

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: <u>0008524</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Fairview Haven</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/01/2024</u> to <u>6/30/2025</u> 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.																							
Address: <u>605 North 4th St</u> <u>Fairbury</u> <u>61739</u>																									
Number City Zip Code																									
County: <u>Livingston</u>																									
Telephone Number: <u>(815) 692-2572</u> Fax # <u>(815) 692-4557</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Larry Templin</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name <u>Larry Templin</u> and Title) <u>Partner</u>	(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()												
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	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>10/2/62</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>Dave Blunier</u> Telephone Number: <u>(815) 692-2572</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/01/2024 Ending: 6/30/2025

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 <u>N/A</u>					
	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	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	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	<u>52</u>	TOTALS	<u>52</u>	<u>18,980</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	204	730	1,493		13,747	695	374	17,243	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	204	730	1,493		13,747	695	374	17,243	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 90.85%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? None (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 8/10/62

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 52

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: 6/30/24 Fiscal Year: 6/30/24
* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	325,227	26,398	6,553	358,178		358,178		358,178			1
2	Food Purchase		132,630		132,630		132,630	(12,141)	120,489			2
3	Housekeeping	165,632	56,419		222,051		222,051		222,051			3
4	Laundry	67,844	15,300		83,144		83,144		83,144			4
5	Heat and Other Utilities			145,982	145,982		145,982		145,982			5
6	Maintenance	187,004	154,606	63,900	405,510		405,510	(8,912)	396,598			6
7	Other (specify):*											7
8	TOTAL General Services	745,707	385,353	216,435	1,347,495		1,347,495	(21,053)	1,326,442			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	2,362,784	112,569	9,073	2,484,426		2,484,426		2,484,426			10
10a	Therapy	58,715			58,715		58,715		58,715			10a
11	Activities	131,713	4,411	11,700	147,824		147,824		147,824			11
12	Social Services	114,646		1,767	116,413		116,413		116,413			12
13	CNA Training			8,400	8,400		8,400		8,400			13
14	Program Transportation			8,748	8,748		8,748	(8,748)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,667,858	116,980	56,488	2,841,326		2,841,326	(8,748)	2,832,578			16
	C. General Administration											
17	Administrative	252,979			252,979		252,979		252,979			17
18	Directors Fees											18
19	Professional Services			224,764	224,764		224,764		224,764			19
20	Dues, Fees, Subscriptions & Promotions			34,860	34,860		34,860	(65)	34,795			20
21	Clerical & General Office Expenses	196,703	49,905	83,317	329,925		329,925	(16,035)	313,890			21
22	Employee Benefits & Payroll Taxes			1,034,804	1,034,804		1,034,804	(5,887)	1,028,917			22
23	Inservice Training & Education			26,695	26,695		26,695		26,695			23
24	Travel and Seminar			3,520	3,520		3,520		3,520			24
25	Other Admin. Staff Transportation			6,661	6,661		6,661		6,661			25
26	Insurance-Prop.Liab.Malpractice			83,049	83,049		83,049		83,049			26
27	Other (specify):*											27
28	TOTAL General Administration	449,682	49,905	1,497,670	1,997,257		1,997,257	(21,987)	1,975,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,863,247	552,238	1,770,593	6,186,078		6,186,078	(51,788)	6,134,290			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			298,782	298,782		298,782	(51,317)	247,465			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,635	13,635		13,635		13,635			35
36	Other (specify):*											36
37	TOTAL Ownership			312,417	312,417		312,417	(51,317)	261,100			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	203,030	36,185	65,587	304,802		304,802		304,802			39
40	Barber and Beauty Shops			17,602	17,602		17,602		17,602			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			140,195	140,195		140,195		140,195			42
43	Other (specify):* Disallowed Costs	33,952		34,585	68,537		68,537	(68,537)				43
44	TOTAL Special Cost Centers	236,982	36,185	257,969	531,136		531,136	(68,537)	462,599			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,100,229	588,423	2,340,979	7,029,631		7,029,631	(171,642)	6,857,989			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,028)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,035)	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	(51,317)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,332)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,116)	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	1,089	43		24
25	Fund Raising, Advertising and Promotional	(11,268)	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	(73,570)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (171,642)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (171,642)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5	Offset Cable TV Income & Disallow Remainder	(21,958)	43	5
6	Disallow Marketing Wages	(33,952)	43	6
7	Offset Transportation Income Against Expense	(8,748)	14	7
8	Offset Maintenance Services	(8,912)	6	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,570)		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
Fairview Haven, Inc.	100	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	None				None			1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Note: No board members or entities in which a Board member has ownership conducted business transactions with the nursing home.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Fairview Haven # 0008524 Report Period Beginning: 7/01/2024 Ending: 5/30/2025

