FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0008524

Facility Name: Fairview Haven

Address: 605 North 4th St (Number) Fairbury (City) 61739 (Zip Code)

County: Livingston

Telephone Number: (815) 692-2572 **Fax #** (815) 692-4557

HFS ID Number:

Date of Initial License for Current Owners: 10/2/62

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 7/1/15 to 6/30/16 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) David Blunier
(Title) Administrator

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	23,058	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	23,058	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	1,796	19,084	1,291	22,171	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,796	19,084	1,291	22,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.15%

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 [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/2/62

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 1,169

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 6/30/16 Fiscal Year: 6/30/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	306,957	18,793	7,661	333,411		333,411	(10,107)	323,304			1
2	Food Purchase		237,569		237,569		237,569	(21,928)	215,641			2
3	Housekeeping	189,842	45,686		235,528		235,528	(37,340)	198,188			3
4	Laundry	24,146	26,864		51,010		51,010		51,010			4
5	Heat and Other Utilities			78,861	78,861		78,861		78,861			5
6	Maintenance	247,143	90,804	18,279	356,226		356,226	(61,969)	294,257			6
7	Other (specify):*											7
8	TOTAL General Services	768,088	419,716	104,801	1,292,605		1,292,605	(131,344)	1,161,261			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,124,265	133,196	67,131	2,324,592		2,324,592	(65,415)	2,259,177			10
10a	Therapy	65,585	1,005	279,569	346,159		346,159		346,159			10a
11	Activities	109,392	12,652	13,746	135,790		135,790		135,790			11
12	Social Services	83,072		960	84,032		84,032		84,032			12
13	CNA Training			3,158	3,158		3,158		3,158			13
14	Program Transportation			15,531	15,531		15,531		15,531			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,382,314	146,853	386,095	2,915,262		2,915,262	(65,415)	2,849,847			16
	C. General Administration											
17	Administrative	137,011			137,011		137,011		137,011			17
18	Directors Fees											18
19	Professional Services			5,397	5,397		5,397		5,397			19
20	Dues, Fees, Subscriptions & Promotions			17,089	17,089		17,089	(2,510)	14,579			20
21	Clerical & General Office Expenses	61,360	22,723	140,748	224,831		224,831	(181)	224,650			21
22	Employee Benefits & Payroll Taxes			851,479	851,479		851,479		851,479			22
23	Inservice Training & Education			12,748	12,748		12,748		12,748			23
24	Travel and Seminar			9,547	9,547		9,547		9,547			24
25	Other Admin. Staff Transportation			4,256	4,256		4,256		4,256			25
26	Insurance-Prop.Liab.Malpractice			74,965	74,965		74,965		74,965			26
27	Other (specify):*											27
28	TOTAL General Administration	198,371	22,723	1,116,229	1,337,323		1,337,323	(2,691)	1,334,632			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,348,773	589,292	1,607,125	5,545,190		5,545,190	(199,450)	5,345,740			29

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

SEE ACCOUNTANTS' PREPARATION 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 & ID Number Fairview Haven #0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			137,390	137,390		137,390	2,729	140,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			713	713		713	(713)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,460	8,460		8,460		8,460			35
36	Other (specify):*											36
37	**TOTAL Ownership**			146,563	146,563		146,563	2,016	148,579			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,167	22,166	93,333		93,333		93,333			39
40	Barber and Beauty Shops			26,500	26,500		26,500		26,500			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,978	160,978		160,978		160,978			42
43	Other (specify):* Disallowed Costs	86,707		253,316	340,023		340,023	(340,023)				43
44	**TOTAL Special Cost Centers**	86,707	71,167	462,960	620,834		620,834	(340,023)	280,811			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,435,480	660,459	2,216,648	6,312,587		6,312,587	(537,457)	5,775,130			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,113)	2		4
5	Telephone, TV & Radio in Resident Rooms	(340)	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	2,729	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	(2,963)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,511)	43		16
17	Non-Care Related Fees	(2,510)	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	(2,512)	43		24
25	Fund Raising, Advertising and Promotional	(14,726)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(494,511)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (537,457)		$	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))**	$ (537,457)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Fairview Haven

