

Facility Name & ID Number Fairview Haven

0008524 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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 N/A

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,392	13,555	1,745	20,692	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,392	13,555	1,745	20,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.98%

D. How many bed-hold days during this year were paid by the Department? None (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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/2/62

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 1,745

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number

Fairview Haven

0008524

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	249,742	31,085	103,344	384,171	384,171	(81,316)	302,855			1
2	Food Purchase		187,801		187,801	187,801	(23,564)	164,237			2
3	Housekeeping	176,638	43,416		220,054	220,054	(29,340)	190,714			3
4	Laundry	42,145	25,055		67,200	67,200		67,200			4
5	Heat and Other Utilities			88,126	88,126	88,126		88,126			5
6	Maintenance	225,282	71,137	29,046	325,465	325,465	(73,351)	252,114			6
7	Other (specify):*										7
8	TOTAL General Services	693,807	358,494	220,516	1,272,817	1,272,817	(207,571)	1,065,246			8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000	6,000		6,000			9
10	Nursing and Medical Records	1,699,945	152,710	46,570	1,899,225	1,899,225	(108,300)	1,790,925			10
10a	Therapy	102,992	1,367	40,472	144,831	144,831		144,831			10a
11	Activities	95,396	8,599	11,198	115,193	115,193		115,193			11
12	Social Services	65,182		1,595	66,777	66,777		66,777			12
13	CNA Training			488	488	488		488			13
14	Program Transportation			12,224	12,224	12,224		12,224			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,963,515	162,676	118,547	2,244,738	2,244,738	(108,300)	2,136,438			16
	C. General Administration										
17	Administrative	161,494			161,494	161,494		161,494			17
18	Directors Fees										18
19	Professional Services			10,726	10,726	10,726		10,726			19
20	Dues, Fees, Subscriptions & Promotions			10,982	10,982	10,982	(1,180)	9,802			20
21	Clerical & General Office Expenses	48,250	12,252	65,960	126,462	126,462	(338)	126,124			21
22	Employee Benefits & Payroll Taxes			680,187	680,187	680,187		680,187			22
23	Inservice Training & Education			12,200	12,200	12,200		12,200			23
24	Travel and Seminar			7,700	7,700	7,700		7,700			24
25	Other Admin. Staff Transportation			2,167	2,167	2,167		2,167			25
26	Insurance-Prop.Liab.Malpractice			64,699	64,699	64,699		64,699			26
27	Other (specify):*										27
28	TOTAL General Administration	209,744	12,252	854,621	1,076,617	1,076,617	(1,518)	1,075,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,867,066	533,422	1,193,684	4,594,172	4,594,172	(317,389)	4,276,783			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:

7/1/2012

Ending:

6/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			100,144	100,144		100,144	1,282	101,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115	115		115	(115)				32
33	Real Estate Taxes			756	756		756	(756)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,691	7,691		7,691		7,691			35
36	Other (specify):*											36
37	TOTAL Ownership			108,706	108,706		108,706	411	109,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,285	17,642	81,927		81,927		81,927			39
40	Barber and Beauty Shops			17,934	17,934		17,934		17,934			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,253	142,253		142,253		142,253			42
43	Other (specify):* Non-allowable Costs			186,379	186,379		186,379	(186,379)				43
44	TOTAL Special Cost Centers		64,285	364,208	428,493		428,493	(186,379)	242,114			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,867,066	597,707	1,666,598	5,131,371		5,131,371	(503,357)	4,628,014			45

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning: 7/1/2012

Ending: 6/30/13

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,454)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,809)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,282	30		9
10	Interest and Other Investment Income	(115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,466)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,393)	43		16
17	Non-Care Related Fees	(1,180)	20		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	(16,057)	43		24
25	Fund Raising, Advertising and Promotional	(8,675)	43		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 See Page 5A	(439,490)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (503,357)		\$	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)	\$ (503,357)		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