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 ☒

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	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

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					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2	N/A												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. \$ 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

2024 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 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.			\$	\$
2.	N/A		\$	\$
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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

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? [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
Serenity Villa-20 Units-Alzheimers Assisted Living

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	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:

7/01/2024

Ending:

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XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	44		1962	1962	\$ 145,220	\$	50	\$	\$	145,220	4
5	8		1999	1999	354,656		39	9,094	9,094	238,861	5
6											6
7											7
8											8
	Improvement Type**										
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		50			26,066	13
14	Additions 72-73		1972		6,314		50			6,314	14
15	Additions 77-78		1978		4,507	90	50	90		4,277	15
16	Sprinkler System		1979		42,306	846	50	846		39,059	16
17	Generator Room		1979		8,460	169	50	169		7,805	17
18	Additions 79-80		1979		1,578	32	50	32		1,481	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		3,225	23
24	Smoke Detector		1980		1,575		15			1,575	24
25	Additions 80-81		1981		16,207	324	50	324		14,423	25
26	Porch Enclosure		1981		9,453	189	50	189		8,285	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		1,731	30
31	Room D2 Addition		1982		432	9	50	9		386	31
32	Room B14 Addition		1982		2,380	48	50	48		2,067	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		6,780	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

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning:

7/01/2024

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

1 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		202	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		14,099	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		25			833	62
63	Replace Main sprinkler system	1995	2,550		15			2,550	63
64	Repair dining room ice machine wall	1996	948		25			948	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	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,136,911	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

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,263,078	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,136,911	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	TOTAL (lines 1 thru 33)		\$ 1,406,527	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,280,360	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:

7/01/2024

Ending:

6/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,406,527	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,280,360	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		20			421	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		15			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		15			3,013	19
20	13 bathroom remodeling	2005	4,979		15			4,979	20
21	Bathroom steel door frames	2006	1,353		15			1,353	21
22	5 ton condensor	2005	8,697		10			8,697	22
23	Fire system engineering	2005	2,787		15			2,787	23
24	North basement office remodel	2006	2,460		15			2,460	24
25	Foam roofing	2006	2,292		15			2,292	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		15			935	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	TOTAL (lines 1 thru 33)		\$ 1,539,378	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,413,211	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:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,539,378	\$ 2,285		\$ 11,379	\$ 9,094	\$ 1,413,211	1
2	Fire alarm system	2006	3,478		7			3,478	2
3	Air conditioning	2006	2,059		15			2,059	3
4	Guttering system	2007	2,573	103	25	103		2,367	4
5	Air conditioning	2007	7,549		15			7,549	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		15				8
9	Fornt door opener	2008	404		10			404	9
10	Blessing way upgrade (paint, handrail, carpet, drywall)	2008	6,331		15			6,331	10
11	Garbage disposal	2008	937		10			937	11
12	RMS b-2,4,5 windows, drywall, trim	2008	8,631		15			8,631	12
13	West side window replacement	2007	16,191		15			16,191	13
14	Rms a-2,4 windows, drywall, trim	2008	3,831		15			3,831	14
15	Furnace	2008	4,070		7			4,070	15
16	Ductwork repair	2008	3,523		15			3,523	16
17	Landscape, sprinkler system repair	2007	29,381		15			29,381	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		15			8,646	20
21	Angel Avenue - Heat/carpet, drywall	2009	10,294		15			10,294	21
22	Blessing Way - Heat/Trim	2009	4,519		15			4,519	22
23	Country Court - Handrail, drywall, carpet	2008	4,515		15			4,515	23
24	Daffodil drive - air conditioner	2009	916		7			916	24
25	Dock Upgrade	2008	11,078		15			11,078	25
26	Fire system upgrade	2008	2,860		15			2,860	26
27	New offices - business/nursing (drywall, paint, carpet, light)	2009	20,230		15			20,230	27
28	New window	2009	316		15			316	28
29	Resident rooms - heating/furn	2009	10,484		15			10,484	29
30	Sprinkler System upgrade	2009	18,674		15			18,674	30
31	Therapy room air conditioner	2009	1,535		7			1,535	31
32	Window	2009	2,974		15			2,974	32
33	Door Alarm/Intercom Upgrades	2010	3,250	144	15	126	(18)	3,250	33
34	TOTAL (lines 1 thru 33)		\$ 1,760,809	\$ 2,532		\$ 11,608	\$ 9,076	\$ 1,631,531	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:

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6/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,760,809	\$ 2,532		\$ 11,608	\$ 9,076	\$ 1,631,531	1
2	Fire alarm upgrade	2009	3,267	73	15	70	(3)	3,267	2
3	Generator Repairs	2010	9,550	478	20	478		6,692	3
4	Cordless phone system for nurses	2010	1,010	106	15		(106)	1,010	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	866	15	871	5	14,841	6
7	New flooring, drywall, paint, handrails & lighting for D wing	2010	34,942	679	15	686	7	34,942	7
8	New flooring, paint and trim doors	2010	5,742	223	15	220	(3)	5,742	8
9	Gut office, new flooring and lights, drywall, paint	2010	27,914	1,551	15	1,550	(1)	27,914	9
10	Room Heaters	2011	1,540		7			1,540	10
11	Windows	2011	5,583	372	15	372		5,224	11
12	Rm remodel A3-5 C6 - plumbing, walls, electrical, flooring	2011	11,645	776	15	776		11,090	12
13	Convert room to social services office, paint, trim, drywall	2011	5,919	395	15	395		5,563	13
14	Sprinkler Pipe Replacement	2011	73,417	4,894	15	4,894		69,740	14
15	Room Remodel - lights, flooring, drywall, painting	2012	6,299	420	15	420		5,565	15
16	Daffodil Drive Shower Room	2012	12,885	859	15	859		11,525	16
17	Gas line for dryers	2012	1,619	108	15	108		1,498	17
18	Generator Repairs	2012	2,299	115	20	115		1,567	18
19	HVAC System for dining room and business office	2012	3,706	247	15	247		3,448	19
20	Living room - fireplace/drywall/lights	2012	20,014	1,334	15	1,334		17,564	20
21	Soc svc office/conf room renov - light, carpet, paint, drywall	2012	1,875	125	15	125		1,630	21
22	Sprinkler Repair	2012	16,446	1,096	15	1,096		14,522	22
23	Social Services AC repair	2012	5,415	361	15	361		4,663	23
24	Front Foyer Remodel - drywall, flooring	2012	6,384	426	15	426		5,467	24
25	Dining Services Office remodel - flooring, shelving, paint, trim	2013	2,361	157	15	157		1,963	25
26	Replace Sprinkler System	2013	57,060	3,804	15	3,804		47,074	26
27	Dining Room Exit Door replaced	2013	3,419	228	15	228		2,812	27
28	Kitchen updates - flooring, ceiling, AC Repair	2013	10,862	724	15	724		8,748	28
29	Resident Room Remodel- Angel Ave 1/15, Blessings Way 1,	2013	31,485	2,099	15	2,099		25,188	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									33
34	TOTAL (lines 1 thru 33)		\$ 2,154,924	\$ 25,048		\$ 34,023	\$ 8,975	\$ 1,988,946	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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,154,924	\$ 25,048		\$ 34,023	\$ 8,975	\$ 1,988,946	1
2	Fire Alarm System Repairs	2013	5,101	340	15	340		3,995	2
3	D-9: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	7,105	474	15	474		5,530	3
4	Doors at Kitchen and timeclock entrances	2013	4,593	306	15	306		3,545	4
5	Kitchen Water Heater Replacement	2013	6,887	459	15	459		5,317	5
6	D-11: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2013	10,470	698	15	698		8,027	6
7	Window Replacement in resident Rooms	2014	8,342	556	15	556		6,348	7
8	C-1, C-2, C Restroom C Bath: Drywall, Electrical, Plumbing, Trim	2014	99,694	6,646	15	6,646		75,598	8
9	Daffodil Shower Room	2014	27,162	1,811	15	1,811		20,525	9
10	D-12: Drywall, Electrical, Plumbing, Trim, Paint, Flooring	2014	5,818	388	15	388		4,332	10
11	Replace HVAC Systems	2014	8,544	570	15	570		5,985	11
12	Flooring - Blessings Way #2	2015	2,633	176	15	176		1,848	12
13	Call System	2015	72,604	4,840	15	4,840		50,820	13
14	Replace Driveway to Dock Area	2015	13,645	910	15	910		9,555	14
15	Drapes for Therapy Room & Resident Room	2015	3,372	225	15	225		2,362	15
16	Replace Concrete Underneath Carport	2016	6,187		15	412	412	3,914	16
17	Activity Room/Kitchen HVAC replacement	2015	8,376	558	15	558		5,301	17
18	Call system additions/replacements	2015	7,636	509	15	509		4,836	18
19	Replace electrical panel	2016	5,905	394	15	394		3,743	19
20	Generator repairs	2016	12,968	865	15	865		8,217	20
21	Replace sconces in hallway	2015	3,716	248	15	248		2,356	21
22	Kitchen HVAC replacement	2016	1,876	125	15	125		1,188	22
23	Installed new key pads	2015	1,763	118	15	118		1,121	23
24	Remodel office area-Moved walls, new floor covering,								24
25	paint, lights, wiring	2015	31,245	2,083	15	2,083		19,789	25
26	Replace floor in timeclock area	2016	5,001	333	15	333		3,164	26
27	Automatic Door Installations	2017	6,430	429	15	429		3,646	27
28	SNF Room B-9 Remodel (Floor Covering, Paint, Electrical, Lighti	2017	5,417	361	15	361		3,069	28
29	Therapy Room Replace HVAC System	2017	4,811	321	15	321		2,728	29
30	Generator Repairs	2016	8,111	541	15	541		4,598	30
31	Kitchen Office HVAC	2017	3,209	214	15	214		1,819	31
32	Laundry Room - Additional Capacity, HVAC System	2017	18,506	1,234	15	1,234		10,489	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,562,051	\$ 51,780		\$ 61,167	\$ 9,387	\$ 2,272,711	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:

7/01/2024

Ending:

6/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,562,051	\$ 51,780		\$ 61,167	\$ 9,387	\$ 2,272,711	1
2	HVAC Repair-Country Court	2017	13,970	1,397	10	1,397		10,594	2
3	Dishwashers	2017	19,211	1,921	10	1,921		14,407	3
4	Kitchen Sinks/Faucets	2018	4,001	200	20	200		1,441	4
5	HVAC-Laundry Room	2018	4,906	1,778	10	491	(1,287)	3,621	5
6	Business Office Curb Redo	2019	3,630		15	242	242	1,462	6
7	Flooring-Angel Ave #7	2018	1,617		5			1,617	7
8	Flooring-Blessings #14	2019	2,401		5			2,401	8
9	Country Court #3 - Flooring/Plumbing/Electrical	2019	6,652		5			6,652	9
10	Dining Services - Kitchen Hood Work	2019	7,150	477	15	477		2,902	10
11	Dining Services - Kitchen HVAC	2018	13,982	932	15	932		6,369	11
12	Dining Services - Walk-in Cooler Restoration	2018	16,573	1,105	15	1,105		7,321	12
13	Gutters on SNF	2019	7,952	530	15	530		3,423	13
14	Living Room/Administrator Office Window	2019	7,706	514	15	514		3,298	14
15	Therapy Room - Flooring	2018	2,379		5			2,379	15
16	Window Coverings- Admin, B14, C3	2019	6,095		5			6,095	16
17	Angel Ave Handicapped Accessible Door	2019	6,051	403	15	403		2,217	17
18	HVAC Upgrades in SNF	2019	9,906	660	15	660		3,630	18
19	Blessings Room 206-208 (Floor cover/paint/electrical/light)	2019	20,138	1,343	5	1,341	(2)	20,138	19
20	Business Office Parking Lot	2019	13,323		15	888	888	5,069	20
21	Activity Room Window Replacement	2020	14,642	976	15	976		5,124	21
22	Housekeeping Room Water Heater	2020	20,214	1,348	15	1,348		7,302	22
23	Conference Room (Kitchenette addition)	2020	5,563	834	5	833	(1)	5,563	23
24	Front Patio and Landscape upgrade	2020	10,154		10	1,015	1,015	5,160	24
25	Administrator Office Remodel-New Drywall/Carpet/Electric/Window	2020	4,904	981	5	981		4,619	25
26	Camera Installation	2020	4,680	936	5	936		4,524	26
27	Conference Room (Kitchenette)	2020	5,656	1,131	5	1,131		5,278	27
28	Generator Repairs	2020	25,917	1,728	15	1,728		8,064	28
29	Maintenance Building	2020	459,958	9,199	50	9,199		45,229	29
30	Window & Door Replacement - Family Room	2020	7,243	483	15	483		2,375	30
31	HVAC Duct Work - Family Room	2021	13,984	932	15	932		4,039	31
32	Reception Area Remodel (Relocate entrance)	2021	116,262	23,252	5	23,252		94,946	32
33	Room 203 Remodel (floor cover, paint, electrical, lights)	2021	6,181	412	15	412		1,768	33
34	TOTAL (lines 1 thru 33)		\$ 3,425,052	\$ 105,252		\$ 115,494	\$ 10,242	\$ 2,571,738	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:

7/01/2024

Ending:

6/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,425,052	\$ 105,252		\$ 115,494	\$ 10,242	\$ 2,571,738	1
2	Sidewalk Light Installation	2021	3,766		15	251	251	1,004	2
3	Mixing Valve Replacements	2021	7,360	1,472	5	1,472		5,888	3
4	Dock Area Door Replacement	2021	2,857	190	15	190		745	4
5	HVAC Replacement - Angel Ave	2021	11,408	761	15	761		2,853	5
6	LED Lighting Upgrade Facility Wide	2022	21,485	1,432	15	1,432		4,535	6
7	Board Room Window Installation and expansion	2022	7,794	520	15	520		1,625	7
8	Outpatient Therapy Gym	2022	182,694	36,539	5	36,539		100,482	8
9	Pager Upgrade	2022	18,840	3,768	5	3,768		10,676	9
10	Maintenance Building - Kitchen-Replace Cabinets, Sink	2022	7,528	1,506	5	1,506		4,204	10
11	Access Control System	2023	117,393	7,826	15	7,826		16,956	11
12	HVAC Replacement - Blessing Way	2023	13,350	890	15	890		1,854	12
13	Housekeeping Room Plumbing Repairs	2023	3,409	682	5	682		1,392	13
14	LED Ligthing Upgrade Facility Wide	2023	3,889	259	15	259		626	14
15	Nursing Office Flooring	2023	2,999	600	5	600		1,250	15
16	Resident Room Flooring	2023	5,618	1,124	5	1,124		2,623	16
17	Dining Room Remodel - Flooring, Paint, Trim, Chairs, Electrical,	2023	43,054	8,611	5	4,305	(4,306)	8,610	17
18	Water Heater-Kitchen	2023	6,496	433	15	217	(216)	434	18
19	Activity Room Remodel: Drywall, Stone, Paint, Electrical,								19
20	Plumbing, Kitchen Cabinetry, Electronics	2024	209,050	41,810	15	6,968	(34,842)	13,040	20
21	Dining Room Windows	2024	8,078	539	15	269	(270)	538	21
22	Fire Alarm System Upgrades	2024	17,885	1,192	15	596	(596)	1,192	22
23	Maintenance Shed Upgrades: Surveillance, Electrical	2024	12,177	2,435	15	406	(2,029)	812	23
24	New Roof	2024	152,383	15,238	15	5,079	(10,159)	10,158	24
25	Resident Room Flooring	2024	4,847	969	15	162	(807)	324	25
26	Room 114 & 115 Remodel: Flooring, Paint, Electrical	2024	4,551	910	15	152	(758)	304	26
27	Install Fuel Tank	2024	9,147	610	15	305	(305)	610	27
28	Additional Roof Replacement	2024	29,427	2,943	15	981	(1,962)	981	28
29	Fire Alarm System Upgrade	2024	3,427	171	15	114	(57)	114	29
30	Sprinkler Head Replacements	2024	6,385	426	15	213	(213)	213	30
31	Descale and reline sewer system	2025	93,672	1,561	15	3,122	1,561	3,122	31
32									32
33	Prior Year Improvements Not Included on Prior Year Cost Reports			6,851			(6,851)		33
34	TOTAL (lines 1 thru 33)		\$ 4,436,021	\$ 247,520		\$ 196,203	\$ (51,317)	\$ 2,768,903	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 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 12H, Carried Forward		\$4,436,021	\$247,520		\$196,203	\$(51,317)	\$2,768,903	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,436,021	\$247,520		\$196,203	\$(51,317)	\$2,768,903	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	\$367,220	\$40,582	\$40,582	\$	5-10 yrs	\$234,773	71