ID# 0008524

Report Period Beginning: 7/1/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Vending Income	$ (815)	2	1
2	Non Care RN Wages	(7,438)	10	2
3	Non Care LPN Wages	(19,335)	10	3
4	Non Care CNA Wages	(38,642)	10	4
5	Non Care Dietary Wages	(10,107)	1	5
6	Non Care Housekeeping Wages	(37,340)	3	6
7	Non Care Maintenance Wages	(61,969)	6	7
8	Non Care Real Estate Taxes	(713)	33	8
9	Non Care Expenses	(88,943)	43	9
10	Non Care Utilities	(58,028)	43	10
11	Non Care Depreciation	(67,882)	43	11
12	Non Care ALF/ILF wages	(48,000)	43	12
13	Offset Cable TV Income	(16,411)	43	13
14	Offset Misc Income against Office Supplies	(181)	21	14
15	Disallow Marketing Wages	(38,707)	43	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**	(494,511)		49

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 [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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	Board of Directors:							1
2	Eric Kaeb-President	0						2
3	Kevin Schaffer-Vice President	0						3
4	Mark Waldbeser-Treasurer	0						4
5	Nelson Zehr-Secretary	0						5
6	Duane Walter-Trustee	0						6
7	Rod Steffen-Trustee	0						7
8	Neil Bahler-Trustee	0						8
9	Dan Banwart-Trustee	0						9
10	Ben Kafer-Trustee	0						10
11								11
12								12
13								13
14								14
15								15
16								16
17	Note: None of the Board of Directors directly provided services to the nursing home.							17
18	Note: There are no entities in which a Board member has ownership that conducted business transactions with this nursing home except the following:							18
19	1) Ben Kafer owns Kafer Tiling and was paid $431 for services							19
20	2) Rod Steffen is part owner of MetzStoller (Insurance) and was paid $200 for services							20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

**** 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 # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	**2015**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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:			
	2011		**8**
	2012		**9**
	2013		**10**
	2014		**11**
	2015		**12**

This facility is exempt from paying real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	**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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Dave Blunier

TELEPHONE (815) 692-2572 FAX #: (815) 692-4557

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/1/15 Ending: 6/30/16

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).