Fairview Haven

ID# 0008524

Report Period Beginning: 7/1/2012

Ending: 6/30/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Revenue	\$ (338)	21	1
2	Offset Vending Income	(2,110)	2	2
3	Non Care LPN Wages	(75,060)	10	3
4	Non Care CNA Wages	(33,240)	10	4
5	Non Care Dietary Wages	(81,316)	1	5
6	Non Care Housekeeping Wages	(29,340)	3	6
7	Non Care Maintenance Wages	(73,351)	6	7
8	Non Care Real Estate Taxes	(756)	33	8
9	Non Care Expenses	(22,511)	43	9
10	Non Care Utilities	(55,442)	43	10
11	Non Care Depreciation	(64,069)	43	11
12	Non Care Laundry	(551)	43	12
13	Other promotional advertising	(1,406)	43	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		(439,490)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	(81,316)	0	0	0	0	0	0	0	0	0	0	(81,316)	1
2	Food Purchase	(23,564)	0	0	0	0	0	0	0	0	0	0	(23,564)	2
3	Housekeeping	(29,340)	0	0	0	0	0	0	0	0	0	0	(29,340)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(73,351)	0	0	0	0	0	0	0	0	0	0	(73,351)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(207,571)	0	(207,571)	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	(108,300)	0	0	0	0	0	0	0	0	0	0	(108,300)	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	(108,300)	0	(108,300)	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	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	20
21	Clerical & General Office Expenses	(338)	0	0	0	0	0	0	0	0	0	0	(338)	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	(1,518)	0	(1,518)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(317,389)	0	(317,389)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/1/2012 Ending:

6/30/13

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	1,282	0	0	0	0	0	0	0	0	0	0	1,282	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115)	0	0	0	0	0	0	0	0	0	0	(115)	32
33	Real Estate Taxes	(756)	0	0	0	0	0	0	0	0	0	0	(756)	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	411	0	0	0	0	0	0	0	0	0	0	411	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):*	(186,379)	0	0	0	0	0	0	0	0	0	0	(186,379)	43
44	TOTAL Special Cost Centers	(186,379)	0	0	0	0	0	0	0	0	0	0	(186,379)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(503,357)	0	0	0	0	0	0	0	0	0	0	(503,357)	45

Facility Name & ID Number

Fairview Haven

0008524

Report Period Beginning:

7/1/2012

Ending:

6/30/13

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule 6A		None		None		

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.

Fairview Haven
0008524
Period Beginning
Period End

7/1/2012
6/30/13

Schedule 6A

VII. Related Parties- Column 1

Board of Directors		
Name	Title	Ownership %
Glen Stedinger	President	0%
Jerry Kaisner	Vice President	0%
Rod Steffen	Treasurer	0%
Marvin Bachtold	Secretary	0%
Ivan Fehr	Trustee	0%
Nelson Zehr	Trustee	0%
Richard Wenger	Trustee	0%
Eric Kaeb	Trustee	0%
Mark Waldbeeser	Trustee	0%

Note: None of the Board of Directors directly provided services to the nursing home

Note: There are no entities in which a Board member has ownership that conducted business transactions with this nursing home

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	None								\$	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: 7/1/2012 Ending: 6/30/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

2012 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 2012 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 2012.

	(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.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

7/1/2012 Ending:

6/30/13

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).

