

## **Fiscal Year 2004 Medicaid Cost Report**

Used in performing analytics; fluctuations in cost and statistical data between fiscal year 2004 cost report and fiscal year 2006.

Informational; the fiscal year 2004 payment rate was primarily determined from the calendar year 2002 cost report, while the fiscal year 2006 payment rate was primarily determined from the calendar year 2003 cost report.

Ohio Department of Job and Family Services  
MEDICAID COST REPORT  
Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

Type of Cost Report Filing pursuant to OAC Rule 5101:3-3-20 and 5101:3-3-24 (Please check one of the following)			
<input checked="" type="checkbox"/> 4.1 Year-End	<input type="checkbox"/> 4.3 Change of Provider Agreement	<input type="checkbox"/> 4.5 Closed Facility	<input type="checkbox"/> 4.7 Capital
<input type="checkbox"/> 4.2 New Facility	<input type="checkbox"/> 4.4 Rate Reconsideration	<input type="checkbox"/> 4.6 Amended	

This cost report must be received or postmarked pursuant to OAC Rule 5101:3-3-20 except for state operated ICFs-MR. Failure to file timely will result in reduction of the current prospective rate by two dollars (\$2.00) per patient per day. The rate reduction shall be adjusted for inflation in accordance with ORC Section 5111.26(A)(2). Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit to Ohio Department of Jobs and Family Services, Bureau of Long Term Care Facilities, Audits and Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Provider Name Fairlawn Haven	Medicaid Provider Number 0010302	Medicare Provider Number
Complete Address Address(1) 407 East Lutz Road Address(2) City Archbold State of Ohio Zip Code 43502	Federal ID Number 340930124 ODH ID Number 2434 County FULTON	Period Covered by Cost Report From 01/01/2002 Through 12/31/2002

TYPE OF CONTROL - (Please check one of the following)		
Proprietary for Profit Corp. Name Address(1) Address(2) City State Zip Code	TYPE OF FACILITY <input checked="" type="checkbox"/> 1. Nursing Facility <input type="checkbox"/> 2. ICF-MR Facility	Is Facility a Unit of a <input type="checkbox"/> a. Hospital <input type="checkbox"/> b. Rehabilitation Center <input type="checkbox"/> c. Other: Specify:
<input type="checkbox"/> 1.1 Individual <input type="checkbox"/> 1.2 Partnership <input type="checkbox"/> 1.3 Corporation <input type="checkbox"/> 1.4 Other: specify control _____		

Voluntary Nonprofit <input checked="" type="checkbox"/> 2.1 Church <input type="checkbox"/> 2.2 Other: specify control _____ <input type="checkbox"/> 2.3 Church Corporation	Name and Address of Owner of Real Estate Fairlawn Haven 407 East Lutz Road Archbold OH Zip Code 43502
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Nonfederal Government <input type="checkbox"/> 3.1 State <input type="checkbox"/> 3.2 County <input type="checkbox"/> 3.3 City <input type="checkbox"/> 3.4 City-County <input type="checkbox"/> 3.5 Hospital <input type="checkbox"/> 3.6 Other: specify control _____	Name and Address of Owner (Operator) of Business Fairlawn Haven 407 East Lutz Road Archbold OH Zip Code 43502
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ALL PATIENTS	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
1. Licensed beds at beginning of period	100.0	100.0
** 2. Licensed beds at end of period	100.0	100.0
3. Total bed days available	36,500.0	36,500.0
4. Total inpatient days (from Sch. A-1, Line 13, Col. 9)	35,848.0	35,848.0
5. Percentage of occupancy (line 4 divided by line 3 X 100)	98.0	98.0
6.1 Indirect allowable days (greater of line 4 or .85 X line 3)	35,848.0	35,848.0
* 6.2 Capital allowable days (greater of line 4 or .95 X line 3)	35,848.0	35,848.0

OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS

7. Total patient days (from Schedule A-1, line 13, column 5)	18,297.0
8. Utilization (line 7 divided by line 4, col. 1 X 100)	51.04

\* Except as provided in OAC rule 5101:3-3-53 (for Nursing Facilities)

\* Except as provided in OAC rule 5101:3-3-86 (for ICF's/MR)

\*\* If line 2 is different from col. 1 line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

\*\* If line 2 is different from col. 1 line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

\*\* If line 2 is different from col. 1 line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

CERTIFICATION BY OFFICER OF PROVIDER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, all cost reports submitted to ODHS will be certified as follows:

**MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.**

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) FAIRLAWN HAVEN, number 0010302 for the cost report period beginning 1/1/2002 and ending 12/31/2002 and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider(s)		Date of Signature	03/20/2003
Print or Type Name of Owner, Officer, or Authorized Representative of Provider(s)			
(Last) Ringenberg	(First) Steven	(M.I.)	
Title Administrator	Telephone Number Area Code (419) 445-3075	Fax Number Area Code (419) 446-2699	

Report Prepared by (Company) Plante & Moran, PLLC	
Report Prepared by (Individual)	Title
(Last)	(M.I.)
Address 3434 Granite Circle	
City, State, Zip Code	Toledo OH 43617
Telephone Number for Person Preparing Cost Report Area Code (419) 843-6000	Fax Number Area Code (419) 843-6099

Location of Records or Probable Audit Site	Telephone Number for Audit Contact Person
Address 407 East Lutz Road	Area Code (419) 445-3075
City Archbold	County FULTON
State OH	Zip Code 43502

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_ at \_\_\_\_\_, county of \_\_\_\_\_, and state of \_\_\_\_\_

Signature of Notary
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SUMMARY OF INPATIENT DAYS

Provider Name <b>FAIRLAWN HAVEN</b>	Medicaid Provider Number <b>0010302</b>	Reporting Period From: <b>01/01/2002</b> Through: <b>12/31/2002</b>
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Note: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. NF's must report each medically necessary leave day and limited absence as 50% of an inpatient day. Please refer to rule 5101:3-3-59 of the OAC for details.

