



Facility Name & ID Number Fairview Haven

# 0008524 Report Period Beginning: 07/01/09 Ending: 06/30/10

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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	7,034	13,138	1,626	21,798	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,034	13,138	1,626	21,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.79%

D. How many bed-hold days during this year were paid by the Department? 142 (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 \_\_\_\_\_ 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 1,626

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: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 07/01/09 Ending: 06/30/10

**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
	<b>A. General Services</b>										
1	Dietary	250,290	20,004	81,010	351,304		351,304		351,304		1
2	Food Purchase		168,553		168,553		168,553	(32,925)	135,628		2
3	Housekeeping	146,265	31,719		177,984		177,984		177,984		3
4	Laundry	63,628	25,056	487	89,171		89,171	(487)	88,684		4
5	Heat and Other Utilities			157,333	157,333		157,333	(59,652)	97,681		5
6	Maintenance	182,369	53,925	30,508	266,802		266,802		266,802		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	642,552	299,257	269,338	1,211,147		1,211,147	(93,064)	1,118,083		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,742,166	143,926	93,195	1,979,287		1,979,287		1,979,287		10
10a	Therapy	92,354	154	25,728	118,236		118,236		118,236		10a
11	Activities	85,412	18,513	2,986	106,911		106,911		106,911		11
12	Social Services	58,228		902	59,130		59,130		59,130		12
13	CNA Training			5,405	5,405		5,405		5,405		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,978,160	162,593	133,016	2,273,769		2,273,769		2,273,769		16
	<b>C. General Administration</b>										
17	Administrative	133,519			133,519		133,519		133,519		17
18	Directors Fees										18
19	Professional Services			9,545	9,545		9,545		9,545		19
20	Dues, Fees, Subscriptions & Promotions			8,167	8,167		8,167		8,167		20
21	Clerical & General Office Expenses	56,492	15,872	103,631	175,995		175,995	(27,245)	148,750		21
22	Employee Benefits & Payroll Taxes			665,269	665,269		665,269		665,269		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,052	12,052		12,052		12,052		24
25	Other Admin. Staff Transportation			9,217	9,217		9,217		9,217		25
26	Insurance-Prop.Liab.Malpractice			67,661	67,661		67,661		67,661		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	190,011	15,872	875,542	1,081,425		1,081,425	(27,245)	1,054,180		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,810,723	477,722	1,277,896	4,566,341		4,566,341	(120,309)	4,446,032		29

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

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

Facility Name &amp; ID Number

Fairview Haven

#0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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			153,245	153,245		153,245	(44,214)	109,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,240	1,240		1,240	(6,307)	(5,067)			32
33	Real Estate Taxes			703	703		703	(703)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,188	7,188		7,188		7,188			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			162,376	162,376		162,376	(51,224)	111,152			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,515		57,515		57,515		57,515			39
40	Barber and Beauty Shops			14,638	14,638		14,638		14,638			40
41	Coffee and Gift Shops			2	2		2		2			41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):*			8,938	8,938		8,938	(8,938)				43
44	<b>TOTAL Special Cost Centers</b>		57,515	58,071	115,586		115,586	(8,938)	106,648			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,810,723	535,237	1,498,343	4,844,303		4,844,303	(180,471)	4,663,832			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	(26,868)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,307)	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	(8,938)	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	(138,358)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (180,471)</b>		<b>\$</b>	<b>30</b>

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (180,471)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY							
48		49		50		51	52