Assisted Living-13 units
Independent Living-17 units

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Fairview Haven

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	1962	1962	\$ 145,220	\$ 698	50	\$ 698	\$	\$ 144,514	4
5	8	1999	1999	354,656		39	9,094	9,094	129,733	5
6										6
7										7
8										8
Improvement Type**										
9	Additions 65-66	1965		258	5	50	5		244	9
10	Additions 66-67	1966		2,116	43	50	42	(1)	1,982	10
11	Additions 67-68	1967		13,436	269	50	269		12,368	11
12	Additions 69-70	1969		1,893	38	50	38		1,669	12
13	Additions 71-72	1971		26,066	521	50	521		21,889	13
14	Additions 72-73	1972		6,314	126	50	126		5,172	14
15	Additions 77-78	1978		4,507	90	50	90		3,197	15
16	Sprinkler System	1979		42,306	846	50	846		28,907	16
17	Generator Room	1979		8,460	169	50	169		5,777	17
18	Additions 79-80	1979		1,578	32	50	32		1,097	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		30			4,260	22
23	Additions 79-80	1979		3,516	70	50	70		2,385	23
24	Smoke Detector	1980		1,575		15			1,575	24
25	Additions 80-81	1981		16,207	324	50	324		10,535	25
26	Porch Enclosure	1981		9,453	189	50	189	(0)	6,017	26
27	Dining Room Lighting	1981		2,838		30			2,838	27
28	Lobby Lighting	1981		763		30			763	28
29	Linen Exhaust Fan	1982		376		10			376	29
30	Sprinkler System Imp	1982		1,977	40	50	40		1,251	30
31	Room D2 Addition	1982		432	9	50	9		278	31
32	Room B14 Addition	1982		2,380	48	50	48		1,491	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		4,812	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:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	New Sign	1983	\$ 994	\$	10	\$	\$	\$ 994	37
38	Landscape	1983	1,455	49	30	39	(10)	1,455	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		142	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		10,511	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	7,735	48
49	Courtyard	1987	19,000	633	30	633		16,513	49
50	Remodel Linen Room	1988	21,731	148	17		(148)	21,731	50
51	Courtyard	1988	1,827	61	30	61		1,540	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		19,073	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)	142,213	57
58	Office Remodel	1994	20,943	838	25	838		16,231	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		15			2,697	61
62	Room B-1	1995	833	33	25	33		605	62
63	Replace Main sprinkler system	1995	2,550		15			2,550	63
64	Repair dining room ice machine wall	1996	948	38	25	38		657	64
65	Front parking lot and sidewalk	1995	20,675		15			20,675	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	\$ 14,197		\$ 22,808	\$ 8,611	\$ 950,294	70

**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:

7/1/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,263,078	\$ 14,197		\$ 22,808	\$ 8,611	\$ 950,294	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		15			649	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		1,635	15
16	Sink	2000	746		7			746	16
17	Water heater	1999	6,669		10			6,669	17
18	Water heater	2001	3,647		10			3,647	18
19	B Wing air conditioner	2000	1,623		7			1,623	19
20	Dry pendants	2000	2,762		10			2,762	20
21	Nurses station carpet	2000	1,151		10			1,151	21
22	Large capacity water heater	2001	5,290		10			5,290	22
23	Telephone system	2002	853		7			853	23
24	Air conditioning unit	2002	1,730		10			1,730	24
25	Nurse call system	2002	64,740		10			64,740	25
26	Draperies	2003	1,243	73	10	77	4	1,243	26
27	Phone system wiring	2002	1,496		7			1,496	27
28	Water cooler	2003	526		7			526	28
29	Lightning arrestors	2002	1,175	39	10	35	(4)	1,175	29
30	Eyewash station	2002	884	37	10	41	4	884	30
31	Firecode updates	2002	4,850	323	15	323		3,417	31
32	Activity draperies	2003	662	61	10	63	2	662	32
33	Concrete improvements	2003	4,566	304	15	304		3,064	33
34	TOTAL (lines 1 thru 33)		\$ 1,406,527	\$ 15,159		\$ 23,776	\$ 8,617	\$ 1,090,570	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:

7/1/2012

Ending:

6/30/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,406,527	\$ 15,159		\$ 23,776	\$ 8,617	\$ 1,090,570	1
2	Plumbing rough in	2004	955	95	10	96	1	888	2
3	Window blinds	2004	643		7			643	3
4	Kitchen grease trap	2003	738	74	10	74		736	4
5	Driveway	2004	4,504	300	15	300		2,724	5
6	Sprinkler system	2004	1,090	109	10	109		995	6
7	Kitchen grease trap	2003	2,561	171	15	171		1,664	7
8	Bath tub	2003	12,232	1,223	10	1,223		11,681	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		199	10
11	Light fixtures	2003	595	60	10	60		573	11
12	Air conditioning units	2003	4,222	281	15	281		2,734	12
13	Dining draperies	2004	1,300		7			1,300	13
14	Front parking lot	2005	5,912	394	15	394		3,168	14
15	Generator Heater	2005	770		7			770	15
16	Door monitors	2004	1,980		7			1,980	16
17	Sprinkler rehab	2004	26,592	2,659	10	2,659		22,744	17
18	5T Air conditioning	2005	2,150		7			2,150	18
19	C Wing ductwork	2005	3,013	201	15	201		1,609	19
20	13 bathroom remodeling	2005	4,979	332	15	332		2,516	20
21	Bathroom steel door frames	2006	1,353	90	15	90		650	21
22	5 ton condensor	2005	8,697	870	10	870		6,810	22
23	Fire system engineering	2005	2,787	186	15	186		1,400	23
24	North basement office remodel	2006	2,460	164	15	164		1,213	24
25	Foam roofing	2006	2,292	153	15	153		1,143	25
26	Door alarm and keypad	2005	2,592	259	10	259		1,954	26
27	Fire door closures and shutters	2005	3,383	338	10	338		2,562	27
28	B hall shower tile	2006	935	62	15	62		460	28
29	Bath tub	2006	10,264	1,026	10	1,026		7,587	29
30	Generator upgrade	2006	15,624	1,856	7	2,232	376	16,180	30
31	Intercom replacement	2006	2,500		7	298	298	2,500	31
32	Generator upgrade	2005	1,697		7	3	3	1,697	32
33	Front door automatic opener	2006	3,610	361	10	361		2,530	33
34	TOTAL (lines 1 thru 33)		\$ 1,539,378	\$ 26,444		\$ 35,739	\$ 9,295	\$ 1,196,330	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:

7/1/2012

Ending:

6/30/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,539,378	\$ 26,444		\$ 35,739	\$ 9,295	\$ 1,196,330	1
2	Fire alarm system	2006	3,478	497	7	497		3,415	2
3	Air conditioning	2006	2,059	137	15	137		1,060	3
4	Guttering system	2007	2,573	103	25	103		1,131	4
5	Air conditioning	2007	7,549	503	15	503		3,112	5
6	Door alarm system	2006	1,033	25	7	148	123	1,017	6
7	Landscaping	2007	25,605	2,561	10	2,561		13,836	7
8	Dock improvements	2008	2,905	194	15		(194)		8
9	Fornt door opener	2008	404	40	10	40		220	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		2,100	10
11	Garbage disposal	2008	937	94	10	94		493	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		2,971	12
13	West side window replacement	2007	16,191	1,079	15	1,079		6,300	13
14	Rms a-2.4 windows, drywall, trim	2008	3,831	255	15	255		1,339	14
15	Furnace	2008	4,070	581	7	581		3,147	15
16	Ductwork repair	2008	3,523	235	15	235		1,236	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		11,099	17
18	Shower repair	2008	820	117	7	117		630	18
19	Kitchen water softener	2008	1,819	260	7	260		1,368	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		3,039	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		2,801	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		1,355	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		1,430	23
24	Daffodil drive - air conditioner	2009	916	131	7	131		535	24
25	Dock Upgrade	2008	11,078	739	15	739		3,448	25
26	Fire system upgrade	2008	2,860	191	15	191		907	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		5,733	27
28	New window	2009	316	21	15	21		88	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		2,854	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		5,602	30
31	Therapy room air conditioner	2009	1,535	219	7	219		986	31
32	Window	2009	2,974	198	15	198		825	32
33	Door Alarm/Intercom Upgrades	2010	3,250	217	15	218	1	726	33
34	TOTAL (lines 1 thru 33)		\$ 1,760,809	\$ 42,954		\$ 52,179	\$ 9,225	\$ 1,281,133	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:

7/1/2012

Ending:

6/30/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,760,809	\$ 42,954		\$ 52,179	\$ 9,225	\$ 1,281,133	1
2	Fire alarm upgrade	2009	3,267	218	15	218		799	2
3	Generator Repairs	2010	9,550	478	20	478		956	3
4	Cordless phone system for nurses	2010	1,010	134	15	67	(67)	229	4
5	New heating/cooling unit	2010	16,616	2,374	7	2,374		7,320	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		3,091	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		8,637	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		1,309	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		5,893	9
10	Room Heaters	2011	1,540	220	7	220		523	10
11	Windows	2011	5,583	372	15	372		760	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		1,778	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		823	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		11,012	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		525	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		1,217	16
17	Gas line for dryers	2012	1,619	108	15	108		202	17
18	Generator Repairs	2012	2,299	115	20	115		187	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		484	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		1,556	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		130	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		1,370	22
23	Social Services AC repair	2012	5,415	331	15	331		331	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	355	15	355		355	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	79	15	79		79	25
26	Replace Sprinkler System	2013	57,060	1,426	15	1,426		1,426	26
27	Dining Room Exit Door replaced	2013	3,419	76	15	76		76	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	60	15	60		60	28
29	Room Remodel - Flooring, windows, cabinets, drywall, trim, paint	2013	31,485		15				29
30									30
31	Prior Year Improvements Not Included on Prior Year Cost Reports			7,876			(7,876)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,154,924	\$ 72,884		\$ 74,166	\$ 1,282	\$ 1,332,261	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 154,644	\$ 22,169	\$ 22,169	\$	5-10	\$ 88,959	71
72	Current Year Purchases	24,844	1,691	1,691		7	1,691	72
73	Fully Depreciated Assets	699,058				5-10	699,058	73
74								74
75	TOTALS	\$ 878,546	\$ 23,860	\$ 23,860	\$		\$ 789,708	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	98 club van and painting	1998/2003	\$ 47,437	\$	\$	\$	5	\$ 47,437	76
77	Patient Transport	03 ford bus	2006	42,561				5	42,561	77
78	Bus Tie Downs	03 ford bus	2006	2,184				5	2,184	78
79	Patient Transport	Chrysler town and country	2011	17,000	3,400	3,400		5	8,358	79
80	TOTALS			\$ 109,182	\$ 3,400	\$ 3,400	\$		\$ 100,540	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)	\$ 3,149,074	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,426	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,282	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,222,509	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	\$ 2,356,275	\$ 61,867	\$ 1,164,719	86
87	Buffet Line	18,500	2,202	18,500	87
88	East Haven Condo (Down Payment)	34,000			88
89					89
90					90
91	TOTALS	\$ 2,408,775	\$ 64,069	\$ 1,183,219	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning: 7/1/2012

Ending: 6/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 N/A.

None

None

9. Option to Buy: YES NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,691 Description: Copier

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. 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: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> 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	\$	\$ 488	\$	\$ 488
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 488	\$	\$ 488
10	SUM OF line 9, col. 1 and 2 (e)	\$	488		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (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	\$	522	\$ 24,072	\$	522	\$ 24,072	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		23	2,049		23	2,049	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		300	14,351	1,367	300	15,718	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				64,285		64,285	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	845	\$ 40,472	\$ 65,652	845	\$ 106,124	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: 7/1/2012

Ending:

6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 295,443	\$ 295,443	1
2	Cash-Patient Deposits	1,881	1,881	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	308,492	308,492	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	466,962	466,962	5
6	Prepaid Insurance	25,397	25,397	6
7	Other Prepaid Expenses	882	882	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Insurance Trusts</u>	15,539	15,539	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,114,596	\$ 1,114,596	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,422	6,422	13
14	Buildings, at Historical Cost	1,884,695	2,154,924	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	987,727	987,728	16
17	Accumulated Depreciation (book methods)	(2,099,065)	(2,222,509)	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: <u>Non-Care Assets</u>)	1,191,556	1,191,556	22
23	Other(specify): <u>East Haven Condo Deposit</u>	34,000	34,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,005,335	\$ 2,152,121	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,119,931	\$ 3,266,717	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,623	\$ 128,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,881	1,881	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,887	121,887	30
31	Accrued Taxes Payable (excluding real estate taxes)	348	348	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 252,739	\$ 252,739	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)	\$ 252,739	\$ 252,739	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,867,192	\$ 3,013,978	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,119,931	\$ 3,266,717	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,647,331	1
2	Restatements (describe):		2
3	Prior Period Adjustments	1,644	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,648,975	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	218,217	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)	\$ 218,217	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)	\$ 2,867,192	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,429,776	1
2	Discounts and Allowances for all Levels	(480,841)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,948,935	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	16,973	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 16,973	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	2,110	12
13	Barber and Beauty Care	16,948	13
14	Non-Patient Meals	21,454	14
15	Telephone, Television and Radio	10,451	15
16	Rental of Facility Space		16
17	Sale of Drugs	6,793	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	266	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 58,022	23
D. Non-Operating Revenue			
24	Contributions	674,354	24
25	Interest and Other Investment Income***	7,411	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 681,765	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent and Assisted Living Fees	631,489	28
28a	Resident Personal Items/Miscellaneous Revenue	12,404	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 643,893	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,349,588	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,272,817	31
32	Health Care	2,244,738	32
33	General Administration	1,076,617	33
B. Capital Expense			
34	Ownership	108,706	34
C. Ancillary Expense			
35	Special Cost Centers	286,240	35
36	Provider Participation Fee	142,253	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,131,371	40
41	Income before Income Taxes (line 30 minus line 40)**	218,217	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 218,217	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 614,878	44
45	Private Pay - Net Inpatient Revenue	2,816,272	45
46	Medicare - Net Inpatient Revenue	538,233	46
47	Other-(specify) <u>Other Contractual Allowances</u>	(20,448)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,948,935	49

* 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:

7/1/2012

Ending:

6/30/13

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	1,928	2,080	\$ 66,989	\$ 32.21	1
2	Assistant Director of Nursing	1,623	1,784	48,017	26.92	2
3	Registered Nurses	6,594	7,065	170,079	24.07	3
4	Licensed Practical Nurses	16,394	17,194	430,134	25.02	4
5	CNAs & Orderlies	64,707	75,858	840,554	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,150	5,745	102,992	17.93	8
9	Activity Director	1,655	1,842	25,676	13.94	9
10	Activity Assistants	6,075	6,517	69,720	10.70	10
11	Social Service Workers	4,836	5,072	65,182	12.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,781	10,766	122,875	11.41	14
15	Cook Helpers/Assistants	14,183	14,739	126,867	8.61	15
16	Dishwashers					16
17	Maintenance Workers	11,173	12,101	225,282	18.62	17
18	Housekeepers	17,158	18,070	176,638	9.78	18
19	Laundry	4,143	4,602	42,145	9.16	19
20	Administrator	1,848	2,080	83,045	39.93	20
21	Assistant Administrator	1,896	2,080	78,449	37.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,085	4,282	48,250	11.27	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	1,541	1,574	41,134	26.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	3,549	3,884	103,038	26.53	33
34	TOTAL (lines 1 - 33)	178,319	197,335	\$ 2,867,066 *	\$ 14.53	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	105	\$ 6,960	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	25	1,769	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	148	4,290	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,128	L11, C3	44
45	Social Service Consultant	20	1,595	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	\$ 21,742		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 367	L10, C3	50
51	Licensed Practical Nurses	199	7,453	L10, C3	51
52	Certified Nurse Assistants/Aides	1,009	25,456	L10, C3	52
53	TOTAL (lines 50 - 52)	1,216	\$ 33,276		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning: 7/1/2012

Ending: 6/30/13

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. 4,504 - LSN
- (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? N/A
- (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? 7-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,810 Line 10
- (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. N/A
- (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. \$ 142,253
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 23,564
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 85
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? No
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.