FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0008524

Facility Name: Fairview Haven, Inc.

Address: 605 North Fourth Street (Number) Fairbury (City) 61739 (Zip Code)

County: Livingston

Telephone Number: (815) 692-2572 **Fax #** (815) 692-4257

HFS ID Number:

Date of Initial License for Current Owners: 1962

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 (c) 3

In the event there are further questions about this report, please contact:
Name: Dave Blunier **Telephone Number:** (815) 692-2572
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/10 to 6/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Rob Schlicht, Director
(Firm Name & Address) Wipfli LLP, 10000 Innovation Drive, Suite 250, Milwaukee WI 53226
(Telephone) (414) 431-9335 Fax # (414) 431-9303

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,233	14,164	1,402	21,799	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,233	14,164	1,402	21,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.80%

D. How many bed-hold days during this year were paid by the Department?
154 (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 [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/28/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 63 and days of care provided 1,402

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	245,441	26,675	100,990	373,106		373,106		373,106			1
2	Food Purchase		204,977		204,977		204,977	(29,084)	175,893			2
3	Housekeeping	134,503	37,793		172,296		172,296		172,296			3
4	Laundry	72,090	29,385	53	101,528		101,528	(53)	101,475			4
5	Heat and Other Utilities			196,718	196,718		196,718	(77,413)	119,305			5
6	Maintenance	210,246	71,900	26,262	308,408		308,408		308,408			6
7	Other (specify):*											7
8	TOTAL General Services	662,280	370,730	324,023	1,357,033		1,357,033	(106,550)	1,250,483			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	1,631,634	125,489	70,269	1,827,392		1,827,392		1,827,392			10
10a	Therapy	100,272		26,792	127,064		127,064		127,064			10a
11	Activities	87,738	19,088	1,891	108,717		108,717		108,717			11
12	Social Services	58,916		930	59,846		59,846		59,846			12
13	CNA Training			(305)	(305)		(305)		(305)			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,878,560	144,577	105,877	2,129,014		2,129,014		2,129,014			16
	C. General Administration											
17	Administrative	134,242			134,242		134,242		134,242			17
18	Directors Fees											18
19	Professional Services			6,319	6,319		6,319		6,319			19
20	Dues, Fees, Subscriptions & Promotions			8,397	8,397		8,397		8,397			20
21	Clerical & General Office Expenses	50,518	15,581	78,127	144,226		144,226	(22,020)	122,206			21
22	Employee Benefits & Payroll Taxes			650,396	650,396		650,396		650,396			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,574	12,574		12,574		12,574			24
25	Other Admin. Staff Transportation			10,284	10,284		10,284		10,284			25
26	Insurance-Prop.Liab.Malpractice			52,181	52,181		52,181		52,181			26
27	Other (specify):*											27
28	TOTAL General Administration	184,760	15,581	818,278	1,018,619		1,018,619	(22,020)	996,599			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,725,600	530,888	1,248,178	4,504,666		4,504,666	(128,570)	4,376,096			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairview Haven, Inc. #0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			162,649	162,649		162,649	(47,357)	115,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			373	373		373	(373)				32
33	Real Estate Taxes			710	710		710	(710)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,742	11,742		11,742		11,742			35
36	Other (specify):*											36
37	**TOTAL Ownership**			175,474	175,474		175,474	(48,440)	127,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,194		70,194		70,194		70,194			39
40	Barber and Beauty Shops			14,876	14,876		14,876		14,876			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):*			9,498	9,498		9,498	(9,498)				43
44	**TOTAL Special Cost Centers**		70,194	58,867	129,061		129,061	(9,498)	119,563			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,725,600	601,082	1,482,519	4,809,201		4,809,201	(186,508)	4,622,693			45

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(27,434)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,897	30		9
10	Interest and Other Investment Income	(373)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,498)	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	(167,100)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,508)		$	30

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (186,508)		37

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

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

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

Fairview Haven, Inc.

