

		FOR BHF USE				

LL1

**2020  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2020)**

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

Address: 605 North 4th St Fairbury 61739  
Number City 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:

VOLUNTARY, NON-PROFIT  
 Charitable Corp.  
 Trust  
IRS Exemption Code \_\_\_\_\_

PROPRIETARY  
 Individual  
 Partnership  
 Corporation  
 "Sub-S" Corp.  
 Limited Liability Co.  
 Trust  
 Other \_\_\_\_\_

GOVERNMENTAL  
 State  
 County  
 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 7/1/2019 to 6/30/20 and certify to the best of my knowledge and belief that the said 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 326, Plainfield, IL 60544-0326  
(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: 7/1/2019 Ending: 6/30/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	19,032	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	52	TOTALS	52	19,032	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			943	943	8
9	SNF/PED					9
10	ICF	2,884	14,182		17,066	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,884	14,182	943	18,009	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.62%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels, Independent and Assisted Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?  
 Date started 8/10/1962

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 52 and days of care provided 692

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/20 Fiscal Year: 6/30/20

\* 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: 7/1/2019 Ending: 6/30/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	281,786	18,627	5,708	306,121		306,121		306,121		1
2	Food Purchase		213,588		213,588		213,588	(19,359)	194,229		2
3	Housekeeping	60,078	43,093		103,171		103,171		103,171		3
4	Laundry	37,081	20,088		57,169		57,169		57,169		4
5	Heat and Other Utilities			101,321	101,321		101,321		101,321		5
6	Maintenance	263,008	109,966	53,624	426,598		426,598	(2,203)	424,395		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>641,953</b>	<b>405,362</b>	<b>160,653</b>	<b>1,207,968</b>		<b>1,207,968</b>	<b>(21,562)</b>	<b>1,186,406</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	2,029,518	126,505	26,106	2,182,129		2,182,129		2,182,129		10
10a	Therapy	28,229			28,229		28,229		28,229		10a
11	Activities	121,079	5,945	12,239	139,263		139,263		139,263		11
12	Social Services	90,005		1,236	91,241		91,241		91,241		12
13	CNA Training										13
14	Program Transportation			9,631	9,631		9,631	(7,028)	2,603		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,268,831</b>	<b>132,450</b>	<b>62,212</b>	<b>2,463,493</b>		<b>2,463,493</b>	<b>(7,028)</b>	<b>2,456,465</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	106,113			106,113		106,113		106,113		17
18	Directors Fees										18
19	Professional Services			9,283	9,283		9,283		9,283		19
20	Dues, Fees, Subscriptions & Promotions			28,675	28,675		28,675	(65)	28,610		20
21	Clerical & General Office Expenses	112,973	32,405	208,765	354,143		354,143	(12,368)	341,775		21
22	Employee Benefits & Payroll Taxes			694,363	694,363		694,363		694,363		22
23	Inservice Training & Education			18,533	18,533		18,533		18,533		23
24	Travel and Seminar			7,082	7,082		7,082	(3,558)	3,524		24
25	Other Admin. Staff Transportation			2,933	2,933		2,933		2,933		25
26	Insurance-Prop.Liab.Malpractice			64,568	64,568		64,568		64,568		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>219,086</b>	<b>32,405</b>	<b>1,034,202</b>	<b>1,285,693</b>		<b>1,285,693</b>	<b>(15,991)</b>	<b>1,269,702</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,129,870</b>	<b>570,217</b>	<b>1,257,067</b>	<b>4,957,154</b>		<b>4,957,154</b>	<b>(44,581)</b>	<b>4,912,573</b>		<b>29</b>

\*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 &amp; ID Number

Fairview Haven

#0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			170,866	170,866		170,866	4,103	174,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			522	522		522	(522)				32
33	Real Estate Taxes			6,595	6,595		6,595	(6,595)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,558	11,558		11,558		11,558			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			189,541	189,541		189,541	(3,014)	186,527			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,177	342,401	376,578		376,578		376,578			39
40	Barber and Beauty Shops			13,185	13,185		13,185		13,185			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,608	163,608		163,608		163,608			42
43	Other (specify):* <b>Disallowed Costs</b>	90,060		49,856	139,916		139,916	(139,916)				43
44	<b>TOTAL Special Cost Centers</b>	90,060	34,177	569,050	693,287		693,287	(139,916)	553,371			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,219,930	604,394	2,015,658	5,839,982		5,839,982	(187,511)	5,652,471			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:

7/1/2019

Ending:

6/30/20

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,003)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,244)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,103	30		9
10	Interest and Other Investment Income	(522)	32		10
11	Discounts, Allowances, Rebates & Refunds	(45)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,306)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(236)	43		16
17	Non-Care Related Fees	(65)	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	(1,619)	43		24
25	Fund Raising, Advertising and Promotional	(9,896)	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	(148,678)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (187,511)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (187,511)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Fairview Haven

ID# 0008524

Report Period Beginning: 7/1/2019

Ending: 6/30/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Offset Vending Income	\$ (1,311)	2	1
2	Offset Cable TV Income & Disallow Remainder	(23,035)	43	2
3	Offset Misc Income against Office Supplies	(1,124)	21	3
4	Disallow Marketing Wages	(76,376)	43	4
5	Disallow Senior Service Wages	(13,684)	43	5
6	Non-Care Related Expenses	(13,764)	43	6
7	Disallow Real Estate Taxes	(6,595)	33	7
8	Disallow Out of State Travel/Seminar	(3,558)	24	8
9	Offset Transportation Income Against Expense	(7,028)	14	9
10	Offset Maintenance Income Against Expense	(2,203)	6	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	<b>Total</b>	(148,678)		49

**VII. RELATED PARTIES**

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

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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	0
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	<b>Total</b>		\$			\$	\$ *	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:

7/1/2019

Ending:

6/30/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<b>Board of Directors:</b>							1
2	<b>Ben Kafer-President</b>							2
3	<b>Neil Bahler-Vice President</b>	0						3
4	<b>Mark Waldbeser-Secretary</b>	0						4
5	<b>Dan Banwart-Treasurer</b>	0						5
6	<b>Duane Walter-Trustee</b>	0						6
7	<b>Rod Steffen-Trustee</b>	0						7
8	<b>Nelson Zehr-Trustee</b>	0						8
9	<b>Kevin Schaffer-Trustee</b>	0						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17	<b>Note: None of the Board of Directors directly provided services to the nursing home.</b>							17
18	<b>Note: There are no entities in which a Board member has ownership that conducted business transactions with this nursing home except the following:</b>							18
19	<b>1) Rod Steffen is part owner of Compass Insurance and was paid \$200 for services</b>							19
20	<b>2) Ben Kafer is owner of Kafer Tiling &amp; Excavating which provided services to help construct Serenity Villa (memory support assisted living). These costs were capitalized and</b>							20
21	<b>included in the non-care section of the balance sheet.</b>							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:

7/1/2019

Ending:

6/30/20

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	N/A								\$	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:

7/1/2019

Ending: 6/30/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 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.)	2019	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2015	8	
	2016	9	
	2017	10	
	2018	11	
	2019	12	
<b>This facility is exempt from paying real estate taxes.</b>			
			<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2019 \$	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

**2019 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 2019 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 2019.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**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:

7/1/2019 Ending:

6/30/20

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,213 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living-13 units