Fairview Haven

ID# 0008524

Report Period Beginning: 07/01/09

Ending: 06/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Fundraising Expense	\$ (8,938)	43	1
2	Non Patient Meals	(26,868)	2	2
3	Miscellaneous Revenue	(3,852)	21	3
4	Interest Income	(6,307)	32	4
5	Vending Income	(6,057)	2	5
6	Non care real estate taxes	(703)	33	6
7	Non care expenes	(21,133)	21	7
8	Non care utilities	(59,652)	5	8
9	Non care depreciation	(57,809)	30	9
10	Non care laundry	(487)	4	10
11	Promotional advertising	(2,260)	21	11
12	S/L Depreciation	13,595	30	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	<b>Total</b>	(180,471)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(32,925)	0	0	0	0	0	0	0	0	0	0	(32,925)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(487)	0	0	0	0	0	0	0	0	0	0	(487)	4
5	Heat and Other Utilities	(59,652)	0	0	0	0	0	0	0	0	0	0	(59,652)	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	<b>TOTAL General Services</b>	<b>(93,064)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(93,064)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(27,245)	0	0	0	0	0	0	0	0	0	0	(27,245)	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	<b>TOTAL General Administration</b>	<b>(27,245)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,245)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(120,309)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(120,309)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(44,214)	0	0	0	0	0	0	0	0	0	0	(44,214)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,307)	0	0	0	0	0	0	0	0	0	0	(6,307)	32
33	Real Estate Taxes	(703)	0	0	0	0	0	0	0	0	0	0	(703)	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	<b>TOTAL Ownership</b>	<b>(51,224)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(51,224)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(8,938)	0	0	0	0	0	0	0	0	0	0	(8,938)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(8,938)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,938)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(180,471)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(180,471)</b>	<b>45</b>

**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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1																			
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6	Bluestem National Bank		x	Opertating		1/31/08	95,000		1/31/11	4.9500	3								
7	Citizens State Bank Cropsey		x	Opertating		5/8/09	156,000	80,000	5/10/11	3.4300	1,237								
8																			
9	<b>TOTAL Facility Related</b>						\$ 251,000	\$ 80,000			\$ 1,240								
<b>B. Non-Facility Related*</b>																			
10																			
11																			
12																			
13																			
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$								
15	<b>TOTALS (line 9+line14)</b>						\$ 251,000	\$ 80,000			\$ 1,240								

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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

  

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

# 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	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	<b>TOTALS</b>	<b>90,000</b>		<b>\$ 6,422</b>	<b>3</b>

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

**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	\$	\$ 138,706	4
5	8		1999	1999	354,656		39	9,094	9,094	102,451	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Additions 65-66		1965		258	5	50	5		229	9
10	Additions 66-67		1966		2,116	42	50	42		1,856	10
11	Additions 67-68		1967		13,436	269	50	269		11,561	11
12	Additions 69-70		1969		1,893	38	50	38		1,555	12
13	Additions 71-72		1971		26,066	521	50	521		20,326	13
14	Additions 72-73		1972		6,314	126	50	126		4,794	14
15	Additions 77-78		1978		4,507	90	50	90		2,927	15
16	Sprinkler System		1979		42,306	846	50	846		26,369	16
17	Generator Room		1979		8,460	169	50	169		5,270	17
18	Additions 79-80		1979		1,578	32	50	32		1,001	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	133	30	133		4,262	22
23	Additions 79-80		1979		3,516	70	50	70		2,175	23
24	Smoke Detector		1980		1,575		15			1,575	24
25	Additions 80-81		1981		16,207	324	50	324		9,563	25
26	Porch Enclosure		1981		9,453	189	50	189		5,450	26
27	Dining Room Lighting		1981		2,838	95	30	95		2,734	27
28	Lobby Lighting		1981		763	25	30	25		720	28
29	Linen Exhaust Fan		1982		376		10			376	29
30	Sprinkler System Imp		1982		1,977	40	50	40		1,131	30
31	Room D2 Addition		1982		432	9	50	9		251	31
32	Room B14 Addition		1982		2,380	48	50	48		1,347	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		4,484	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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		1,318	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		127	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		9,614	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	6,877	48
49	Courtyard	1987	19,000	633	30	633		14,614	49
50	Remodel Linen Room	1988	21,731		17			21,731	50
51	Courtyard	1988	1,827	61	30	61		1,357	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		16,472	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)	121,408	57
58	Office Remodel	1994	20,943	838	25	838		13,617	58
59	Kitchen Remodeling	1993	14,811		10			14,811	59
60	Kitchen Door, trees, carpet	1994	2,855		15			2,855	60
61	Sewer Extension	1995	2,697	117	15	117		2,697	61
62	Room B-1	1995	833	33	25	33		506	62
63	Replace Main sprinkler system	1995	2,550	127	15	127		2,540	63
64	Repair dining room ice machine wall	1996	948	38	25	38		543	64
65	Front parking lot and sidewalk	1995	20,675	1,378	15	1,378		20,206	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	\$ 18,128		\$ 26,898	\$ 8,770	\$ 877,576	70