ID# 0008524

Report Period Beginning: 7/1/10

Ending: 6/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,650)	2	1
2	Non-care real estate taxes	(710)	33	2
3	Non care expenses	(18,069)	21	3
4	Non care utilities	(77,413)	5	4
5	Non care depreciation	(65,254)	30	5
6	Non care laundry	(53)	4	6
7	Other promotional advertising	(2,848)	21	7
8	Miscellaneous Revenue	(1,103)	21	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(167,100)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Fairview Haven, Inc. **#** 0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(29,084)	0	0	0	0	0	0	0	0	0	0	(29,084)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(53)	0	0	0	0	0	0	0	0	0	0	(53)	4
5	Heat and Other Utilities	(77,413)	0	0	0	0	0	0	0	0	0	0	(77,413)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(106,550)	0	0	0	0	0	0	0	0	0	0	(106,550)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(22,020)	0	0	0	0	0	0	0	0	0	0	(22,020)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,020)	0	0	0	0	0	0	0	0	0	0	(22,020)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,570)	0	0	0	0	0	0	0	0	0	0	(128,570)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(47,357)	0	0	0	0	0	0	0	0	0	0	(47,357)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(373)	0	0	0	0	0	0	0	0	0	0	(373)	32
33	Real Estate Taxes	(710)	0	0	0	0	0	0	0	0	0	0	(710)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(48,440)	0	0	0	0	0	0	0	0	0	0	(48,440)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,498)	0	0	0	0	0	0	0	0	0	0	(9,498)	43
44	**TOTAL Special Cost Centers**	(9,498)	0	0	0	0	0	0	0	0	0	0	(9,498)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(186,508)	0	0	0	0	0	0	0	0	0	0	(186,508)	45

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

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 [x] 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 Item	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)	
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.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

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

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 [x]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bluestem National Bank		x	Operating		1/31/08			1/31/11	4.9500	10	6
7	Fairbury/Cropsey		x	Operating		5/8/09			5/10/11	3.4300	363	7
8												8
9	TOTAL Facility Related						$	$			$ 373	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 373	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line # _____

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

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	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. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	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:		
2006		8
2007		9
2008		10
2009		11
2010		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven, Inc. 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 2010 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 2010.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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? [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		1962	1962	$ 145,220	$ 2,904	50	$ 2,904	$	$ 141,610	4
5	8		1999	1999	354,656		39	9,094	9,094	111,545	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			1965	258	5	50	5		234	9
10	Additions 66-67			1966	2,116	42	50	42		1,898	10
11	Additions 67-68			1967	13,436	269	50	269		11,830	11
12	Additions 69-70			1969	1,893	38	50	38		1,593	12
13	Additions 71-72			1971	26,066	521	50	521		20,847	13
14	Additions 72-73			1972	6,314	126	50	126		4,920	14
15	Additions 77-78			1978	4,507	90	50	90		3,017	15
16	Sprinkler System			1979	42,306	846	50	846		27,215	16
17	Generator Room			1979	8,460	169	50	169		5,439	17
18	Additions 79-80			1979	1,578	32	50	32		1,033	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			4,262	22
23	Additions 79-80			1979	3,516	70	50	70		2,245	23
24	Smoke Detector			1980	1,575		15			1,575	24
25	Additions 80-81			1981	16,207	324	50	324		9,887	25
26	Porch Enclosure			1981	9,453	189	50	189		5,639	26
27	Dining Room Lighting			1981	2,838	95	30	95		2,829	27
28	Lobby Lighting			1981	763	25	30	25		745	28
29	Linen Exhaust Fan			1982	376		10			376	29
30	Sprinkler System Imp			1982	1,977	40	50	40		1,171	30
31	Room D2 Addition			1982	432	9	50	9		260	31
32	Room B14 Addition			1982	2,380	48	50	48		1,395	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		4,648	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Sign	1983	$ 994	$	10	$	$	$ 994	37
38	Landscape	1983	1,455	49	30	49		1,367	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		132	41
42	Outside Light Fixture	1986	437		10			437	42
43	Blacktop Drive & Trees	1962	2,750		10			2,750	43
44	Laundry Room	1978	14,944	299	50	299		9,913	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	286	30	286		7,163	48
49	Courtyard	1987	19,000	633	30	633		15,247	49
50	Remodel Linen Room	1988	21,731		17			21,731	50
51	Courtyard	1988	1,827	61	30	61		1,418	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		17,339	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	6,935	25	6,935		128,343	57
58	Office Remodel	1994	20,943	838	25	838		14,455	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		539	62
63	Replace Main sprinkler system	1995	2,550	10	15	10		2,550	63
64	Repair dining room ice machine wall	1996	948	38	25	38		581	64
65	Front parking lot and sidewalk	1995	20,675	469	15	469		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	$ 16,528		$ 25,622	$ 9,094	$ 903,199	70