Independent Living-15 units

East Haven Condominium-14 units located off campus

Serenity Villa-20 Units-Alzheimers Assisted Living

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: 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:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	1962	1962	\$ 145,220	\$	50	\$	\$	\$ 145,220	4
5	8	1999	1999	354,656		39	9,094	9,094	193,391	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Additions 65-66		1965	258		50			258	9
10	Additions 66-67		1966	2,116		50			2,116	10
11	Additions 67-68		1967	13,436		50			13,436	11
12	Additions 69-70		1969	1,893		50			1,893	12
13	Additions 71-72		1971	26,066	521	50	521		25,536	13
14	Additions 72-73		1972	6,314	126	50	126		6,054	14
15	Additions 77-78		1978	4,507	90	50	90		3,827	15
16	Sprinkler System		1979	42,306	846	50	846		34,829	16
17	Generator Room		1979	8,460	169	50	169		6,960	17
18	Additions 79-80		1979	1,578	32	50	32		1,321	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		2,875	23
24	Smoke Detector		1980	1,575		15			1,575	24
25	Additions 80-81		1981	16,207	324	50	324		12,803	25
26	Porch Enclosure		1981	9,453	189	50	189		7,340	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		1,531	30
31	Room D2 Addition		1982	432	9	50	9		341	31
32	Room B14 Addition		1982	2,380	48	50	48		1,827	32
33	Exhaust Fan		1982	322		10			322	33
34	New Roof		1982	3,582		10			3,582	34
35	New Air Conditioning		1982	2,590		10			2,590	35
36	Remodel Kitchen and D.R.		1983	8,205	164	50	164		5,960	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	New Sign	1983	\$ 994	\$	10	\$	\$	\$ 994	37
38	Landscape	1983	1,455		30			1,455	38
39	Attic Fan	1983	1,381		10			1,381	39
40	Kitchen Cabinets & Fixtures	1983	619		20			619	40
41	Social Service office	1986	227	5	50	5		177	41
42	Outside Light Fixture	1986	437		10			437	42
43	Blacktop Drive & Trees	1962	2,750	50	10		(50)	2,750	43
44	Laundry Room	1978	14,944	299	50	299		12,604	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		30			8,585	48
49	Courtyard	1987	19,000		30			19,000	49
50	Remodel Linen Room	1988	21,731		17			21,731	50
51	Courtyard	1988	1,827		30			1,827	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		25			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		25			173,371	57
58	Office Remodel	1994	20,943		25			20,943	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	22	25	30	8	833	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		923	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	\$ 3,042		\$ 12,094	\$ 9,052	\$ 1,079,201	70