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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$	50	$	$	$ 145,220	4
5	8		1999	1999	354,656		39	9,094	9,094	157,015	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			1965	258		50	4	4	258	9
10	Additions 66-67			1966	2,116	44	50	42	(2)	2,108	10
11	Additions 67-68			1967	13,436	269	50	269		13,175	11
12	Additions 69-70			1969	1,893	38	50	38		1,783	12
13	Additions 71-72			1971	26,066	521	50	521		23,452	13
14	Additions 72-73			1972	6,314	126	50	126		5,550	14
15	Additions 77-78			1978	4,507	90	50	90		3,467	15
16	Sprinkler System			1979	42,306	846	50	846		31,445	16
17	Generator Room			1979	8,460	169	50	169		6,284	17
18	Additions 79-80			1979	1,578	32	50	32		1,193	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		2,595	23
24	Smoke Detector			1980	1,575		15			1,575	24
25	Additions 80-81			1981	16,207	324	50	324		11,507	25
26	Porch Enclosure			1981	9,453	189	50	189		6,584	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		1,371	30
31	Room D2 Addition			1982	432	9	50	9		305	31
32	Room B14 Addition			1982	2,380	48	50	48		1,635	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				1983	8,205	164	50	164		5,304	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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		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		157	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		11,408	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	278	7	8,585	48
49	Courtyard	1987	19,000	633	30	633		18,412	49
50	Remodel Linen Room	1988	21,731	148	17		(148)	21,731	50
51	Courtyard	1988	1,827	61	30	61		1,723	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	857	(10)	21,664	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)	163,018	57
58	Office Remodel	1994	20,943	838	25	838		18,745	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		704	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		771	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	$ 13,446		$ 22,052	$ 8,606	$ 1,017,194	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 13,446		$ 22,052	$ 8,606	$ 1,017,194	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		15			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		7			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		4,386	31
32	Activity draperies	2003	662		10			662	32
33	Concrete improvements	2003	4,566	304	15	304		3,976	33
34	TOTAL (lines 1 thru 33)		$ 1,406,527	$ 14,073		$ 22,679	$ 8,606	$ 1,159,589	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 14,073		$ 22,679	$ 8,606	$ 1,159,589	1
2	Plumbing rough in	2004	955		10			955	2
3	Window blinds	2004	643		7			643	3
4	Kitchen grease trap	2003	738		10			738	4
5	Driveway	2004	4,504	300	15	300		3,624	5
6	Sprinkler system	2004	1,090		10			1,090	6
7	Kitchen grease trap	2003	2,561	171	15	171		2,177	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		262	10
11	Light fixtures	2003	595		10			595	11
12	Air conditioning units	2003	4,222	281	15	281		3,577	12
13	Dining draperies	2004	1,300		7			1,300	13
14	Front parking lot	2005	5,912	394	15	394		4,350	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		10			26,592	17
18	5T Air conditioning	2005	2,150		7			2,150	18
19	C Wing ductwork	2005	3,013	201	15	201		2,212	19
20	13 bathroom remodeling	2005	4,979	332	15	332		3,512	20
21	Bathroom steel door frames	2006	1,353	90	15	90		920	21
22	5 ton condensor	2005	8,697	145	10	147	2	8,697	22
23	Fire system engineering	2005	2,787	186	15	186		1,958	23
24	North basement office remodel	2006	2,460	164	15	164		1,705	24
25	Foam roofing	2006	2,292	153	15	153		1,602	25
26	Door alarm and keypad	2005	2,592	108	10	120	12	2,592	26
27	Fire door closures and shutters	2005	3,383	141	10	145	4	3,383	27