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,263,078	$ 16,528		$ 25,622	$ 9,094	$ 903,199	1
2	Draperies	1997	1,086		7			1,086	2
3	Phone System	1997	12,981		10			12,981	3
4	Fire alarm system	1997	324		7			324	4
5	Door alarm system	1997	439		7			439	5
6	Ceiling Mount smoke detectors	1997	191		7			191	6
7	Door alarm system	1996	724		7			724	7
8	Courtyard landscaping	1996	649	43	15	43		641	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		1,385	15
16	Sink	2000	746		7			746	16
17	Water heater	1999	6,669		10			6,669	17
18	Water heater	2001	3,647	252	10	252		3,647	18
19	B Wing air conditioner	2000	1,623		7			1,623	19
20	Dry pendants	2000	2,762		10			2,725	20
21	Nurses station carpet	2000	1,151	25	10	25		1,151	21
22	Large capacity water heater	2001	5,290	442	10	442		5,290	22
23	Telephone system	2002	853		7			853	23
24	Air conditioning unit	2002	1,730	173	10	173		1,579	24
25	Nurse call system	2002	64,740	6,474	10	6,474		60,944	25
26	Draperies	2003	1,243	124	10	124		1,042	26
27	Phone system wiring	2002	1,496		7			1,496	27
28	Water cooler	2003	526		7			526	28
29	Lightning arrestors	2002	1,175	118	10	118		1,022	29
30	Eyewash station	2002	884	88	10	88		755	30
31	Firecode updates	2002	4,850	323	15	323		2,771	31
32	Activity draperies	2003	662	66	10	66		533	32
33	Concrete improvements	2003	4,566	304	15	304		2,456	33
34	TOTAL (lines 1 thru 33)		$ 1,406,527	$ 25,086		$ 34,180	$ 9,094	$ 1,037,367	34

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,406,527	$ 25,086		$ 34,180	$ 9,094	$ 1,037,367	1
2	Plumbing rough in	2004	955	96	10	96		696	2
3	Window blinds	2004	643	52	7	52		643	3
4	Kitchen grease trap	2003	738	74	10	74		588	4
5	Driveway	2004	4,504	300	15	300		2,124	5
6	Sprinkler system	2004	1,090	109	10	109		777	6
7	Kitchen grease trap	2003	2,561	171	15	171		1,322	7
8	Bath tub	2003	12,232	1,223	10	1,223		9,235	8
9	Time clock system-remove per audit	2004							9
10	D-wing fire safety	2003	421	21	20	21		157	10
11	Light fixtures	2003	595	60	10	60		453	11
12	Air conditioning units	2003	4,222	281	15	281		2,172	12
13	Dining draperies	2004	1,300	186	7	186		1,273	13
14	Front parking lot	2005	5,912	394	15	394		2,380	14
15	Generator Heater	2005	770	110	7	110		689	15
16	Door monitors	2004	1,980	283	7	283		1,876	16
17	Sprinkler rehab	2004	26,592	2,659	10	2,659		17,426	17
18	5T Air conditioning	2005	2,150	307	7	307		1,882	18
19	C Wing ductwork	2005	3,013	201	15	201		1,207	19
20	13 bathroom remodeling	2005	4,979	332	15	332		1,852	20
21	Bathroom steel door frames	2006	1,353	90	15	90		470	21
22	5 ton condensor	2005	8,697	870	10	870		5,070	22
23	Fire system engineering	2005	2,787	186	15	186		1,028	23
24	North basement office remodel	2006	2,460	164	15	164		885	24
25	Foam roofing	2006	2,292	153	15	153		837	25
26	Door alarm and keypad	2005	2,592	259	10	259		1,436	26
27	Fire door closures and shutters	2005	3,383	338	10	338		1,886	27
28	B hall shower tile	2006	935	62	15	62		336	28
29	Bathtub	2006	10,264	1,026	10	1,026		5,535	29
30	Generator upgrade	2006	15,624	2,474	7	2,232	(242)	11,716	30
31	Intercom replacement	2006	2,500		7	357	357	1,845	31
32	Generator upgrade	2005	1,697		7	242	242	1,452	32
33	Front door automatic opener	2006	3,610	361	10	361		1,808	33
34	TOTAL (lines 1 thru 33)		$ 1,539,378	$ 37,928		$ 47,379	$ 9,451	$ 1,118,423	34