72	Current Year Purchases	12,775	539	539		5 Yrs	539	72
73	Fully Depreciated Assets	1,108,937				5-10 yrs	1,108,937	73
74								74
75	TOTALS	\$1,488,932	\$41,121	\$41,121	\$		\$1,344,249	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			189,777	10,141	10,141			152,817	79
80	TOTALS			\$298,959	\$10,141	\$10,141	\$		\$261,999	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)	\$6,230,334	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$298,782	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$247,465	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(51,317)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,375,151	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	Assisted Living	\$2,129,791	\$71,440	\$1,173,937	86
87	Memory Care Facility	3,925,627	87,784	550,577	87
88	Independent Living	1,169,540	39,148	944,038	88
89	Other Non Care	485,721	7,096	64,616	89
90					90
91	TOTALS	\$7,710,679	\$205,468	\$2,733,168	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.

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	\$	\$	\$	\$ -		\$	71	
72	Current Year Purchases				-			72	
73	Fully Depreciated Assets				-			73	
74					-			74	
75	TOTALS	\$ 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	\$	\$	\$ -	5	\$ 59,285	76
77	Patient Transport	2017 Chrysler town and country	2018	29,072			-	5	29,072	77
78	Patient Transport	2018 Chrysler Town & Country	2018	\$ 35,572			-	4	35,572	78
79	Patient Transport	2010 Ford 150	2019	10,500			-	4	10,500	
79	See Attached Schedule 13B			55,348	10,141	10,141	-		18,388	79
80	TOTALS			\$ 189,777	\$ 10,141	\$ 10,141	\$ -		\$ 152,817	80

E. Summary of Care-Related Assets					1	2	
		Reference				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)				\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$	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.

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	\$	\$	\$	\$ -		\$	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	\$ 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	Golf Cart	2022	\$ 10,995	2,749	2,749	-	4	10,996	76
77	Patient Transport	2024 Chrysler Pacifica	2024	44,353	7,392	7,392	-	4	7,392	77
78							-			78
79							-			
79							-			79
80	TOTALS			\$ 55,348	\$ 10,141	\$ 10,141	\$ -		\$ 18,388	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)	\$ 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 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.