28	B hall shower tile	2006	935	62	15	62		646	28
29	Bathtub	2006	10,264	599	10	625	26	10,264	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	358	(3)	3,610	33
34	TOTAL (lines 1 thru 33)		$ 1,539,378	$ 17,782		$ 26,429	$ 8,647	$ 1,283,546	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 17,782		$ 26,429	$ 8,647	$ 1,283,546	1
2	Fire alarm system	2006	3,478		7			3,478	2
3	Air conditioning	2006	2,059	137	15	137		1,471	3
4	Guttering system	2007	2,573	103	25	103		1,440	4
5	Air conditioning	2007	7,549	503	15	503		4,621	5
6	Door alarm system	2006	1,033		7			1,033	6
7	Landscaping	2007	25,605	2,561	10	2,561		21,519	7
8	Dock improvements	2008	2,905	194	15		(194)		8
9	Fornt door opener	2008	404	40	10	40		340	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		3,366	10
11	Garbage disposal	2008	937	94	10	94		775	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		4,696	12
13	West side window replacement	2007	16,191	1,079	15	1,079		9,537	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831	255	15	255		2,104	14
15	Furnace	2008	4,070		7			4,070	15
16	Ductwork repair	2008	3,523	235	15	235		1,941	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		16,976	17
18	Shower repair	2008	820		7			820	18
19	Kitchen water softener	2008	1,819		7			1,819	19
20	Carpeting b-wing and rooms	2008	8,646	576	15	576		4,767	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		4,859	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		2,258	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		2,333	23
24	Daffodil drive - air conditioner	2009	916	120	7	119	(1)	916	24
25	Dock Upgrade	2008	11,078	739	15	739		5,665	25
26	Fire system upgrade	2008	2,860	191	15	191		1,480	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		9,780	27
28	New window	2009	316	21	15	21		151	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		4,951	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		9,337	30
31	Therapy room air conditioner	2009	1,535	110	7	111	1	1,535	31
32	Window	2009	2,974	198	15	198		1,419	32
33	Door Alarm/Intercom Upgrades	2010	3,250	217	15	218	1	1,380	33
34	TOTAL (lines 1 thru 33)		$ 1,760,809	$ 32,692		$ 41,146	$ 8,454	$ 1,414,383	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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		$ 1,760,809	$ 32,692		$ 41,146	$ 8,454	$ 1,414,383	1
2	Fire alarm upgrade	2009	3,267	218	15	218		1,453	2
3	Generator Repairs	2010	9,550	478	20	478		2,390	3
4	Cordless phone system for nurses	2010	1,010	134	15	67	(67)	430	4
5	New heating/cooling unit	2010	16,616	2,374	7	2,374		14,442	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		6,058	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		15,624	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		2,458	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		11,476	9
10	Room Heaters	2011	1,540	220	7	220		1,183	10
11	Windows	2011	5,583	372	15	372		1,876	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		4,106	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		2,008	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		25,694	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		1,785	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		3,794	16
17	Gas line for dryers	2012	1,619	108	15	108		526	17
18	Generator Repairs	2012	2,299	115	20	115		532	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		1,225	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		5,558	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		505	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		4,658	22
23	Social Services AC repair	2012	5,415	361	15	361		1,414	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	426	15	426		1,633	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	157	15	157		550	25