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,539,378	$ 37,928		$ 47,379	$ 9,451	$ 1,118,423	1
2	Fire alarm system	2006	3,478	497	7	497		2,421	2
3	Air conditioning	2006	2,059	137	15	137		786	3
4	Guttering system	2007	2,573	103	25	103		925	4
5	Air conditioning	2007	7,549	503	15	503		2,106	5
6	Door alarm system	2006	1,033	148	7	148		721	6
7	Landscaping	2007	25,605	2,561	10	2,561		8,714	7
8	Dock improvements	2008	2,905		15				8
9	Fornt door opener	2008	404	40	10	40		140	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		1,256	10
11	Garbage disposal	2008	937	94	10	94		305	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		1,821	12
13	West side window replacement	2007	16,191	1,079	15	1,079		4,142	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831	255	15	255		829	14
15	Furnace	2008	4,070	581	7	581		1,985	15
16	Ductwork repair	2008	3,523	235	15	235		766	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		7,181	17
18	Shower repair	2008	820	117	7	117		396	18
19	Kitchen water softener	2008	1,819	260	7	260		848	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		1,887	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		1,429	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		753	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		828	23
24	Daffodil drive - air conditioner	2009	916	131	7	131		273	24
25	Dock Upgrade	2008	11,078	739	15	739		1,970	25
26	Fire system upgrade	2008	2,860	191	15	191		525	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		3,035	27
28	New window	2009	316	21	15	21		46	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		1,456	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		3,112	30
31	Therapy room air conditioner	2009	1,535	219	7	219		548	31
32	Window	2009	2,974	198	15	198		429	32
33	Door Alarm/Intercom Upgrades	2010	3,267	218	15	218		290	33
34	TOTAL (lines 1 thru 33)		$ 1,760,826	$ 54,369		$ 63,820	$ 9,451	$ 1,170,346	34

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,760,826	$ 54,369		$ 63,820	$ 9,451	$ 1,170,346	1
2	Fire alarm upgrade	2009	3,267	218	15	218		363	2
3	Generator Repairs	2010	9,550		20				3
4	Cordless phone system for nurses	2010	1,010	67	15	67		95	4
5	New heating/cooling unit	2010	16,616	2,374	7	2,374		2,572	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		1,113	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		3,979	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		543	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		2,171	9
10	Room Heaters	2011	1,540	83	7	83		83	10
11	Windows	2011	5,583	16	15	16		16	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	226	15	226		226	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	33	15	33		33	13
14	Sprinkler Pipe Replacement	2011	73,417	1,224	15	1,224		1,224	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,972,811	$ 64,172		$ 73,624	$ 9,451	$ 1,182,764	34

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	$ 343,736	$ 38,935	$ 38,935	$	various	$ 258,850	71
72	Current Year Purchases	12,235	869	869		various	869	72
73	Fully Depreciated Assets	501,806						73
74								74
75	TOTALS	$ 857,777	$ 39,804	$ 39,804	$		$ 259,719	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 Clubvan & Painting	1998/2003	$ 47,437	$	$	$		$ 47,437	76
77	Patient Transport	03 Ford Bus	2006	42,561					42,561	77
78	Bus Tie Downs	03 Ford Bus	2006	2,184	306	306			2,184	78
79	Patient Transport	Chrysler Town and Ctry	2011	17,000	1,558	1,558			1,558	79
80	TOTALS			$ 109,182	$ 1,864	$ 1,864	$		$ 93,740	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,946,192	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,840	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,292	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,451	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,536,223	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	Noncare assets	$ 2,372,913	$ 62,611	$ 1,061,639	86
87	Buffet Line	18,500	2,643	13,655	87
88					88
89					89
90					90
91	TOTALS	$ 2,391,413	$ 65,254	$ 1,075,294	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 11,742 Description: Copy System
    (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.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,370	$	$ 1,370
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,370	$	$ 1,370
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,370			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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.

STATE OF ILLINOIS

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	165	$ 9,872	$	165	$ 9,872	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		31	1,661		31	1,661	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		126	7,550		126	7,550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): physical therapy asst	10a.1	1319	28,895	44	1,850		1,363	30,745	12
13	Other (specify): COTA	10a.3			136	617		136	617	13
14	TOTAL			$ 28,895	502	$ 21,550	$	1,821	$ 50,445	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.