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,263,078	\$ 18,128		\$ 26,898	\$ 8,770	\$ 877,576	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		598	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		1,260	15
16	Sink	2000	746		7			746	16
17	Water heater	1999	6,669	56	10	56		6,669	17
18	Water heater	2001	3,647	365	10	365		3,395	18
19	B Wing air conditioner	2000	1,623		7			1,623	19
20	Dry pendants	2000	2,762	276	10	276		2,725	20
21	Nurses station carpet	2000	1,151	115	10	115		1,126	21
22	Large capacity water heater	2001	5,290	529	10	529		4,848	22
23	Telephone system	2002	853		7			853	23
24	Air conditioning unit	2002	1,730	173	10	173		1,406	24
25	Nurse call system	2002	64,740	6,474	10	6,474		54,470	25
26	Draperies	2003	1,243	124	10	124		918	26
27	Phone system wiring	2002	1,496	18	7	18		1,496	27
28	Water cooler	2003	526	70	7	70		526	28
29	Lightning arrestors	2002	1,175	117	10	118	1	904	29
30	Eyewash station	2002	884	88	10	88		667	30
31	Firecode updates	2002	4,850	323	15	323		2,448	31
32	Activity draperies	2003	662	66	10	66		467	32
33	Concrete improvements	2003	4,566	304	15	304		2,152	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,406,527	\$ 27,395		\$ 36,166	\$ 8,771	\$ 1,003,187	34

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,406,527	\$ 27,395		\$ 36,166	\$ 8,771	\$ 1,003,187	1
2	Plumbing rough in	2004	955	95	10	96	1	600	2
3	Window blinds	2004	643	92	7	92		591	3
4	Kitchen grease trap	2003	738	74	10	74		514	4
5	Driveway	2004	4,504	300	15	300		1,824	5
6	Sprinkler system	2004	1,090	109	10	109		668	6
7	Kitchen grease trap	2003	2,561	171	15	171		1,151	7
8	Bath tub	2003	12,232	1,223	10	1,223		8,012	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		136	10
11	Light fixtures	2003	595	60	10	60		393	11
12	Air conditioning units	2003	4,222	281	15	281		1,891	12
13	Dining draperies	2004	1,300	186	7	186		1,087	13
14	Front parking lot	2005	5,912	394	15	394		1,986	14
15	Generator Heater	2005	770	110	7	110		579	15
16	Door monitors	2004	1,980	283	7	283		1,593	16
17	Sprinkler rehab	2004	26,592	2,659	10	2,659		14,767	17
18	5T Air conditioning	2005	2,150	307	7	307		1,575	18
19	C Wing ductwork	2005	3,013	201	15	201		1,006	19
20	13 bathroom remodeling	2005	4,979	332	15	332		1,520	20
21	Bathroom steel door frames	2006	1,353	90	15	90		380	21
22	5 ton condensor	2005	8,697	870	10	870		4,200	22
23	Fire system engineering	2005	2,787	186	15	186		842	23
24	North basement office remodel	2006	2,460	164	15	164		721	24
25	Foam roofing	2006	2,292	153	15	153		684	25
26	Door alarm and keypad	2005	2,592	259	10	259		1,177	26
27	Fire door closures and shutters	2005	3,383	338	10	338		1,548	27
28	B hall shower tile	2006	935	62	15	62		274	28
29	Bathtub	2006	10,264	1,026	10	1,026		4,509	29
30	Generator upgrade	2006	15,624	2,474	7	2,232	(242)	9,484	30
31	Intercom replacement	2006	2,500		7	357	357	1,488	31
32	Generator upgrade	2005	1,697		7	242	242	1,210	32
33	Front door automatic opener	2006	3,610	361	10	361		1,447	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,539,378	\$ 40,277		\$ 49,406	\$ 9,129	\$ 1,071,044	34

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/09

Ending:

06/30/10

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,539,378	\$ 40,277		\$ 49,406	\$ 9,129	\$ 1,071,044	1
2	Fire alarm system	2006	3,478	497	7	497		1,924	2
3	Air conditioning	2006	2,059	137	15	137		649	3
4	Guttering system	2007	2,573	103	25	103		822	4
5	Air conditioning	2007	7,549	503	15	503		1,603	5
6	Door alarm system	2006	1,033	148	7	148		573	6
7	Landscaping	2007	25,605	2,561	10	2,561		6,153	7
8	Dock improvements	2008	2,905		15				8
9	Fornt door opener	2008	404	40	10	40		100	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		834	10
11	Garbage disposal	2008	937	94	10	94		211	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		1,246	12
13	West side window replacement	2007	16,191	1,079	15	1,079		3,063	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831	255	15	255		574	14
15	Furnace	2008	4,070	581	7	581		1,404	15
16	Ductwork repair	2008	3,523	235	15	235		531	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		5,222	17
18	Shower repair	2008	820	117	7	117		279	18
19	Kitchen water softener	2008	1,819	260	7	260		588	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		1,311	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		743	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		452	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		527	23
24	Daffodil drive - air conditioner	2009	916	131	7	131		142	24
25	Dock Upgrade	2008	11,078	739	15	739		1,231	25
26	Fire system upgrade	2008	2,860	191	15	191		334	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		1,686	27
28	New window	2009	316	21	15	21		25	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		757	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		1,867	30
31	Therapy room air conditioner	2009	1,535	219	7	219		329	31
32	Window	2009	2,974	198	15	198		231	32
33	Door Alarm/Intercom Upgrades	2010	3,267	72	15	72		72	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,760,826	\$ 56,572		\$ 65,701	\$ 9,129	\$ 1,106,527	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,760,826	\$ 56,572		\$ 65,701	\$ 9,129	\$ 1,106,527	1
2	Fire alarm upgrade	2009	3,267	145	15	145		145	2
3	Generator Repairs	2010	9,550		20				3
4	Cordless phone system for nurses	2010	1,010	28	15	28		28	4
5	New heating/cooling unit	2010	16,616	198	7	198		198	5
6	Constructed new nurses office	2010	14,841	124	15	124		124	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	1,650	15	1,650		1,650	7
8	New flooring, paint and trim doors	2010	5,742	160	15	160		160	8
9	Construct tranquility room	2010	27,914	310	15	310		310	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,874,708	\$ 59,187		\$ 68,316	\$ 9,129	\$ 1,109,142	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:

07/01/09

Ending:

06/30/10

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	\$ 304,155	\$ 38,480	\$ 38,480	\$	various	\$ 219,915	71
72	Current Year Purchases	39,581	1,798	1,798		various	1,798	72
73	Fully Depreciated Assets	501,806				various	501,806	73
74								74
75	TOTALS	\$ 845,542	\$ 40,278	\$ 40,278	\$		\$ 723,519	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	1998	\$ 46,290	\$	\$	\$		\$ 46,290	76
77	Patient Transportation	Paint Clubvan	2003	1,147					1,147	77
78	Bus Tie Downs	03 Ford Bus	2006	2,184	437	437			1,878	78
79	Patient Transportation	03 Ford Bus	2004	42,561					42,561	79
80	TOTALS			\$ 92,182	\$ 437	\$ 437	\$		\$ 91,876	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)	\$ 2,818,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,902	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,031	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,129	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,924,537	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	\$ 2,350,966	\$ 62,387	\$ 999,028	86
87	Buffet Line	18,500	2,643	11,012	87
88					88
89					89
90					90
91	TOTALS	\$ 2,369,466	\$ 65,030	\$ 1,010,040	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: \$ 7,188 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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 5,165	\$	\$ 5,165
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		240		240
9	TOTALS	\$	\$ 5,405	\$	\$ 5,405
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,405		