SEE ACCOUNTANTS' PREPARATION REPORT

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



Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,263,078	\$ 3,042		\$ 12,094	\$ 9,052	\$ 1,079,201	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		15			4,850	31
32	Activity draperies	2003	662		10			662	32
33	Concrete improvements	2003	4,566		15			4,566	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,406,527	\$ 3,042		\$ 12,094	\$ 9,052	\$ 1,222,650	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,406,527	\$ 3,042		\$ 12,094	\$ 9,052	\$ 1,222,650	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		15			4,504	5
6	Sprinkler system	2004	1,090		10			1,090	6
7	Kitchen grease trap	2003	2,561		15			2,561	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		346	10
11	Light fixtures	2003	595		10			595	11
12	Air conditioning units	2003	4,222		15			4,222	12
13	Dining draperies	2004	1,300		7			1,300	13
14	Front parking lot	2005	5,912	361	15	380	19	5,912	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	198	(3)	3,013	19
20	13 bathroom remodeling	2005	4,979	332	15	332		4,840	20
21	Bathroom steel door frames	2006	1,353	90	15	90		1,280	21
22	5 ton condensor	2005	8,697		10			8,697	22
23	Fire system engineering	2005	2,787	186	15	186		2,702	23
24	North basement office remodel	2006	2,460	164	15	164		2,361	24
25	Foam roofing	2006	2,292	153	15	153		2,214	25
26	Door alarm and keypad	2005	2,592		10			2,592	26
27	Fire door closures and shutters	2005	3,383		10			3,383	27
28	B hall shower tile	2006	935	62	15	62		894	28
29	Bathtub	2006	10,264		10			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		10			3,610	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,539,378	\$ 4,612		\$ 13,680	\$ 9,068	\$ 1,354,911	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,539,378	\$ 4,612		\$ 13,680	\$ 9,068	\$ 1,354,911	1
2	Fire alarm system	2006	3,478		7			3,478	2
3	Air conditioning	2006	2,059	137	15	137		2,019	3
4	Guttering system	2007	2,573	103	25	103		1,852	4
5	Air conditioning	2007	7,549	503	15	503		6,633	5
6	Door alarm system	2006	1,033		7			1,033	6
7	Landscaping	2007	25,605		10			25,605	7
8	Dock improvements	2008	2,905	194	15		(194)		8
9	Fornt door opener	2008	404		10			404	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331	422	15	422		5,054	10
11	Garbage disposal	2008	937		10			937	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631	575	15	575		6,996	12
13	West side window replacement	2007	16,191	1,079	15	1,079		13,853	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831	255	15	255		3,124	14
15	Furnace	2008	4,070		7			4,070	15
16	Ductwork repair	2008	3,523	235	15	235		2,881	16
17	Landscape, sprinkler system repair	2007	29,381	1,959	15	1,959		24,812	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		7,071	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294	686	15	686		7,603	21
22	Blessing Way - Heat/Trim	2009	4,519	301	15	301		3,462	22
23	Country Court - Handrail, drywall, carpet	2008	4,515	301	15	301		3,537	23
24	Daffodil drive - air conditioner	2009	916		7			916	24
25	Dock Upgrade	2008	11,078	739	15	739		8,621	25
26	Fire system upgrade	2008	2,860	191	15	191		2,244	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230	1,349	15	1,349		15,176	27
28	New window	2009	316	21	15	21		235	28
29	Resident rooms - heating/furn	2009	10,484	699	15	699		7,747	29
30	Sprinkler System upgrade	2009	18,674	1,245	15	1,245		14,317	30
31	Therapy room air conditioner	2009	1,535		7			1,535	31
32	Window	2009	2,974	198	15	198		2,211	32
33	Door Alarm/Intercom Upgrades	2010	3,250	217	15	218	1	2,252	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,760,809	\$ 16,597		\$ 25,472	\$ 8,875	\$ 1,537,228	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 1,760,809	\$ 16,597		\$ 25,472	\$ 8,875	\$ 1,537,228	1
2	Fire alarm upgrade	2009	3,267	218	15	218		2,325	2
3	Generator Repairs	2010	9,550	478	20	478		4,302	3
4	Cordless phone system for nurses	2010	1,010	134	15	67	(67)	698	4
5	New heating/cooling unit	2010	16,616		7			16,616	5
6	Convert nsg station to office, paint, trim, wall cover, drywall	2010	14,841	989	15	989		10,014	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	2,329	15	2,329		24,940	7
8	New flooring, paint and trim doors	2010	5,742	383	15	383		3,990	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,861	15	1,861		18,920	9
10	Room Heaters	2011	1,540		7			1,540	10
11	Windows	2011	5,583	372	15	372		3,364	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		7,210	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		3,588	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		45,270	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		3,465	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		7,230	16
17	Gas line for dryers	2012	1,619	108	15	108		958	17
18	Generator Repairs	2012	2,299	115	20	115		992	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		2,213	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		10,894	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		1,005	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		9,042	22
23	Social Services AC repair	2012	5,415	361	15	361		2,858	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	426	15	426		3,337	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	157	15	157		1,178	25
26	Replace Sprinkler System	2013	57,060	3,804	15	3,804		28,054	26
27	Dining Room Exit Door replaced	2013	3,419	228	15	228		1,672	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	724	15	724		5,128	28
29	Resident Room Remodel- Angel Ave 1/15, Blessings Way 1,	2013	31,485	2,099	15	2,099		14,693	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			4,705			(4,705)		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,154,924	\$ 46,234		\$ 50,337	\$ 4,103	\$ 1,772,724	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 2,154,924	\$ 46,234		\$ 50,337	\$ 4,103	\$ 1,772,724	1
2	Fire Alarm System Repairs	2013	5,101	340	15	340		2,295	2
3	D-9: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	7,105	474	15	474		3,160	3
4	Doors at Kitchen and timeclock entrances	2013	4,593	306	15	306		2,015	4
5	Kitchen Water Heater Replacement	2013	6,887	459	15	459		3,022	5
6	D-11: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	10,470	698	15	698		4,537	6
7	Window Replacement in resident Rooms	2014	8,342	556	15	556		3,568	7
8	C-1, C-2, C Restroom C Bath: Drywall, Electrical, Plumbing, Trim	2014	99,694	6,646	15	6,646		42,368	8
9	Daffodil Shower Room	2014	27,162	1,811	15	1,811		11,470	9
10	D-12: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2014	5,818	388	15	388		2,392	10
11	Replace HVAC Systems	2014	8,544	570	15	570		3,135	11
12	Flooring - Blessings Way #2	2015	2,633	176	15	176		968	12
13	Call System	2015	72,604	4,840	15	4,840		26,620	13
14	Replace Driveway to Dock Area	2015	13,645	910	15	910		5,005	14
15	Drapes for Therapy Room & Resident Room	2015	3,372	225	15	225		1,237	15
16	Replace Concrete Underneath Carport	2016	6,187	412	15	412		1,854	16
17	Activity Room/Kitchen HVAC replacement	2015	8,376	558	15	558		2,511	17
18	Call system additions/replacements	2015	7,636	509	15	509		2,291	18
19	Replace electrical panel	2016	5,905	394	15	394		1,773	19
20	Generator repairs	2016	12,968	865	15	865		3,892	20
21	Replace sconces in hallway	2015	3,716	248	15	248		1,116	21
22	Kitchen HVAC replacement	2016	1,876	125	15	125		563	22
23	Installed new key pads	2015	1,763	118	15	118		531	23
24	Remodel office area-Moved walls, new floor covering,								24
25	paint, lights, wiring	2015	31,245	2,083	15	2,083		9,374	25
26	Replace floor in timeclock area	2016	5,001	333	15	333		1,499	26
27	Automatic Door Installations	2017	6,430	429	15	429		1,501	27
28	SNF Room B-9 Remodel (Floor Covering, Paint, Electrical, Lightii	2017	5,417	361	15	361		1,264	28
29	Therapy Room Replace HVAC System	2017	4,811	321	15	321		1,123	29
30	Generator Repairs	2016	8,111	541	15	541		1,893	30
31	Kitchen Office HVAC	2017	3,209	214	15	214		749	31
32	Laundry Room - Additional Capacity, HVAC System	2017	18,506	1,234	15	1,234		4,319	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,562,051	\$ 73,378		\$ 77,481	\$ 4,103	\$ 1,920,769	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:

7/1/2019

Ending:

6/30/20

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 2,562,051	\$ 73,378		\$ 77,481	\$ 4,103	\$ 1,920,769	1
2	HVAC Repair-Country Court	2017	13,970	1,397	10	1,397		3,609	2
3	Dishwashers	2017	19,211	1,921	10	1,921		4,802	3
4	Kitchen Sinks/Faucets	2018	4,001	200	20	200		441	4
5	HVAC-Laundry Room	2018	4,906	491	10	491		1,166	5
6	Business Office Curb Redo	2019	3,630	242	15	242		252	6
7	Flooring-Angel Ave #7	2018	1,617	324	5	324		620	7
8	Flooring-Blessings #14	2019	2,401	480	5	480		680	8
9	Country Court #3 - Flooring/Plumbing/Electrical	2019	6,652	1,330	5	1,330		1,663	9
10	Dining Services - Kitchen Hood Work	2019	7,150	477	15	477		517	10
11	Dining Services - Kitchen HVAC	2018	13,982	932	15	932		1,709	11
12	Dining Services - Walk-in Cooler Restoration	2018	16,573	1,105	15	1,105		1,796	12
13	Gutters on SNF	2019	7,952	530	15	530		773	13
14	Living Room/Administrator Office Window	2019	7,706	514	15	514		728	14
15	Therapy Room - Flooring	2018	2,379	476	5	476		734	15
16	Window Coverings- Admin, B14, C3	2019	6,095	1,219	5	1,219		1,473	16
17	Angel Ave Handicapped Accessible Door	2019	6,051	202	15	202		202	17
18	HVAC Upgrades in SNF	2019	9,906	330	15	330		330	18
19	Blessings Room 206-208 (Floor cover/paint/electrical/light)	2019	20,138	2,685	5	2,685		2,685	19
20	Business Office Parking Lot	2019	13,323	629	15	629		629	20
21	Activity Room Window Replacement	2020	14,642	244	15	244		244	21
22	Housekeeping Room Water Heater	2020	20,214	562	15	562		562	22
23	Conference Room (Kitchenette addition)	2020	5,563	278	5	278		278	23
24	Front Patio and Landscape upgrade	2020	10,154	85	10	85		85	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,780,267	\$ 90,031		\$ 94,134	\$ 4,103	\$ 1,946,747	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 313,236	\$ 46,977	\$ 46,977	\$	5-10 yrs	\$ 181,734	71
72	Current Year Purchases	77,004	5,280	5,280		5 yrs	5,280	72
73	Fully Depreciated Assets	877,588	1,859	1,859		5-10 yrs	877,588	73
74								74
75	TOTALS	\$ 1,267,828	\$ 54,116	\$ 54,116	\$		\$ 1,064,602	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 D	03 ford bus	2006	44,745				5	44,745	77
78	Maintenance	2008 Chrysler town and country	2011	17,000				5	17,000	78
79	See Attached Schedule 13A			134,429	26,719	26,719			97,576	79
80	TOTALS			\$ 243,611	\$ 26,719	\$ 26,719	\$		\$ 206,758	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)	\$ 4,298,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,866	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,969	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,103	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,218,107	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	\$ 2,604,420	\$ 74,756	\$ 1,618,709	86
87	Buffet Line	18,500		18,500	87
88	East Haven Condo #10	220,541	7,476	40,253	88
89	Memory Support Facility	3,854,311	77,086	141,325	89
90					90
91	TOTALS	\$ 6,697,772	\$ 159,318	\$ 1,818,787	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

