst	10a.3			10	436		10	436	12
13	Other (specify): COTA	10a.3			62	2,636		62	2,636	13
14	TOTAL			\$	226	\$ 12,229	\$ 21,763	226	\$ 33,992	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# 0008524Report Period Beginning: 7/1/08Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 182,957	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	178,016		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	315,456		5
6	Prepaid Insurance	50,221		6
7	Other Prepaid Expenses	1,169		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 727,819	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,249		13
14	Buildings, at Historical Cost	3,382,544		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,220,653		16
17	Accumulated Depreciation (book methods)	(2,643,228)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,984,218	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,712,037	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 57,322	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,259		30
31	Accrued Taxes Payable (excluding real estate taxes)	495		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Operating loan payable</u>	15,000		36
37	<u>Refund Payable</u>	(9,179)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 265,897	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 265,897	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,446,140	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,712,037	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,365,092	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,365,092	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	81,048	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)	\$ 81,048	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)	\$ 2,446,140	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning: 7/1/08

Ending: 6/30/09

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	\$ 3,825,791	1
2	Discounts and Allowances for all Levels	(407,166)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,418,625	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,680	6
7	Oxygen	(599)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 54,081	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	2,035	12
13	Barber and Beauty Care	13,983	13
14	Non-Patient Meals	27,345	14
15	Telephone, Television and Radio	7,923	15
16	Rental of Facility Space		16
17	Sale of Drugs	21,763	17
18	Sale of Supplies to Non-Patients	272	18
19	Laboratory	6,630	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,143	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 91,094	23
D. Non-Operating Revenue			
24	Contributions	453,600	24
25	Interest and Other Investment Income***	12,473	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 466,073	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Residential Revenue</u>	540,372	28
28a	<u>Other Income</u>	1,630	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 542,002	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,571,875	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,204,805	31
32	Health Care	2,039,795	32
33	General Administration	980,406	33
B. Capital Expense			
34	Ownership	168,725	34
C. Ancillary Expense			
35	Special Cost Centers	62,603	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)*	\$ 4,490,827	40
41	Income before Income Taxes (line 30 minus line 40)**	81,048	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 81,048	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

0008524

Report Period Beginning:

7/1/08

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6/30/09

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	2,016	2,096	\$ 59,316	\$ 28.30	1
2	Assistant Director of Nursing	1,412	1,412	31,772	22.50	2
3	Registered Nurses	10,233	10,980	204,396	18.62	3
4	Licensed Practical Nurses	23,143	24,798	395,514	15.95	4
5	CNAs & Orderlies	91,908	96,815	812,464	8.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,705	1,918	24,523	12.79	9
10	Activity Assistants	5,210	5,522	54,771	9.92	10
11	Social Service Workers	4,353	4,670	54,690	11.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	19,033	20,176	134,475	6.67	14
15	Cook Helpers/Assistants	19,279	19,798	117,164	5.92	15
16	Dishwashers					16
17	Maintenance Workers	9,828	10,588	170,408	16.09	17
18	Housekeepers	13,560	14,832	122,301	8.25	18
19	Laundry	9,322	9,881	79,782	8.07	19
20	Administrator	1,976	2,080	68,693	33.03	20
21	Assistant Administrator	1,872	2,080	61,702	29.66	21
22	Other Administrative	4,496	4,836	49,687	10.27	22
23	Office Manager					23
24	Clerical					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	3,177	3,437	36,530	10.63	31
32	Other Health C: Support Nurses	3,935	4,126	95,793	23.22	32
33	Other(specify) PTA	1,755	1,862	90,361	48.53	33
34	TOTAL (lines 1 - 33)	228,213	241,907	\$ 2,664,342 *	\$ 11.01	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	122	\$ 5,865	1,3	35
36	Medical Director	48	4,800	9.3	36
37	Medical Records Consultant	32	1,874	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,856	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,562	11.3	44
45	Social Service Consultant	16	2,089	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	238	\$ 18,046		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses	8	336	10.3	51
52	Certified Nurse Assistants/Aides	626	15,426	10.3	52
53	TOTAL (lines 50 - 52)	634	\$ 15,762		53

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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 \$2921
- (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) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,424 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. \$ 12,673
- (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: _____
- (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.