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (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	\$	130	\$ 7,790	\$	130	\$ 7,790	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		22	1,202		22	1,202	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		110	6,561		110	6,561	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>physical therapy asst</u>	10a.1	1789	40,758	20	829		1,809	41,587	12
13	Other (specify): <u>COTA</u>	10a.3			149	6,335		149	6,335	13
14	TOTAL			\$ 40,758	431	\$ 22,717	\$	2,220	\$ 63,475	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: 07/01/09Ending: 06/30/10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 202,255	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	250,136		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	328,813		5
6	Prepaid Insurance	24,089		6
7	Other Prepaid Expenses	464		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Insurance Trusts</u>	10,018		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 815,775	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,249		13
14	Buildings, at Historical Cost	3,511,564		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,256,566		16
17	Accumulated Depreciation (book methods)	(2,796,473)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,995,906	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,811,681	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 82,719	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	182,488		30
31	Accrued Taxes Payable (excluding real estate taxes)	462		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Operating loan payable</u>	80,000		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 345,669	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 345,669	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,466,012	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,811,681	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 2,446,145	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 2,446,145	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	19,867	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 19,867	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,466,012	<b>24</b> *

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning: 07/01/09

Ending: 06/30/10

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,921,182	1
2	Discounts and Allowances for all Levels	(318,868)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,602,314	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,263	6
7	Oxygen	2,320	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 96,583	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,057	12
13	Barber and Beauty Care	14,357	13
14	Non-Patient Meals	26,868	14
15	Telephone, Television and Radio	9,590	15
16	Rental of Facility Space		16
17	Sale of Drugs	31,373	17
18	Sale of Supplies to Non-Patients	1,878	18
19	Laboratory	11,473	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,021	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 102,617	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	484,008	24
25	Interest and Other Investment Income***	15,528	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 499,536	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Residential Revenue</u>	559,268	28
28a	<u>Other Income</u>	3,852	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 563,120	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,864,170	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,211,147	31
32	Health Care	2,273,769	32
33	General Administration	1,081,425	33
<b>B. Capital Expense</b>			
34	Ownership	162,376	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	81,093	35
36	Provider Participation Fee	34,493	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,844,303	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	19,867	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 19,867	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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:

07/01/09

Ending:

06/30/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,080	\$ 59,139	\$ 28.43	1
2	Assistant Director of Nursing	1,413	1,482	26,900	18.15	2
3	Registered Nurses	9,257	10,882	352,516	32.39	3
4	Licensed Practical Nurses	15,630	19,447	377,479	19.41	4
5	CNAs & Orderlies	63,691	77,137	895,732	11.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,745	2,007	26,350	13.13	9
10	Activity Assistants	4,824	5,310	59,062	11.12	10
11	Social Service Workers	4,466	4,932	58,228	11.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,008	13,204	136,995	10.38	14
15	Cook Helpers/Assistants	11,320	12,920	113,295	8.77	15
16	Dishwashers					16
17	Maintenance Workers	7,355	7,971	128,021	16.06	17
18	Housekeepers	12,476	13,907	146,265	10.52	18
19	Laundry	5,941	6,691	63,628	9.51	19
20	Administrator	1,968	2,160	70,828	32.79	20
21	Assistant Administrator	2,056	2,160	62,691	29.02	21
22	Other Administrative	4,431	4,707	56,492	12.00	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	3,018	3,352	30,400	9.07	31
32	Other Health C: PTA	1,723	1,936	92,354	47.70	32
33	Other(specify) Env Serv Dir	1,984	2,160	54,348	25.16	33
34	TOTAL (lines 1 - 33)	166,258	194,445	\$ 2,810,723 *	\$ 14.46	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	120	\$ 5,560	1.3	35
36	Medical Director		4,800	9.3	36
37	Medical Records Consultant	34	2,210	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,438	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	21	1,226	11.3	44
45	Social Service Consultant	12	780	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	187	\$ 17,014		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	95	\$ 5,241	10.3	50
51	Licensed Practical Nurses	357	15,610	10.3	51
52	Certified Nurse Assistants/Aides	1,409	26,712	10.3	52
53	TOTAL (lines 50 - 52)	1,861	\$ 47,563		53





Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning: 07/01/09

Ending: 06/30/10

**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 \$2800
- (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. \$ 40,206 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. \$ 26,868
- (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.