



Facility Name & ID Number Fairview Haven

# 0008524 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,474	15,000	1,319	20,793	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,474	15,000	1,319	20,793	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.42%

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 1,319

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: 06/30/14 Fiscal Year: 06/30/14

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

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	251,358	23,883	105,415	380,656		380,656	(74,892)	305,764		1
2	Food Purchase		201,010		201,010		201,010	(22,421)	178,589		2
3	Housekeeping	174,754	43,894		218,648		218,648	(29,220)	189,428		3
4	Laundry	46,191	23,296		69,487		69,487		69,487		4
5	Heat and Other Utilities			98,634	98,634		98,634		98,634		5
6	Maintenance	233,094	83,020	31,184	347,298		347,298	(58,567)	288,731		6
7	Other (specify):* Waste Removal										7
8	<b>TOTAL General Services</b>	705,397	375,103	235,233	1,315,733		1,315,733	(185,100)	1,130,633		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,696,749	138,551	68,376	1,903,676		1,903,676	(59,389)	1,844,287		10
10a	Therapy	97,468	509	111,884	209,861		209,861		209,861		10a
11	Activities	91,536	10,055	11,097	112,688		112,688		112,688		11
12	Social Services	67,424		1,280	68,704		68,704		68,704		12
13	CNA Training										13
14	Program Transportation			10,837	10,837		10,837		10,837		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,953,177	149,115	209,474	2,311,766		2,311,766	(59,389)	2,252,377		16
	<b>C. General Administration</b>										
17	Administrative	165,008			165,008		165,008		165,008		17
18	Directors Fees										18
19	Professional Services			6,107	6,107		6,107		6,107		19
20	Dues, Fees, Subscriptions & Promotions			16,342	16,342		16,342	(50)	16,292		20
21	Clerical & General Office Expenses	46,421	11,269	76,576	134,266		134,266		134,266		21
22	Employee Benefits & Payroll Taxes			659,145	659,145		659,145		659,145		22
23	Inservice Training & Education			14,327	14,327		14,327		14,327		23
24	Travel and Seminar			7,341	7,341		7,341		7,341		24
25	Other Admin. Staff Transportation			2,174	2,174		2,174		2,174		25
26	Insurance-Prop.Liab.Malpractice			65,672	65,672		65,672		65,672		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	211,429	11,269	847,684	1,070,382		1,070,382	(50)	1,070,332		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,870,003	535,487	1,292,391	4,697,881		4,697,881	(244,539)	4,453,342		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:

07/01/2013

Ending:

06/30/2014

## 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	
	<b>D. Ownership</b>											
30	Depreciation			107,573	107,573	107,573	1,217	108,790				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172	172	172	(172)					32
33	Real Estate Taxes			3,236	3,236	3,236	(3,236)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,863	7,863	7,863		7,863				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			118,844	118,844	118,844	(2,191)	116,653				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,087	13,125	72,212	72,212		72,212				39
40	Barber and Beauty Shops			19,339	19,339	19,339		19,339				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,820	159,820	159,820		159,820				42
43	Other (specify):* Non-allowable Costs	52,000		206,208	258,208	258,208	(258,208)					43
44	<b>TOTAL Special Cost Centers</b>	52,000	59,087	398,492	509,579	509,579	(258,208)	251,371				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,922,003	594,574	1,809,727	5,326,304	5,326,304	(504,938)	4,821,366				45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,109)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,857)	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	1,217	30		9
10	Interest and Other Investment Income	(172)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,497)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,066)	43		16
17	Non-Care Related Fees	(50)	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	(15,881)	43		24
25	Fund Raising, Advertising and Promotional	(8,427)	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	(444,096)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (504,938)</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>\$ (504,938)</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

Report Period Beginning: 07/01/2013  
 Ending: 06/30/2014

ID# 0008524

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Vending Income	\$ (1,312)	2	1
2	Non Care RN Wages	(7,138)	10	2
3	Non Care LPN Wages	(18,443)	10	3
4	Non Care CNA Wages	(33,808)	10	4
5	Non Care Dietary Wages	(74,892)	1	5
6	Non Care Housekeeping Wages	(29,220)	3	6
7	Non Care Maintenance Wages	(58,567)	6	7
8	Non Care Real Estate Taxes	(3,236)	33	8
9	Non Care Expenses	(41,866)	43	9
10	Non Care Utilities	(67,931)	43	10
11	Non Care Depreciation	(55,516)	43	11
12	Non Care Laundry	(167)	43	12
13	Non Care ALF/ILF wages	(52,000)	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	<b>Total</b>	(444,096)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