26	Replace Sprinkler System	2013	57,060	3,804	15	3,804		12,838	26
27	Dining Room Exit Door replaced	2013	3,419	228	15	228		760	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	724	15	724		2,232	28
29	Resident Room Remodel- Angel Ave 1/15, Blessings Way 1,	2013	31,485	2,099	15	2,099		6,297	29
30	Country Ct 4, Daffodil Dr 1/3/4 (A-1 & 15, B-1, C-4 and D-1 & 3)								30
31	Flooring, windows, cabinets, drywall, trim, paint								31
32									32
33	Prior Year Improvements Not Included on Prior Year Cost Reports			7,641			(7,641)		33
34	TOTAL (lines 1 thru 33)		$ 2,154,924	$ 67,859		$ 68,605	$ 746	$ 1,547,888	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 12E, Carried Forward		$ 2,154,924	$ 67,859		$ 68,605	$ 746	$ 1,547,888	1
2	Fire Alarm System Repairs	2013	5,101	340	15	340		935	2
3	D-9: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	7,105	474	15	474		1,264	3
4	Doors at Kitchen and timeclock entrances	2013	4,593	306	15	306		791	4
5	Kitchen Water Heater Replacement	2013	6,887	459	15	459		1,186	5
6	D-11: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	10,470	698	15	698		1,745	6
7	Window Replacement in resident Rooms	2014	8,342	556	15	556		1,344	7
8	C-1, C-2, C Restroom C Bath: Drywall, Electrical, Plumbing, Trin	2014	99,694	6,646	15	6,646		15,784	8
9	Daffodil Shower Room	2014	27,162	1,811	15	1,811		4,226	9
10	D-12: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2014	5,818	388	15	388		840	10
11	Replace HVAC Systems	2014	8,544	570	15	570		855	11
12	Flooring - Blessings Way #2	2015	2,633	176	15	176		264	12
13	Call System	2015	72,604	4,840	15	4,840		7,260	13
14	Replace Driveway to Dock Area	2015	13,645	910	15	910		1,365	14
15	Drapes for Therapy Room & Resident Room	2015	3,372	225	15	225		337	15
16	Replace Concrete Underneath Carport	2016	6,187	52	15	206	154	206	16
17	Activity Room/Kitchen HVAC replacement	2015	8,376	326	15	279	(47)	279	17
18	Call system additions/replacements	2015	7,636	509	15	255	(254)	255	18
19	Replace electrical panel	2016	5,905	49	15	197	148	197	19
20	Generator repairs	2016	12,968	36	15	432	396	432	20
21	Replace sconces in hallway	2015	3,716	31	15	124	93	124	21
22	Kitchen HVAC replacement	2016	1,876	16	15	63	47	63	22
23	Installed new key pads	2015	1,763	64	15	59	(5)	59	23
24	Remodel office area-Moved walls, new floor covering,								24
25	paint, lights, wiring	2015	31,245	1,475	15	1,042	(433)	1,042	25
26	Replace floor in timeclock area	2016	5,001	125	15	167	42	167	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,515,567	$ 88,941		$ 89,828	$ 887	$ 1,588,908	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 208,715	$ 29,018	$ 29,018	$		$ 106,419	71
72	Current Year Purchases	88,772	6,647	6,647			6,647	72
73	Fully Depreciated Assets	767,213	927	927			767,213	73
74								74
75	TOTALS	$ 1,064,700	$ 36,592	$ 36,592	$		$ 880,279	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 Do	03 ford bus	2006	44,745				5	44,745	77
78	Patient Transport	Chrysler town and country	2011	17,000		1,842	1,842	5	17,000	78
79	Bus	Midwest Transit	2015	59,285	11,857	11,857		5	14,327	79
80	TOTALS			$ 168,467	$ 11,857	$ 13,699	$ 1,842		$ 123,509	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)	$ 3,755,156	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,390	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,119	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,729	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,592,696	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	$ 2,361,264	$ 60,689	$ 1,349,266	86
87	Buffet Line	18,500		18,500	87
88	East Haven Condo #10	205,153	7,193	10,559	88
89					89
90					90
91	TOTALS	$ 2,584,917	$ 67,882	$ 1,378,325	91