STATE OF ILLINOIS

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 106,242	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	169,585		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	364,712		5
6	Prepaid Insurance	13,811		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Insurance trusts	15,539		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 669,889	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,249		13
14	Buildings, at Historical Cost	3,680,390		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,291,301		16
17	Accumulated Depreciation (book methods)	(2,958,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,036,972	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,706,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 66,399	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,913		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,794		30
31	Accrued Taxes Payable (excluding real estate taxes)	468		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 144,574	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 144,574	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,562,287	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,706,861	$	48

*(See instructions.)

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,466,012	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,466,012	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	93,157	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,118	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)**	$ 96,275	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,562,287	24 *

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

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,995,189	1
2	Discounts and Allowances for all Levels	(335,910)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,659,279	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,344	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 88,344	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,650	12
13	Barber and Beauty Care	14,297	13
14	Non-Patient Meals	27,434	14
15	Telephone, Television and Radio	6,592	15
16	Rental of Facility Space		16
17	Sale of Drugs	28,083	17
18	Sale of Supplies to Non-Patients	2,626	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	24	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 80,706	23
	D. Non-Operating Revenue		
24	Contributions	549,597	24
25	Interest and Other Investment Income***	6,755	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 556,352	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	516,574	28
28a	Other income	1,103	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 517,677	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,902,358	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,357,033	31
32	Health Care	2,129,014	32
33	General Administration	1,018,619	33
	B. Capital Expense		
34	Ownership	175,474	34
	C. Ancillary Expense		
35	Special Cost Centers	94,568	35
36	Provider Participation Fee	34,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,809,201	40
41	**Income before Income Taxes (line 30 minus line 40)****	93,157	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 93,157	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,160	$ 61,302	$ 28.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,831	8,125	174,291	21.45	3
4	Licensed Practical Nurses	15,236	18,785	405,390	21.58	4
5	CNAs & Orderlies	59,820	71,618	936,040	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,618	1,853	23,834	12.86	9
10	Activity Assistants	5,333	5,942	63,904	10.75	10
11	Social Service Workers	4,626	4,851	58,916	12.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,146	12,016	126,006	10.49	14
15	Cook Helpers/Assistants	12,562	14,028	119,435	8.51	15
16	Dishwashers					16
17	Maintenance Workers	10,957	11,245	210,246	18.70	17
18	Housekeepers	13,016	14,792	134,503	9.09	18
19	Laundry	7,301	8,099	72,090	8.90	19
20	Administrator	1,960	2,160	70,081	32.44	20
21	Assistant Administrator	2,000	2,160	64,161	29.70	21
22	Other Administrative	4,494	4,753	50,518	10.63	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,313	4,807	54,610	11.36	31
32	Other Health C: PTA	1,775	2,003	45,401	22.67	32
33	Other(specify) COTA	2,229	2,508	54,872	21.88	33
34	TOTAL (lines 1 - 33)	166,145	191,905	$ 2,725,600 *	$ 14.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	122	$ 6,167	1.3	35
36	Medical Director		6,300	9.3	36
37	Medical Records Consultant	35	2,457	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,610	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,106	11.3	44
45	Social Service Consultant	12	930	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	185	$ 20,570		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	175	7,881	10.3	51
52	Certified Nurse Assistants/Aides	1,782	40,640	10.3	52
53	TOTAL (lines 50 - 52)	1,957	$ 48,521		53

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rick Plattner	Administrator	0	$ 70,081
Dave Blunier	Assistant Adm	0	64,161
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,242

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wipfli LLP	Accounting	$ 6,100
FR&R Healthcare Consulting	Medicare Consultation	69
Apostolic Christian Restmoor	Indep Salary/benefits survey	150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,319

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,220
Unemployment Compensation Insurance	9,808
FICA Taxes	208,383
Employee Health Insurance	241,165
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Oher insurance	29,098
Employee pension plan	56,263
Employee physicals	1,925
Uniforms	654
Employee appreciation	11,964
Scholarship	681
Employee education	7,235
TOTAL (agree to Schedule V, line 22, col.8)	$ 650,396

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	38
Health Care Worker Background Check	
(Indicate # of checks performed 21)	588
Patient Background Checks	
Life Services Network dues	2,786
Leading Age Dues	1,436
Other dues	2,230
Other subscriptions	1,319
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,397

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,487
Seminar Expense	9,087
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,574

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Svs Network $2786, Leading Age $1436**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,593** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **34,493**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **27,344**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.