## 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	(74,892)	0	0	0	0	0	0	0	0	0	0	(74,892)	1
2	Food Purchase	(22,421)	0	0	0	0	0	0	0	0	0	0	(22,421)	2
3	Housekeeping	(29,220)	0	0	0	0	0	0	0	0	0	0	(29,220)	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	(58,567)	0	0	0	0	0	0	0	0	0	0	(58,567)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(185,100)</b>	<b>0</b>	<b>(185,100)</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	(59,389)	0	0	0	0	0	0	0	0	0	0	(59,389)	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>(59,389)</b>	<b>0</b>	<b>(59,389)</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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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>(50)</b>	<b>0</b>	<b>(50)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(244,539)</b>	<b>0</b>	<b>(244,539)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

## 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	1,217	0	0	0	0	0	0	0	0	0	0	1,217	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(172)	0	0	0	0	0	0	0	0	0	0	(172)	32
33	Real Estate Taxes	(3,236)	0	0	0	0	0	0	0	0	0	0	(3,236)	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>(2,191)</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>(2,191)</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):*	(258,208)	0	0	0	0	0	0	0	0	0	0	(258,208)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(258,208)</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>(258,208)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(504,938)</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>(504,938)</b>	<b>45</b>

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item							
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

7/1/2013  
6/30/2014

**Schedule 6A**

**VII. Related Parties- Column 1**

<b>Board of Directors</b>		
<b>Name</b>	<b>Title</b>	<b>Ownership %</b>
Jerry Kaisner	President	0%
Eric Kaeb	Vice President	0%
Rod Steffen	Treasurer	0%
Richard Wenger	Secretary	0%
Duane Walter	Trustee	0%
Nelson Zehr	Trustee	0%
Ivan Fehr	Trustee	0%
Mark Waldbeeser	Trustee	0%
Kevin Schaffer	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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	None							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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

## 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								\$	L17, C7	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: 07/01/2013 Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Fairview Haven

# 0008524

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1							\$	\$			\$						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6	Bluestem National Bank		X	Operations	Interest Only	1/31/08				0.0410	172						
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 172						
<b>B. Non-Facility Related*</b>																	
10																	
11								Interest Income Offset			(172)						
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (172)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 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.)	2013		\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2014 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:	2009	_____	8	<b>FOR BHF USE ONLY</b>		
	2010	_____	9			
	2011	_____	10			
	2012	_____	11			
	2013	_____	12			
<b>This facility is exempt from paying real estate taxes.</b>						
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.**

## 2013 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 2013 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 2013.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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:

07/01/2013 Ending:

06/30/2014

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-15 units

East Haven Condominium-14 units located off campus

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>	1
2					2
3	<b>TOTALS</b>	<b>90,000</b>		<b>\$ 6,422</b>	3

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

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06/30/2014

**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	\$	50	\$ 698	\$ 698	\$ 145,212	4
5	8		1999	1999	354,656		39	9,094	9,094	138,827	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Additions 65-66		1965		258	5	50	5		249	9
10	Additions 66-67		1966		2,116	42	50	42		2,024	10
11	Additions 67-68		1967		13,436	269	50	269		12,637	11
12	Additions 69-70		1969		1,893	38	50	38		1,707	12
13	Additions 71-72		1971		26,066	521	50	521		22,410	13
14	Additions 72-73		1972		6,314	126	50	126		5,298	14
15	Additions 77-78		1978		4,507	90	50	90		3,287	15
16	Sprinkler System		1979		42,306	846	50	846		29,753	16
17	Generator Room		1979		8,460	169	50	169		5,946	17
18	Additions 79-80		1979		1,578	32	50	32		1,129	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		2,455	23
24	Smoke Detector		1980		1,575		15			1,575	24
25	Additions 80-81		1981		16,207	324	50	324		10,859	25
26	Porch Enclosure		1981		9,453	189	50	189		6,206	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		1,291	30
31	Room D2 Addition		1982		432	9	50	9		287	31
32	Room B14 Addition		1982		2,380	48	50	48		1,539	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		4,976	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:

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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		30			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		147	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		10,810	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	8,021	48
49	Courtyard	1987	19,000	633	30	633		17,146	49
50	Remodel Linen Room	1988	21,731	98	17		(98)	21,731	50
51	Courtyard	1988	1,827	61	30	61		1,601	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		19,940	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)	149,148	57
58	Office Remodel	1994	20,943	838	25	838		17,069	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		638	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		695	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,263,078	\$ 13,399		\$ 22,769	\$ 9,370	\$ 973,063	70

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

Facility Name &amp; 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	
	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	\$ 13,399		\$ 22,769	\$ 9,370	\$ 973,063	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		1,760	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		10			1,243	26
27	Phone system wiring	2002	1,496	50	7		(50)	1,496	27
28	Water cooler	2003	526		7			526	28
29	Lightning arrestors	2002	1,175		10			1,175	29
30	Eyewash station	2002	884		10			884	30
31	Firecode updates	2002	4,850	323	15	323		3,740	31
32	Activity draperies	2003	662		10			662	32
33	Concrete improvements	2003	4,566	304	15	304		3,368	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,406,527	\$ 14,201		\$ 23,521	\$ 9,320	\$ 1,114,091	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:

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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	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,406,527	\$ 14,201		\$ 23,521	\$ 9,320	\$ 1,114,091	1
2	Plumbing rough in	2004	955	72	10	67	(5)	955	2
3	Window blinds	2004	643		7			643	3
4	Kitchen grease trap	2003	738		10	2	2	738	4
5	Driveway	2004	4,504	300	15	300		3,024	5
6	Sprinkler system	2004	1,090	91	10	95	4	1,090	6
7	Kitchen grease trap	2003	2,561	171	15	171		1,835	7
8	Bath tub	2003	12,232	510	10	551	41	12,232	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		220	10
11	Light fixtures	2003	595	25	10	22	(3)	595	11
12	Air conditioning units	2003	4,222	281	15	281		3,015	12
13	Dining draperies	2004	1,300		7			1,300	13
14	Front parking lot	2005	5,912	394	15	394		3,562	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		25,403	17
18	5T Air conditioning	2005	2,150		7			2,150	18
19	C Wing ductwork	2005	3,013	201	15	201		1,810	19
20	13 bathroom remodeling	2005	4,979	332	15	332		2,848	20
21	Bathroom steel door frames	2006	1,353	90	15	90		740	21
22	5 ton condensor	2005	8,697	870	10	870		7,680	22
23	Fire system engineering	2005	2,787	186	15	186		1,586	23
24	North basement office remodel	2006	2,460	164	15	164		1,377	24
25	Foam roofing	2006	2,292	153	15	153		1,296	25
26	Door alarm and keypad	2005	2,592	259	10	259		2,213	26
27	Fire door closures and shutters	2005	3,383	338	10	338		2,900	27
28	B hall shower tile	2006	935	62	15	62		522	28
29	Bathtub	2006	10,264	1,026	10	1,026		8,613	29
30	Generator upgrade	2006	15,624		7			15,624	30
31	Intercom replacement	2006	2,500		7			2,500	31
32	Generator upgrade	2005	1,697		7			1,697	32
33	Front door automatic opener	2006	3,610	361	10	361		2,891	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,539,378	\$ 22,767		\$ 32,126	\$ 9,359	\$ 1,227,900	34

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

Facility Name &amp; ID Number Fairview Haven

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,539,378	\$ 22,767		\$ 32,126	\$ 9,359	\$ 1,227,900	1
2	Fire alarm system	2006	3,478	83	7	63	(20)	3,478	2
3	Air conditioning	2006	2,059	137	15	137		1,197	3
4	Guttering system	2007	2,573	103	25	103		1,234	4
5	Air conditioning	2007	7,549	503	15	503		3,615	5
6	Door alarm system	2006	1,033		7	16	16	1,033	6
7	Landscaping	2007	25,605	2,561	10	2,561		16,397	7
8	Dock improvements	2008	2,905	194	15		(194)		8
9	Fornt door opener	2008	404	40	10	40		260	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		2,522	10
11	Garbage disposal	2008	937	94	10	94		587	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		3,546	12
13	West side window replacement	2007	16,191	1,079	15	1,079		7,379	13
14	Rms a-2.4 windows, drywall, trim	2008	3,831	255	15	255		1,594	14
15	Furnace	2008	4,070	581	7	581		3,728	15
16	Ductwork repair	2008	3,523	235	15	235		1,471	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		13,058	17
18	Shower repair	2008	820	117	7	117		747	18
19	Kitchen water softener	2008	1,819	260	7	260		1,628	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		3,615	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		3,487	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		1,656	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		1,731	23
24	Daffodil drive - air conditioner	2009	916	131	7	131		666	24
25	Dock Upgrade	2008	11,078	739	15	739		4,187	25
26	Fire system upgrade	2008	2,860	191	15	191		1,098	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		7,082	27
28	New window	2009	316	21	15	21		109	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		3,553	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		6,847	30
31	Therapy room air conditioner	2009	1,535	219	7	219		1,205	31
32	Window	2009	2,974	198	15	198		1,023	32
33	Door Alarm/Intercom Upgrades	2010	3,250	217	15	218	1	944	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,760,809	\$ 38,838		\$ 48,000	\$ 9,162	\$ 1,328,577	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:

07/01/2013

Ending:

06/30/2014

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 1,760,809	\$ 38,838		\$ 48,000	\$ 9,162	\$ 1,328,577	1
2	Fire alarm upgrade	2009	3,267	218	15	218		1,017	2
3	Generator Repairs	2010	9,550	478	20	478		1,434	3
4	Cordless phone system for nurses	2010	1,010	134	15	67	(67)	296	4
5	New heating/cooling unit	2010	16,616	2,374	7	2,374		9,694	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		4,080	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		10,966	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		1,692	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		7,754	9
10	Room Heaters	2011	1,540	220	7	220		743	10
11	Windows	2011	5,583	372	15	372		1,132	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		2,554	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		1,218	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		15,906	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		945	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		2,076	16
17	Gas line for dryers	2012	1,619	108	15	108		310	17
18	Generator Repairs	2012	2,299	115	20	115		302	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		731	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		2,890	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		255	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		2,466	22
23	Social Services AC repair	2012	5,415	361	15	361		692	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	426	15	426		781	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	157	15	157		236	25
26	Replace Sprinkler System	2013	57,060	3,804	15	3,804		5,230	26
27	Dining Room Exit Door replaced	2013	3,419	228	15	228		304	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	724	15	724		784	28
29	Resident Room Remodel- Angel Ave 1/15, Blessings Way 1, Country Ct 4, Daffodil Dr 1/3/4 (A-1 & 15, B-1, C-4 and D-1 & 3)	2013	31,485	2,099	15	2,099		2,099	29
30									30
31	Flooring, windows, cabinets, drywall, trim, paint								31
32									32
33	Prior Year Improvements Not Included on Prior Year Cost Reports			7,878			(7,878)		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,154,924	\$ 74,242		\$ 75,459	\$ 1,217	\$ 1,407,164	34