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	\$	\$	\$	\$ 0		\$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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	2015 Midwest Transit Bus	2015	\$ 59,285	\$ 9,387	\$ 9,387	\$ 0	5	\$ 59,285	76
77	Patient Transport	2017 Chrysler town and country	2018	29,072	5,814	5,814	0	5	17,442	77
78	Patient Transport	2018 Chrysler Town & Country	2018	\$ 35,572	\$ 8,893	\$ 8,893	0	5	17,786	78
79	Patient Transport	2010 Ford 150	2019	10,500	2,625	2,625	0	5	3,063	79
80	TOTALS			\$ 134,429	\$ 26,719	\$ 26,719	\$ 0		\$ 97,576	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)	\$ 2,921,118	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,750	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,853	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,103	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,044,323	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2020</u>	\$ _____
13.	<u>/2021</u>	\$ _____
14.	<u>/2022</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A. N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 11,558 Description: Copiers

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	41,292	\$ 127,743	\$	41,292	\$ 127,743	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		15,392	42,553		15,392	42,553	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		51,068	156,335	1,180	51,068	157,515	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 prescripts				32,997		32,997	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>					401			401	12
13	Other (specify): <u>Lab/X-Ray</u>					15,369			15,369	13
14	<b>TOTAL</b>			\$	107,752	\$ 342,401	\$ 34,177	107,752	\$ 376,578	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

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,933,621	\$ 3,933,621	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	40,763	40,763	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	14,038	14,038	5
6	Prepaid Insurance	21,152	21,152	6
7	Other Prepaid Expenses	33,574	33,574	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,043,148	\$ 4,043,148	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		6,422	13
14	Buildings, at Historical Cost	202,877	2,780,267	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	112,933	1,511,439	16
17	Accumulated Depreciation (book methods)	(180,056)	(3,218,107)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify <u>Non SNF Assets</u> )	66,784	4,878,985	22
23	Other(specify): <u>Investment in East Haven Condo</u>	157,546	157,546	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 360,084	\$ 6,116,552	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,403,232	\$ 10,159,700	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 17,102	\$ 17,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,940	89,940	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivisional Payable</u>	3,336,166	3,336,166	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,443,208	\$ 3,443,208	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Restricted Gifts</u>	1,132,660	1,132,660	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,132,660	\$ 1,132,660	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,575,868	\$ 4,575,868	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (172,636)	\$ 5,583,832	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,403,232	\$ 10,159,700	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,928,134	1
2	Restatements (describe):		2
3			3
4	Transfer of Non-Nursing Home Equity	(7,972,757)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (44,623)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(128,013)	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)	\$ (128,013)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (172,636)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning: 7/1/2019

Ending:

6/30/20

**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		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,046,504	1
2	Discounts and Allowances for all Levels	(433,367)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,613,137	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	281,261	6
7	Oxygen	226	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 281,487	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,311	12
13	Barber and Beauty Care	12,751	13
14	Non-Patient Meals	18,003	14
15	Telephone, Television and Radio	17,426	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	107	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,452	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 51,050	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	710,382	24
25	Interest and Other Investment Income***	18,992	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 729,374	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Independent and Assisted Living Fees</b>	25,081	28
28a	<b>Resident Personal Items/Miscellaneous Revenue</b>	11,840	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 36,921	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,711,969	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,207,968	31
32	Health Care	2,463,493	32
33	General Administration	1,285,693	33
<b>B. Capital Expense</b>			
34	Ownership	189,541	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	529,679	35
36	Provider Participation Fee	163,608	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,839,982	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(128,013)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (128,013)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 368,297	44
45	Private Pay - Net Inpatient Revenue	3,845,277	45
46	Medicare - Net Inpatient Revenue	405,306	46
47	Other-(specify) <b>Other Contractual Allowances</b>	(5,743)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,613,137	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No-See Note A 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.

