



Facility Name & ID Number Fairview Haven

# 0008524 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	2,622	17,238	1,945	21,805	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,622	17,238	1,945	21,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.82%

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 1,930

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	271,013	23,924	64,267	359,204		359,204	(75,628)	283,576	1	
2	Food Purchase		228,010		228,010		228,010	(24,121)	203,889	2	
3	Housekeeping	196,413	45,038		241,451		241,451	(29,430)	212,021	3	
4	Laundry	38,516	23,925		62,441		62,441		62,441	4	
5	Heat and Other Utilities			95,279	95,279		95,279		95,279	5	
6	Maintenance	227,472	110,353	19,982	357,807		357,807	(57,084)	300,723	6	
7	Other (specify):* <b>Waste Removal</b>									7	
8	<b>TOTAL General Services</b>	733,414	431,250	179,528	1,344,192		1,344,192	(186,263)	1,157,929	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	1,894,119	175,843	76,301	2,146,263		2,146,263	(65,946)	2,080,317	10	
10a	Therapy	85,971	3,405	309,245	398,621		398,621		398,621	10a	
11	Activities	104,257	8,278	13,646	126,181		126,181		126,181	11	
12	Social Services	67,972		960	68,932		68,932		68,932	12	
13	CNA Training									13	
14	Program Transportation			8,719	8,719		8,719		8,719	14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	2,152,319	187,526	414,871	2,754,716		2,754,716	(65,946)	2,688,770	16	
	<b>C. General Administration</b>										
17	Administrative	172,309			172,309		172,309		172,309	17	
18	Directors Fees									18	
19	Professional Services			5,342	5,342		5,342		5,342	19	
20	Dues, Fees, Subscriptions & Promotions			11,639	11,639		11,639	(50)	11,589	20	
21	Clerical & General Office Expenses	73,144	13,334	95,686	182,164		182,164	(383)	181,781	21	
22	Employee Benefits & Payroll Taxes			734,150	734,150		734,150		734,150	22	
23	Inservice Training & Education			17,606	17,606		17,606		17,606	23	
24	Travel and Seminar			9,086	9,086		9,086		9,086	24	
25	Other Admin. Staff Transportation			3,511	3,511		3,511		3,511	25	
26	Insurance-Prop.Liab.Malpractice			70,620	70,620		70,620		70,620	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	245,453	13,334	947,640	1,206,427		1,206,427	(433)	1,205,994	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,131,186	632,110	1,542,039	5,305,335		5,305,335	(252,642)	5,052,693	29	

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

7/1/2014

Ending:

6/30/2015

## 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			121,313	121,313		121,313	521	121,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			4,219	4,219		4,219	(4,219)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,268	6,268		6,268		6,268			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			131,800	131,800		131,800	(3,698)	128,102			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,380	25,041	82,421		82,421		82,421			39
40	Barber and Beauty Shops			22,759	22,759		22,759		22,759			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,564	154,564		154,564		154,564			42
43	Other (specify):* Disallowed Costs	50,000		219,901	269,901		269,901	(269,901)				43
44	<b>TOTAL Special Cost Centers</b>	50,000	57,380	422,265	529,645		529,645	(269,901)	259,744			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,181,186	689,490	2,096,104	5,966,780		5,966,780	(526,241)	5,440,539			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(22,648)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,167)	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	521	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,860)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,187)	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	(7,379)	43		24
25	Fund Raising, Advertising and Promotional	(9,424)	43		25
	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	(482,047)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (526,241)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49	50	51	52

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>\$ (526,241)</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>

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview HavenID# 0008524Report Period Beginning: 7/1/2014Ending: 6/30/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Income	\$ (1,473)	2	1
2	Non Care RN Wages	(7,453)	10	2
3	Non Care LPN Wages	(19,530)	10	3
4	Non Care CNA Wages	(38,963)	10	4
5	Non Care Dietary Wages	(75,628)	1	5
6	Non Care Housekeeping Wages	(29,430)	3	6
7	Non Care Maintenance Wages	(57,084)	6	7
8	Non Care Real Estate Taxes	(4,219)	33	8
9	Non Care Expenses	(55,717)	43	9
10	Non Care Utilities	(64,571)	43	10
11	Non Care Depreciation	(66,132)	43	11
12	Non Care Laundry	(315)	43	12
13	Non Care ALF/ILF wages	(50,000)	43	13
14	Offset Cable TV Income	(11,149)	43	14
15	Offset Misc Income against Office Supplies	(383)	21	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>		(482,047)	49