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

Facility Name & ID Number Fairview Haven

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 12E, Carried Forward		\$ 2,154,924	\$ 74,242		\$ 75,459	\$ 1,217	\$ 1,407,164	1
2	Fire Alarm System Repairs	2013	5,101	255	15	255		255	2
3	D-9: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	7,105	316	15	316		316	3
4	Doors at Kitchen and timeclock entrances	2013	4,593	179	15	179		179	4
5	Kitchen Water Heater Replacement	2013	6,887	268	15	268		268	5
6	D-11: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	10,470	349	15	349		349	6
7	Window Replacement in resident Rooms	2014	8,342	232	15	232		232	7
8	C-1, C-2, C Restroom C Bath: Drywall, Electrical, Plumbing, Trim	2014	99,694	2,492	15	2,492		2,492	8
9	Daffodil Shower Room	2014	27,162	604	15	604		604	9
10	D-12: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2014	5,818	64	15	64		64	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)		\$ 2,330,096	\$ 79,001		\$ 80,218	\$ 1,217	\$ 1,411,923	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	\$ 169,395	\$ 22,523	\$ 22,523	\$	5-10 Yrs	\$ 103,080	71
72	Current Year Purchases	34,921	2,649	2,649		7 Yrs	2,649	72
73	Fully Depreciated Assets	709,151				5-10 Yrs	709,151	73
74								74
75	TOTALS	\$ 913,467	\$ 25,172	\$ 25,172	\$		\$ 814,880	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	11,758	79
80	TOTALS			\$ 109,182	\$ 3,400	\$ 3,400	\$		\$ 103,940	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)	\$ 3,359,167	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,573	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 108,790	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,217	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,330,743	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	\$ 2,376,055	\$ 55,516	\$ 1,228,786	86
87	Buffet Line	18,500		18,500	87
88	East Haven Condo #10	97,260			88
89					89
90					90
91	TOTALS	\$ 2,491,815	\$ 55,516	\$ 1,247,286	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: 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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 7,863 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			\$	\$	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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" 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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,016	\$ 58,649	\$	1,016	\$ 58,649	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		174	11,330		174	11,330	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		400	41,905	509	400	42,414	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				59,087		59,087	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			\$	1,590	\$ 111,884	\$ 59,596	1,590	\$ 171,480	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: 07/01/2013Ending: 06/30/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,164,994	\$ 1,164,994	1
2	Cash-Patient Deposits	1,633	1,633	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	295,948	295,948	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	521,402	521,402	5
6	Prepaid Insurance	22,147	22,147	6
7	Other Prepaid Expenses	85	85	7
8	Accounts Receivable (owners or related parties)	15,000	15,000	8
9	Other(specify): <u>Insurance Trusts</u>	15,539	15,539	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,036,748	\$ 2,036,748	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,422	6,422	13
14	Buildings, at Historical Cost	2,059,867	2,330,096	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,022,648	1,022,649	16
17	Accumulated Depreciation (book methods)	(2,198,086)	(2,330,743)	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):	1,244,529	1,244,529	22
23	Other(specify): <u>Investment in East Haven Condo</u>	518,433	518,433	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,653,813	\$ 2,791,386	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,690,561	\$ 4,828,134	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 185,822	\$ 185,822	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,633	1,633	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,209	117,209	30
31	Accrued Taxes Payable (excluding real estate taxes)	351	351	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				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 305,015	\$ 305,015	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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 305,015	\$ 305,015	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,385,546	\$ 4,523,119	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,690,561	\$ 4,828,134	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,867,192	1
2	Restatements (describe):		2
3	Miscellaneous Difference	(260)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,866,932	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,518,614	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)	\$ 1,518,614	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,385,546	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,523,892	1
2	Discounts and Allowances for all Levels	(391,824)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,132,068	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,251	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 63,251	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	1,312	12
13	Barber and Beauty Care	18,869	13
14	Non-Patient Meals	21,109	14
15	Telephone, Television and Radio	10,913	15
16	Rental of Facility Space		16
17	Sale of Drugs	4,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	664	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 57,393	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,919,943	24
25	Interest and Other Investment Income***	4,729	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,924,672	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Independent and Assisted Living Fees</b>	656,121	28
28a	<b>Resident Personal Items/Miscellaneous Revenue</b>	11,413	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 667,534	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,844,918	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,315,733	31
32	Health Care	2,311,766	32
33	General Administration	1,070,382	33
<b>B. Capital Expense</b>			
34	Ownership	118,844	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	349,759	35
36	Provider Participation Fee	159,820	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,326,304	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,518,614	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,518,614	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 569,202	44
45	Private Pay - Net Inpatient Revenue	3,138,837	45
46	Medicare - Net Inpatient Revenue	456,869	46
47	Other-(specify) <u>Other Contractual Allowances</u>	(32,840)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,132,068	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:

07/01/2013

Ending:

06/30/2014

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	1,824	2,080	\$ 69,851	\$ 33.58	1
2	Assistant Director of Nursing	1,597	1,814	55,657	30.68	2
3	Registered Nurses	6,993	8,125	232,007	28.55	3
4	Licensed Practical Nurses	13,142	15,881	390,584	24.59	4
5	CNAs & Orderlies	54,933	65,076	804,329	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,565	5,276	97,468	18.47	8
9	Activity Director	1,523	1,753	25,466	14.53	9
10	Activity Assistants	5,237	6,025	66,070	10.97	10
11	Social Service Workers	4,873	5,234	67,424	12.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,849	10,352	121,615	11.75	14
15	Cook Helpers/Assistants	13,455	14,190	129,743	9.14	15
16	Dishwashers					16
17	Maintenance Workers	10,647	11,572	233,094	20.14	17
18	Housekeepers	16,598	18,049	174,754	9.68	18
19	Laundry	4,630	4,968	46,191	9.30	19
20	Administrator	1,952	2,080	82,219	39.53	20
21	Assistant Administrator	1,912	2,080	82,789	39.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,694	4,025	46,421	11.53	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	3,138	3,305	39,123	11.84	31
32	Other Health C: ALF Caregiver	3,534	4,186	52,000	12.42	32
33	Other(specify) <u>Care Plan Coord.</u>	3,342	3,748	105,198	28.07	33
34	TOTAL (lines 1 - 33)	166,438	189,819	\$ 2,922,003 *	\$ 15.39	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	152	\$ 7,811	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	65	2,773	L10, C3	37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	Monthly	4,425	L10, C3	39
40	Physical Therapy Consultant			L10a, C3	40
41	Occupational Therapy Consultant			L10a, C3	41
42	Respiratory Therapy Consultant			L10a, C3	42
43	Speech Therapy Consultant			L10a, C3	43
44	Activity Consultant	19	1,150	L11, C3	44
45	Social Service Consultant	18	1,280	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	254	\$ 23,439		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	89	\$ 4,363	L10, C3	50
51	Licensed Practical Nurses	698	29,989	L10, C3	51
52	Certified Nurse Assistants/Aides	566	12,865	L10, C3	52
53	TOTAL (lines 50 - 52)	1,353	\$ 47,217		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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning: 07/01/2013 Ending: 06/30/2014

## 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. Leading Age - 4,582
- (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. \$ \_\_\_\_\_ 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 159,820  
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. \$ 22,421
- (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? 83
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Fairview Haven  
06/30/2014  
Travel and Seminar Attachment

Name of Seminar	Date	Employee	Title	Location	Sponsor	Cost	Mileage	Lodging/Food /Etc.
Yet More Updates to HIPAA Privacy and Security	Jul-13	Sally Fehr	Social Services Director	Springfield, IL	Illinois Health Care Association	150.00		
Yet More Updates to HIPAA Privacy and Security	Jul-13	Dave Blunier	Assistant Administrator	Springfield, IL	Illinois Health Care Association	150.00	35.00	
Matrix Directions	Sep-13	Dave Blunier	Assistant Administrator	Chicago, IL	MDI Achieve	390.00		1,432.49
Interact 3.0 Webinar	Jul-13	Bonita Frank	Director of Nursing	Webinar	Life Services Network	199.00		
Pioneer Summit	Oct-13	Rick Plattner	Administrator	Springfield, IL	Illinois Pioneer Coalition	160.00	106.08	
Pioneer Summit	Oct-13	Roberta Preston	CNA Care Coach	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Dixie Steidinger	Activity Director	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Diana Kester	Activity Assistant	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Kristie Lee	ADON	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Kaye Lynch	MDS Coordinator	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Bonita Frank	Director of Nursing	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Al Kupferschmid	Environmental Services Director	Springfield, IL	Illinois Pioneer Coalition	160.00		
Pioneer Summit	Oct-13	Dawn Metz	Physical Therapy Assistant	Springfield, IL	Illinois Pioneer Coalition	160.00		
Life Services Network Conference	May-14	Rick Plattner	Administrator	Rosemont, IL	Life Services Network	480.00	35.00	379.39
Life Services Network Conference	May-14	Dave Blunier	Assistant Administrator	Rosemont, IL	Life Services Network	525.00	105.00	806.03

Life Services Network Conference	May-14 Bonita Frank	Director of Nursing	Rosemont, IL	Life Services Network	480.00		361.26
A Difficult Act to Follow	Apr-14 Bonita Frank	Director of Nursing	Webinar	Life Services Network	99.00		
How we Heal Ourselves and Others	Oct-14 Dawn Metz	Physical Therapy Assistant	Champaign, IL	IBPCEU	79.00		
ICD-10 Preperation and Implementation Strategies	Aug-13 Bonita Frank	Director of Nursing	Webinar	Pathway Health	89.00		
					4,081.00	281.08	2,979.17 7,341.25

Fairview Haven  
06/30/2014  
Inservice Training Attachment

Description	Cost
Nursing Reference Materials	3,139.82
Crucial Conversations for Mgmt Team	1,095.00
Employee Inservice On Line System	8,824.09
Employee All Staff Training Day	80.00
Computer Program for Nursing Education	791.66
Dietary Saniation Training	200.00
Nursing Inservice	116.00
Employment Law Postings	80.19
	<u>14,326.76</u>