Note A: The 990 tax return also includes the income statement of the other divisions SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning: 7/1/2019

Ending: 6/30/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,043	2,083	\$ 83,444	\$ 40.06	1
2	Assistant Director of Nursing	1,588	1,588	51,931	32.70	2
3	Registered Nurses	8,085	10,895	313,355	28.76	3
4	Licensed Practical Nurses	12,468	16,571	400,410	24.16	4
5	CNAs & Orderlies	55,037	58,102	904,069	15.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,877	2,117	28,229	13.33	8
9	Activity Director	1,503	1,680	29,685	17.67	9
10	Activity Assistants	5,923	6,298	91,394	14.51	10
11	Social Service Workers	5,079	5,397	90,005	16.68	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	41,827	20.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,052	21,189	239,959	11.32	15
16	Dishwashers					16
17	Maintenance Workers	10,673	11,714	263,008	22.45	17
18	Housekeepers	4,874	5,083	60,078	11.82	18
19	Laundry	2,772	3,348	37,081	11.08	19
20	Administrator	2,016	2,080	106,113	51.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,865	6,149	112,973	18.37	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	2,749	3,334	56,720	17.01	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Att Sch 20A</u>	7,792	8,690	309,649	35.63	33
34	TOTAL (lines 1 - 33)	152,252	168,398	\$ 3,219,930 *	\$ 19.12	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	99	\$ 5,708	L1, C3	35
36	Medical Director	Monthly	13,000	L9, C3	36
37	Medical Records Consultant	26	2,192	L10, C3	37
38	Nurse Consultant	Monthly	23,750	L10, C3	38
39	Pharmacist Consultant	629	3,458	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	20	1,498	L11, C3	44
45	Social Service Consultant	10	1,236	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	784	\$ 50,842		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

**Fairview Haven**

**Period Beginning**      **7/1/2019**  
**Period End**            **6/30/20**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Restorative Nurse</b>	1,339	1,456	49,466	33.97
<b>Care Plan Coordinator</b>	4,568	4,940	162,145	32.82
<b>Marketing</b>	1,504	1,680	76,376	45.46
<b>Clinical Team Supervisor</b>	227	244	7,978	32.70
<b>Director of Senior Services</b>	154	370	13,684	36.98
<b>TOTAL</b>	<b>7,792</b>	<b>8,690</b>	<b>309,649</b>	



Facility Name & ID Number Fairview Haven

# 0008524

Report Period Beginning: 7/1/2019

Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
David Blunier	Administrator	0	\$ 106,113	Workers' Compensation Insurance		\$ 52,848	IDPH License Fee		\$ 3,980		
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		6,856		
				FICA Taxes		231,944	Health Care Worker Background Check		235		
				Employee Health Insurance		320,660	(Indicate # of checks performed 9 )				
				Employee Meals			Patient Background Checks	48	480		
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Aging Services Network		5,823		
				Other Insurance		15,672	Leading Age dues		6,360		
				Pension Plan		56,771	Misc Subscriptions		1,512		
				Employee Physicals		1,002	Misc Dues and Licenses		3,429		
				Uniforms		3,762	Non-Allowable Licenses				
				Employee Appreciation		7,350	Less: Public Relations Expense		(65)		
				Other Employee Benefits		4,354	Non-allowable advertising	( )			
							Yellow page advertising	( )			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 106,113	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 28,610		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Description		Line #	Description		Amount		
N/A				N/A			Out-of-State Travel		\$		
							In-State Travel		107		
							Seminar Expense		3,417		
							Entertainment Expense		( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,524		
C. Professional Services											
Vendor/Payee	Type		Amount								
Templin Healthcare Acctg Svc	Accounting		\$ 5,831								
Farnsworth Group, Inc.	Research Fees		452								
Hennelly, Jacob, Quinlan & Associates	Medicaid Application Fee		3,000								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						\$ 9,283					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name &amp; ID Number Fairview Haven

# 0008524

Report Period Beginning:

7/1/2019

Ending:

6/30/20

**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. 6,360 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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,654 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 163,608  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,003
- (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? 100% Line 14
- 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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' PREPARATION REPORT**

Fairview Haven  
6/30/2020  
Inservice Training Attachment

Description	Cost
Online Training	11,785
Inservices Supplies/Speakers	3,922
CPR Classes/SELCAS	60
Powtoon - Video Software	708
Safe Food Handling Courses	620
ACHC Restorative Class	370
LeadingAge Webinar Subscription	695
Miscellaneous	374
	<u>18,533</u>