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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease 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: \$ 13,635 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	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.

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?

☒ 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

10

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

10

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		8,400		8,400
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,400	\$	\$ 8,400
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,400			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(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		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(1)(3)	2213	hrs	\$ 90,833	115	\$ 2,268	\$	2,328	\$ 93,101	1
2	Licensed Speech and Language Development Therapist	39(1)(3)	247	hrs	14,648				247	14,648	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(1)(2)(3)	2784	hrs	97,549	742	36,259	910	3,526	134,718	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				35,275		35,275	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): Lab/X-Ray	39(3)					3,668			3,668	13
14	TOTAL				\$ 203,030	857	\$ 42,195	\$ 36,185	6,101	\$ 281,410	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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,514,713	\$ 1,514,713	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	343,706	343,706	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,389,985	3,389,985	5
6	Prepaid Insurance	70,873	70,873	6
7	Other Prepaid Expenses	44,690	44,690	7
8	Accounts Receivable (owners or related parties)	32,901	32,901	8
9	Other(specify): <u>Insurance Savings</u>	32,601	32,601	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,429,469	\$ 5,429,469	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	3,950,859	4,436,021	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,011,000	1,787,891	16
17	Accumulated Depreciation (book methods)	(4,290,534)	(4,375,151)	17
18	Deferred Charges	277,601		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Non Care Assets</u>	4,977,511	4,977,511	22
23	Other(specify): <u>East Haven Condo Investment</u>	743,531	743,531	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,676,390	\$ 7,576,225	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,105,859	\$ 13,005,694	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 368,507	\$ 368,507	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	319,782	319,782	30
	Accrued Taxes Payable			
31	(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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 688,289	\$ 688,289	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	<u>Restricted Gifts</u>	1,901,066	1,901,066	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,901,066	\$ 1,901,066	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,589,355	\$ 2,589,355	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,516,504	\$ 10,416,339	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,105,859	\$ 13,005,694	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,421,975	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,421,974	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(538,066)	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)	\$ (538,066)	17
	B. Transfers (Itemize):		
18			18
19			19
20	Net Income of Other Divisions	1,632,596	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,632,596	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,516,504	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairview Haven

0008524

Report Period Beginning: 7/01/2024

Ending: 6/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,449,084	1
2	Discounts and Allowances for all Levels	(301,426)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,147,658	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,390	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,390	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	16,569	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	18,028	14
15	Telephone, Television and Radio	37,194	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,332	19
20	Radiology and X-Ray		20
21	Other Medical Services	69,463	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 142,586	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent and Assisted Living Fees	11,000	28
28a	Resident Personal Items/Miscellaneous Revenue	25,931	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,931	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,491,565	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,347,495	31
32	Health Care	2,841,326	32
33	General Administration	1,997,257	33
	B. Capital Expense		
34	Ownership	312,417	34
	C. Ancillary Expense		
35	Special Cost Centers	390,941	35
36	Provider Participation Fee	140,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,029,631	40
41	Income before Income Taxes (line 30 minus line 40)**	(538,066)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (538,066)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 48,826	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	174,720	45
46	MMAI-Medicaid is the Primary Payer	357,338	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	5,057,896	48
49	Medicare Part A	330,842	49
50	Other-(specify) Insurance	178,036	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,147,658	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,776	2,024	\$ 95,894	\$ 47.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,607	9,179	408,504	44.50	3
4	Licensed Practical Nurses	10,771	11,573	460,089	39.76	4
5	CNAs & Orderlies	44,572	47,214	1,119,788	23.72	5
6	CNA Trainees					6
7	Licensed Therapist	4,970	5,244	203,030	38.72	7
8	Rehab/Therapy Aides	2,285	2,505	58,715	23.44	8
9	Activity Director	1,506	1,690	37,580	22.24	9
10	Activity Assistants	4,809	5,103	94,133	18.45	10
11	Social Service Workers	4,492	4,655	114,646	24.63	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	55,060	26.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,613	16,328	270,167	16.55	15
16	Dishwashers					16
17	Maintenance Workers	8,592	9,603	187,004	19.47	17
18	Housekeepers	8,469	9,090	165,632	18.22	18
19	Laundry	3,678	4,015	67,844	16.90	19
20	Administrator	1,832	2,000	158,103	79.05	20
21	Assistant Administrator	1,872	2,000	94,876	47.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,180	9,705	196,703	20.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,205	1,277	24,956	19.54	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	7,197	7,990	287,505	35.98	33
34	TOTAL (lines 1 - 33)	143,354	153,275	\$ 4,100,229 *	\$ 26.75	34