**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 Page 6-Supp		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	<b>Board of Directors:</b>							1
2	Jerry Kaisner-President	0						2
3	Eric Kaeb-Vice President	0						3
4	Rod Steffen-Treasurer	0						4
5	Richard Wenger-Secretary	0						5
6	Duane Walter-Trustee	0						6
7	Nelson Zehr-Trustee	0						7
8	Neil Bahler-Trustee	0						8
9	Mark Waldbeser-Trustee	0						9
10	Kevin Schaffer-Trustee	0						10
11								11
12								12
13								13
14								14
15								15
16								16
17	<b>Note: None of the Board of Directors directly provided services to the nursing home.</b>							17
18	<b>Note: There are no entities in which a Board member has ownership that conducted business transactions with this nursing home.</b>							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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

## 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2014

Ending: 7/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Haven

# 0008524

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	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	N/A																	
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>					\$	\$			\$								
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$								
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. \$ N/A Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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 2014 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2015 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:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
<b>This facility is exempt from paying real estate taxes.</b>						
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

## 2014 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 2014 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 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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:

7/1/2014 Ending:

6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

**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	\$ 8	\$ 8	\$ 145,220	4
5	8	1999	1999	354,656		39	9,094	9,094	147,921	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Additions 65-66	1965		258	6	50	5	(1)	254	9
10	Additions 66-67	1966		2,116	42	50	42		2,066	10
11	Additions 67-68	1967		13,436	269	50	269		12,906	11
12	Additions 69-70	1969		1,893	38	50	38		1,745	12
13	Additions 71-72	1971		26,066	521	50	521		22,931	13
14	Additions 72-73	1972		6,314	126	50	126		5,424	14
15	Additions 77-78	1978		4,507	90	50	90		3,377	15
16	Sprinkler System	1979		42,306	846	50	846		30,599	16
17	Generator Room	1979		8,460	169	50	169		6,115	17
18	Additions 79-80	1979		1,578	32	50	32		1,161	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		2,525	23
24	Smoke Detector	1980		1,575		15			1,575	24
25	Additions 80-81	1981		16,207	324	50	324		11,183	25
26	Porch Enclosure	1981		9,453	189	50	189		6,395	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		1,331	30
31	Room D2 Addition	1982		432	9	50	9		296	31
32	Room B14 Addition	1982		2,380	48	50	48		1,587	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		5,140	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

**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		152	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		11,109	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	8,307	48
49	Courtyard	1987	19,000	633	30	633		17,779	49
50	Remodel Linen Room	1988	21,731	98	17		(98)	21,731	50
51	Courtyard	1988	1,827	61	30	61		1,662	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		20,807	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)	156,083	57
58	Office Remodel	1994	20,943	838	25	838		17,907	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		671	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		733	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	\$ 13,400		\$ 22,079	\$ 8,679	\$ 995,142	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

7/1/2014

Ending:

6/30/2015

**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 12A, Carried Forward</b>		\$ 1,263,078	\$ 13,400		\$ 22,079	\$ 8,679	\$ 995,142	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	114	15	113	(1)	1,873	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		4,063	31
32	Activity draperies	2003	662		10			662	32
33	Concrete improvements	2003	4,566	304	15	304		3,672	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,406,527	\$ 14,191		\$ 22,819	\$ 8,628	\$ 1,136,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

7/1/2014

Ending:

6/30/2015

**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	\$ 14,191		\$ 22,819	\$ 8,628	\$ 1,136,910	1
2	Plumbing rough in	2004	955		10			955	2
3	Window blinds	2004	643		7			643	3
4	Kitchen grease trap	2003	738	6	10		(6)	738	4
5	Driveway	2004	4,504	300	15	300		3,324	5
6	Sprinkler system	2004	1,090		10			1,090	6
7	Kitchen grease trap	2003	2,561	171	15	171		2,006	7
8	Bath tub	2003	12,232		10			12,232	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		241	10
11	Light fixtures	2003	595		10			595	11
12	Air conditioning units	2003	4,222	281	15	281		3,296	12
13	Dining draperies	2004	1,300		7			1,300	13
14	Front parking lot	2005	5,912	394	15	394		3,956	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	1,108	10	1,189	81	26,592	17
18	5T Air conditioning	2005	2,150		7			2,150	18
19	C Wing ductwork	2005	3,013	201	15	201		2,011	19
20	13 bathroom remodeling	2005	4,979	332	15	332		3,180	20
21	Bathroom steel door frames	2006	1,353	90	15	90		830	21
22	5 ton condensor	2005	8,697	870	10	870		8,550	22
23	Fire system engineering	2005	2,787	186	15	186		1,772	23
24	North basement office remodel	2006	2,460	164	15	164		1,541	24
25	Foam roofing	2006	2,292	153	15	153		1,449	25
26	Door alarm and keypad	2005	2,592	259	10	259		2,472	26
27	Fire door closures and shutters	2005	3,383	338	10	338		3,238	27
28	B hall shower tile	2006	935	62	15	62		584	28
29	Bathtub	2006	10,264	1,026	10	1,026		9,639	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		3,252	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,539,378	\$ 20,514		\$ 29,217	\$ 8,703	\$ 1,257,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

7/1/2014

Ending:

6/30/2015

**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	\$ 20,514		\$ 29,217	\$ 8,703	\$ 1,257,117	1
2	Fire alarm system	2006	3,478		7			3,478	2
3	Air conditioning	2006	2,059	137	15	137		1,334	3
4	Guttering system	2007	2,573	103	25	103		1,337	4
5	Air conditioning	2007	7,549	503	15	503		4,118	5
6	Door alarm system	2006	1,033		7			1,033	6
7	Landscaping	2007	25,605	2,561	10	2,561		18,958	7
8	Dock improvements	2008	2,905	194	15		(194)		8
9	Fornt door opener	2008	404	40	10	40		300	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		2,944	10
11	Garbage disposal	2008	937	94	10	94		681	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		4,121	12
13	West side window replacement	2007	16,191	1,079	15	1,079		8,458	13
14	Rms a-2.4 windows, drywall, trim	2008	3,831	255	15	255		1,849	14
15	Furnace	2008	4,070	339	7	342	3	4,070	15
16	Ductwork repair	2008	3,523	235	15	235		1,706	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		15,017	17
18	Shower repair	2008	820	68	7	73	5	820	18
19	Kitchen water softener	2008	1,819	195	7	191	(4)	1,819	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		4,191	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		4,173	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		1,957	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		2,032	23
24	Daffodil drive - air conditioner	2009	916	131	7	131		797	24
25	Dock Upgrade	2008	11,078	739	15	739		4,926	25
26	Fire system upgrade	2008	2,860	191	15	191		1,289	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		8,431	27
28	New window	2009	316	21	15	21		130	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		4,252	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		8,092	30
31	Therapy room air conditioner	2009	1,535	219	7	219		1,424	31
32	Window	2009	2,974	198	15	198		1,221	32
33	Door Alarm/Intercom Upgrades	2010	3,250	217	15	218	1	1,162	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,760,809	\$ 36,146		\$ 44,660	\$ 8,514	\$ 1,373,237	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

7/1/2014

Ending:

6/30/2015

**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 12D, Carried Forward</b>		\$ 1,760,809	\$ 36,146		\$ 44,660	\$ 8,514	\$ 1,373,237	1
2	Fire alarm upgrade	2009	3,267	218	15	218		1,235	2
3	Generator Repairs	2010	9,550	478	20	478		1,912	3
4	Cordless phone system for nurses	2010	1,010	134	15	67	(67)	363	4
5	New heating/cooling unit	2010	16,616	2,374	7	2,374		12,068	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		5,069	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		13,295	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		2,075	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		9,615	9
10	Room Heaters	2011	1,540	220	7	220		963	10
11	Windows	2011	5,583	372	15	372		1,504	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		3,330	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		1,613	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		20,800	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		1,365	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		2,935	16
17	Gas line for dryers	2012	1,619	108	15	108		418	17
18	Generator Repairs	2012	2,299	115	20	115		417	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		978	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		4,224	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		380	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		3,562	22
23	Social Services AC repair	2012	5,415	361	15	361		1,053	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	426	15	426		1,207	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	157	15	157		393	25
26	Replace Sprinkler System	2013	57,060	3,804	15	3,804		9,034	26
27	Dining Room Exit Door replaced	2013	3,419	228	15	228		532	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	724	15	724		1,508	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		4,198	29
30									30
31	Flooring, windows, cabinets, drywall, trim, paint								31
32									32
33	Prior Year Improvements Not Included on Prior Year Cost Reports			7,563			(7,563)		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,154,924	\$ 71,235		\$ 72,119	\$ 884	\$ 1,479,283	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12E, Carried Forward		\$ 2,154,924	\$ 71,235		\$ 72,119	\$ 884	\$ 1,479,283	1
2	Fire Alarm System Repairs	2013	5,101	340	15	340		595	2
3	D-9: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	7,105	474	15	474		790	3
4	Doors at Kitchen and timeclock entrances	2013	4,593	306	15	306		485	4
5	Kitchen Water Heater Replacement	2013	6,887	459	15	459		727	5
6	D-11: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	10,470	698	15	698		1,047	6
7	Window Replacement in resident Rooms	2014	8,342	556	15	556		788	7
8	C-1, C-2, C Restroom C Bath: Drywall, Electrical, Plumbing, Trim	2014	99,694	6,646	15	6,646		9,138	8
9	Daffodil shower room included, tile, drywall, painting,	2014	27,162	1,811	15	1,811		2,415	9
10	new tub, shower, light fixtures								10
11	D-12: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2014	5,818	388	15	388		452	11
12	Replace HVAC Systems	2014	8,544	522	15	285	(237)	285	12
13	Flooring - Blessings Way #2	2015	2,633	73	15	88	15	88	13
14	Call System	2015	72,604	2,017	15	2,420	403	2,420	14
15	Replace Driveway to Dock Area	2015	13,645	682	15	455	(227)	455	15
16	Drapes for Therapy Room & Resident Room	2015	3,372	112	15	112		112	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)		\$ 2,430,894	\$ 86,319		\$ 87,157	\$ 838	\$ 1,499,080	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 175,538	\$ 24,450	\$ 24,450	\$	5-10 Yrs	\$ 102,042	71
72	Current Year Purchases	62,461	3,716	3,716		5-10 Yrs	3,716	72
73	Fully Depreciated Assets	737,929	641	641		5-10 Yrs	737,929	73
74								74
75	TOTALS	\$ 975,928	\$ 28,807	\$ 28,807	\$		\$ 843,687	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/Bus Tie Dc	03 ford bus	2006	44,745				5	44,745	77
78	Patient Transport	Chrysler town and country	2011	17,000	3,400	3,400		5	15,158	78
79	Bus	Midwest Transit	2015	59,285	2,470	2,470		5	2,470	79
80	TOTALS			\$ 168,467	\$ 5,870	\$ 5,870	\$		\$ 109,810	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)	\$ 3,581,711	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,996	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,834	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 838	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,452,577	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	\$ 2,321,400	\$ 59,791	\$ 1,288,577	86
87	Buffet Line	18,500		18,500	87
88	East Haven Condo #10	205,153	3,366	3,366	88
89					89
90					90
91	TOTALS	\$ 2,545,053	\$ 63,157	\$ 1,310,443	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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:				\$			3
4	Additions	<u>N/A</u>						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.	<u>/2016</u>	\$ _____
13.	<u>/2017</u>	\$ _____
14.	<u>/2018</u>	\$ _____

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 N/A

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: \$ 6,268 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	<u>N/A</u>				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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/2014 Ending: 6/30/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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><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>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	937	\$ 115,400			937	\$ 115,400						1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		221	62,563			221	62,563						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		986	131,282		3,405	986	134,687						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					57,380		57,380						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	<b>TOTAL</b>			\$	2,144	\$ 309,245		\$ 60,785	2,144	\$ 370,030						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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Haven# 0008524Report Period Beginning: 7/1/2014

Ending:

6/30/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 389,439	\$ 389,439	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	334,048	334,048	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,360,576	1,360,576	5
6	Prepaid Insurance	31,767	31,767	6
7	Other Prepaid Expenses	2,114	2,114	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 (sum of lines 1 thru 9)</b>	<b>\$ 2,148,483</b>	<b>\$ 2,148,483</b>	<b>10</b>
<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	2,162,920	2,430,894	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,142,138	1,144,395	16
17	Accumulated Depreciation (book methods)	(2,327,315)	(2,452,577)	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 (spec AL/IL Assets)	1,336,811	1,336,811	22
23	Other(specify): <u>Investment in East Haven Condo</u>	501,463	501,463	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 2,822,439</b>	<b>\$ 2,967,408</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 4,970,922</b>	<b>\$ 5,115,891</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 97,149	\$ 97,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,781	160,781	30
31	Accrued Taxes Payable (excluding real estate taxes)	462	462	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 258,392</b>	<b>\$ 258,392</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 258,392</b>	<b>\$ 258,392</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 4,712,530</b>	<b>\$ 4,857,499</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 4,970,922</b>	<b>\$ 5,115,891</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,385,546	1
2	Restatements (describe):		2
3	Prior year post closing adjustments	(401)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,385,145	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	327,385	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)	\$ 327,385	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)	\$ 4,712,530	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,927,751	1
2	Discounts and Allowances for all Levels	(184,687)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,743,064	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	220,591	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 220,591	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	1,473	12
13	Barber and Beauty Care	21,349	13
14	Non-Patient Meals	22,648	14
15	Telephone, Television and Radio	11,149	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,326	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	259	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 58,204	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	590,331	24
25	Interest and Other Investment Income***	18,365	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 608,696	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Independent and Assisted Living Fees</b>	651,494	28
28a	<b>Resident Personal Items/Miscellaneous Revenue</b>	12,116	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 663,610	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,294,165	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,344,192	31
32	Health Care	2,754,716	32
33	General Administration	1,206,427	33
<b>B. Capital Expense</b>			
34	Ownership	131,800	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	375,081	35
36	Provider Participation Fee	154,564	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,966,780	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	327,385	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 327,385	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 360,485	44
45	Private Pay - Net Inpatient Revenue	3,626,484	45
46	Medicare - Net Inpatient Revenue	788,478	46
47	Other-(specify) <u>Other Contractual Allowances</u>	(32,383)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,743,064	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,173	2,358	\$ 63,206	\$ 26.80	1
2	Assistant Director of Nursing	1,971	2,183	64,386	29.49	2
3	Registered Nurses	10,569	11,288	336,455	29.81	3
4	Licensed Practical Nurses	14,537	15,536	404,501	26.04	4
5	CNAs & Orderlies	60,920	64,670	865,110	13.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,309	4,865	85,971	17.67	8
9	Activity Director	1,524	1,665	26,097	15.67	9
10	Activity Assistants	6,282	6,648	78,160	11.76	10
11	Social Service Workers	6,515	7,056	67,972	9.63	11
12	Dietician					12
13	Food Service Supervisor	916	924	16,485	17.84	13
14	Head Cook	10,242	11,313	134,025	11.85	14
15	Cook Helpers/Assistants	12,574	13,036	120,503	9.24	15
16	Dishwashers					16
17	Maintenance Workers	10,668	11,586	227,472	19.63	17
18	Housekeepers	18,518	20,018	196,413	9.81	18
19	Laundry	4,096	4,434	38,516	8.69	19
20	Administrator	1,888	2,080	84,214	40.49	20
21	Assistant Administrator	1,896	2,080	88,095	42.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,861	5,198	73,144	14.07	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	3,142	3,377	41,504	12.29	31
32	Other Health C: ALF Caregiver	4,380	4,380	50,000	11.42	32
33	Other(specify) <u>Care Plan Coord.</u>	3,565	3,803	118,957	31.28	33
34	TOTAL (lines 1 - 33)	185,546	198,498	\$ 3,181,186 *	\$ 16.03	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	177	\$ 8,974	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	32	2,507	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,251	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	12	882	L11, C3	44
45	Social Service Consultant	12	960	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	233	\$ 23,574		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	25	\$ 1,175	L10, C3	50
51	Licensed Practical Nurses	584	25,072	L10, C3	51
52	Certified Nurse Assistants/Aides	1,179	27,617	L10, C3	52
53	TOTAL (lines 50 - 52)	1,788	\$ 53,864		53

SEE ACCOUNTANTS' COMPILATION REPORT



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												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

**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. 4,599 Leading Age
- (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? N/A
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,780 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. \$ 154,564  
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. \$ 22,648
- (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? 71  
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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**