G. Construction-in-Progress

	Description	Cost	
92	Memory Support Consulting	$ 55,156	92
93			93
94			94
95		$ 55,156	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' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	N/A						4
5								5
6								6
7	TOTAL				$ **			7

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

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

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 8,460 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	N/A				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' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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: 7
- IN OTHER FACILITY:
- COMMUNITY COLLEGE:
- HOURS PER CNA: 85

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM: 7
- IN OTHER FACILITY:
- HOURS PER CNA: 45

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 765	$	$ 765
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,393		2,393
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 3,158	$	$ 3,158
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,158			

C. CONTRACTUAL INCOME

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

$ None

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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	$	40,564	$	125,014	$	40,564	$ 125,014	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		10,666		41,507		10,666	41,507	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		37,388		113,048	1,005	37,388	114,053	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					71,167		71,167	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			$	88,618	$	279,569	$ 72,172	88,618	$ 351,741	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' PREPARATION REPORT

Facility Name & ID Number Fairview Haven **#** 0008524 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(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	$ 308,922	$ 308,922	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	229,615	229,615	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,320,578	1,320,578	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,608	1,608	7
8	Accounts Receivable (owners or related parties)	15,000	15,000	8
9	Other(specify): Insurance Trusts	15,539	15,539	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,891,262	$ 1,891,262	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,422	6,422	13
14	Buildings, at Historical Cost	2,029,751	2,515,567	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,442,898	1,233,167	16
17	Accumulated Depreciation (book methods)	(2,461,241)	(2,592,696)	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 (spe AL/IL Assets	1,569,612	1,261,748	22
23	Other(specify): Investment in East Haven Condo	579,689	579,689	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,167,131	$ 3,003,897	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,058,393	$ 4,895,159	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,017	$ 127,017	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,834	192,834	30
31	Accrued Taxes Payable (excluding real estate taxes)	226	226	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	Accrued Insurance	6,289	6,289	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 326,366	$ 326,366	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)**	$ 326,366	$ 326,366	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,732,027	$ 4,568,793	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,058,393	$ 4,895,159	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,712,530	1
2	Restatements (describe):		2
3	**Prior year post closing adjustments**	(32,068)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,680,462	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,565	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)**	$ 51,565	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)**	$ 4,732,027	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,045,901	1
2	Discounts and Allowances for all Levels	(192,198)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,853,703	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,929	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,929	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	815	12
13	Barber and Beauty Care	26,288	13
14	Non-Patient Meals	21,113	14
15	Telephone, Television and Radio	16,411	15
16	Rental of Facility Space		16
17	Sale of Drugs	4	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,421	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 68,052	23
	D. Non-Operating Revenue		
24	Contributions	493,117	24
25	Interest and Other Investment Income***	76,449	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 569,566	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent and Assisted Living Fees	673,321	28
28a	Resident Personal Items/Miscellaneous Revenue	19,581	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 692,902	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,364,152	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,292,605	31
32	Health Care	2,915,262	32
33	General Administration	1,337,323	33
	B. Capital Expense		
34	Ownership	146,563	34
	C. Ancillary Expense		
35	Special Cost Centers	459,856	35
36	Provider Participation Fee	160,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,312,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	51,565	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 51,565	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 294,351	44
45	Private Pay - Net Inpatient Revenue	4,039,822	45
46	Medicare - Net Inpatient Revenue	530,855	46
47	Other-(specify) Other Contractual Allowances	(11,325)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,853,703	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' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	2,040	2,080	$ 67,441	$ 32.42	1
2	Assistant Director of Nursing	2,062	2,131	62,938	29.53	2
3	Registered Nurses	11,659	11,952	355,589	29.75	3
4	Licensed Practical Nurses	17,135	17,509	451,321	25.78	4
5	CNAs & Orderlies	75,246	76,658	1,016,881	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,271	3,311	65,585	19.81	8
9	Activity Director	1,745	1,773	26,590	15.00	9
10	Activity Assistants	6,649	6,738	82,802	12.29	10
11	Social Service Workers	6,410	6,494	83,072	12.79	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,575	17.58	13
14	Head Cook	11,567	11,664	145,779	12.50	14
15	Cook Helpers/Assistants	13,369	13,495	124,603	9.23	15
16	Dishwashers					16
17	Maintenance Workers	11,536	11,595	247,143	21.31	17
18	Housekeepers	20,324	20,545	189,842	9.24	18
19	Laundry	2,539	2,617	24,146	9.23	19
20	Administrator	2,080	2,080	91,524	44.00	20
21	Assistant Administrator	971	1,040	45,487	43.74	21
22	Other Administrative	832	832	38,707	46.52	22
23	Office Manager					23
24	Clerical	4,154	4,217	61,360	14.55	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	3,459	3,513	47,068	13.40	31
32	Other Health C: ALF Caregiver	2,912	2,912	48,000	16.48	32
33	Other(specify) See Att Sch 20A	3,920	3,997	123,027	30.78	33
34	TOTAL (lines 1 - 33)	205,960	209,233	$ 3,435,480 *	$ 16.42	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	132	$ 7,661	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	41	3,029	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,960	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	17	1,301	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)	202	$ 22,911		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	227	$ 8,218	L10, C3	50
51	Licensed Practical Nurses	458	20,197	L10, C3	51
52	Certified Nurse Assistants/Aides	988	22,877	L10, C3	52
53	TOTAL (lines 50 - 52)	1,673	$ 51,292		53

Fairview Haven

Period Beginning **7/1/15**
Period End **6/30/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Restorative Nurse		1,392	1,439	47,242	32.83
MDS Coordinator		2,528	2,558	75,785	29.63
	TOTAL	3,920	3,997	123,027	

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Plattner	Administrator	0	$ 44,024
David Blunier	Administrator/Asst Admin	0	92,987
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,011

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Templin Healthcare Acctg Svc	Accounting	$ 5,210
FR & R Healthcare Consulting	Medicare Consultant	187
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,397

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 190,850
Unemployment Compensation Insurance	593
FICA Taxes	251,346
Employee Health Insurance	297,976
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Insurance	30,213
Pension Plan	57,092
Employee Physicals	2,680
Uniforms	2,083
Employee Appreciation	16,326
Scholarship	434
Employee Recruitment	1,886
TOTAL (agree to Schedule V, line 22, col.8)	$ 851,479

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 17)	491
Patient Background Checks 38	380
Leading Age dues	4,647
Misc Subscriptions	3,169
Misc Dues and Licenses	1,912
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,893
Seminar Expense	7,654
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,547

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/1/15 Ending: 6/30/16

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. **4,647 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. $ **41,892** 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. $ **160,978**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **21,928**

(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? **78**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Fairview Haven
6/30/2016
Inservice Training Attachment

Description	Cost
Food Certification Classes	420
Relias Learning (Electronic Services)	9,054
Miscellaneous Materials Inservice	3,274
	12,748