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	88	\$ 6,553	L1, C3	35
36	Medical Director	Monthly	16,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Annual	322	L10, C3	38
39	Pharmacist Consultant	Monthly	4,382	L10, C3	39
40	Physical Therapy Consultant	Monthly	23,392	L39, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,438	L11, C3	44
45	Social Service Consultant	20	1,767	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	124	\$ 54,654		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

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

** See instructions.

Fairview Haven

Period Beginning 7/01/2024
Period End 6/30/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS/Care Plan Coordinator	2,482	2,844	119,489	42.01
Infection Preventist	979	1,007	41,369	41.08
Marketing	720	800	33,952	42.44
Clinical Team Supervisor	1,237	1,290	36,901	28.61
Scheduler	1,779	2,049	55,794	27.23
TOTAL	7,197	7,990	287,505	

Facility Name & ID Number		Fairview Haven	STATE OF ILLINOIS		#	0008524	Report Period Beginning:		7/01/2024	Page 21		Ending:	6/30/2025	
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	\$ 158,103	Workers' Compensation Insurance		\$ 86,486	IDPH License Fee		\$				
Brandon Stoller		Asst Administrator	0	94,876	Unemployment Compensation Insurance			Advertising: Employee Recruitment		11,858				
					FICA Taxes		435,411	Health Care Worker Background Check						
					Employee Health Insurance		712,552	(Indicate # of checks performed 35)		1,130				
					Employee Meals		32,202	Patient Background Checks		48 1,100				
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		17,368				
					Other Insurance		33,691							
					Pension Plan		100,884	Misc Dues and Subscriptions		2,138				
					Employee Appreciation		48,492	Misc Licenses		1,266				
					Other Employee Benefits		3,440							
								Less: Public Relations Expense		(65)				
					Allocation to AL/IL		(424,241)	PAC and Lobbying payments		()				
								All non-allowable advertising		()				
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 252,979	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,028,917	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 34,795				
(List each licensed administrator separately.)														
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**						
Description		Amount		Description		Line #	Amount	Description		Amount				
N/A		\$		N/A				Out-of-State Travel		\$				
								In-State Travel		857				
TOTAL (agree to Schedule V, line 17, col. 3)		\$						Seminar Expense		2,663				
(Attach a copy of any management service agreement)														
C. Professional Services														
Vendor/Payee		Type	Amount											
Templin Healthcare Acctg Svc		Accounting	\$ 7,389											
Inovalon		Computer Services	9,033											
Onshift		Scheduling Software	8,184											
Pointclick Care		Accounting Software	43,154											
UKG		Payroll Provider	50,802											
Sharpline Solutions		Computer Services	106,202											
TOTAL (agree to Schedule V, line 19, column 3)		\$ 224,764		TOTAL			\$	Entertainment Expense		()				
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)		TOTAL 3,520				

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
LEADING AGE	10,000
Other, please specify Illinois Aging Services Network	7,368
	17,368 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE	
Other, please specify Illinois Aging Services Network	
	Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

LEADING AGE	10,000
Other, please specify Illinois Aging Services Network	7,368
	17,368 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 29,151 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 140,195
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 32,202 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,141
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) 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.