Month	Number of Medicaid Certified Beds (1)	Patient Days (Per Census) for Medicaid Patients Only				Non-Medicaid Eligible Patients			Inpatient Days for Patients (sum of col. 5-8) (9)
		Authorized Days (2)	Hospital Leave Days * @50% (3)	Therapeutic Leave Days * @50% (4)	Total Medicaid Days (sum of col. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January	100	1,457	0.0	0.0	1,457.0	1,556	0	0	3,013.0
2. February	100	1,330	0.0	0.0	1,330.0	1,451	0	0	2,781.0
3. March	100	1,497	3.5	0.0	1,500.5	1,542	0	0	3,042.5
4. April	100	1,502	3.0	0.0	1,505.0	1,434	0	0	2,939.0
5. May	100	1,610	2.0	0.0	1,612.0	1,461	0	0	3,073.0
6. June	100	1,584	0.5	0.0	1,584.5	1,375	0	0	2,959.5
7. July	100	1,648	0.0	0.0	1,648.0	1,421	0	0	3,069.0
8. August	100	1,571	2.5	0.0	1,573.5	1,468	0	0	3,041.5
9. September	100	1,463	2.5	0.0	1,465.5	1,446	0	0	2,911.5
10. October	100	1,546	2.5	0.0	1,548.5	1,518	0	0	3,066.5
11. November	100	1,464	8.5	0.0	1,472.5	1,438	0	0	2,910.5
12. December	100	1,594	6.0	0.0	1,600.0	1,441	0	0	3,041.0
13. TOTAL (sum of lines 1 through 12)		18,266	31.0	0.0	18,297.0	17,551	0	0	35,848.0
					to ODHS 2524 Schedule A line 7				to ODHS 2524 Schedule A line 4, col. 1

\* CONSULT THE OHIO ADMINISTRATIVE CODE RULE 5101:3-3-59 (NFs) AND 5101:3-3-92 (ICFs-MR) FOR AN EXPLANATION OF THE DIFFERENCE BETWEEN HOSPITAL AND THERAPEUTIC LEAVE DAYS.

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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Instructions: List GROSS CHARGES for resident days shown in Schedule A-1 and Attachment 4. GROSS CHARGES must be reported from the uniform charge structure that is applicable to all residents.

SECTION A (1)	Medicare Part B Primary Payer is		Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
	Medicaid (2)	Other (3)					
1a. Medical Supplies Revenue	0	0	0	0	0	0	0
1b. Percentage (line 1a col. (x) divided by total on line 1a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
2a. Medical Minor Equipment	0	0	0	0	0	0	0
2b. Percentage (line 2a col. (x) divided by total on line 2a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
3a. Enteral Feeding Revenue	0	0	0	0	0	0	0
3b. Percentage (line 3a col. (x) divided by total on line 3a col. 8)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
4. TOTAL (Sum of 1a through 3a)	0	0	0	0	0	0	0

SECTION B: COSTS (1)	MEDICARE PART B OFFSET CALCULATIONS			
	Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)
5. Percentage of Medicare Part B Charges where the primary payer is Medicaid (from Sch A-2, col. 2, applicable line b)	0.00%	0.00%	0.00%	
6. Costs (from Schedule B-1, column 3, lines 1 and 4 and Schedule C, column 3, line 11)	0	0	0	
7. Costs to be offset (line 5 times line 6). Offset costs in col. 4 on applicable cost report lines identified in line 6 of this section.	0	0	0	0

SECTION C: INDIRECT COST - OFFSET	
8. Indirect costs (Schedule C Line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col. 3)	379,348
9. Total costs (total of Sch. B-1 line 26, B-2 line 56, C line 63, D lines 11, 13, 19, 30 and 44.)	4,802,356
10. Line 8 divided by line 9	0.0790
11. Costs offset (from line 7 column 5 above)	0
12. Indirect cost to be offset (line 10 times line 11) offset costs on Schedule C line 47 column 4	0

SUMMARY OF COSTS

Provider Name FAIRLAWN HAVEN		Medicaid Provider Number 0010302		Reporting Period From: 1/1/2002 Through: 12/31/2002	
REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (Col 3 / 4) (5)
<b>OTHER PROTECTED COST CENTER</b>					
1. Other Protected Costs use allowable patient days Sch A line 4 Col 1	B1 line 26 Col 7		242,500	35,848.0	6.76
<b>DIRECT CARE COST CENTER</b>					
2. Direct Care Cost use allowable patient days Sch A line 4 Col 1	B2 line 56 Col 7		2,584,246	35,848.0	72.09
<b>INDIRECT CARE COST CENTER</b>					
3. Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7		1,622,523	35,848.0	45.26
<b>CAPITAL COST CENTER COST OF OWNERSHIP</b>					
4. Assets Acquired Group A	Group A D line 11 Col 7	103,055			
5. Assets thru Change of Ownership Group B	Group B D line 19 Col 7	0			
6. TOTAL Cost of Ownership (sum of lines 4 and 5)		103,055			
<b>RENOVATIONS COST CENTER</b>					
7. Renovations Group A	Group A D line 13 Col 7	100,743			
8. TOTAL Capital Cost (sum of lines 6 and 7) use allowable patient days Sch A line 6.2 Col 1			203,798	35,848.0	5.69
<b>EQUITY</b>					
9. Return on Equity	E-1 line 36 Col 5				0.00
10. TOTAL Reimbursable Costs (sum of lines 1, 2, 3, and 8) Col 3			4,653,067		
11. TOTAL Filed Cost Per Diem (sum of lines 1, 2, 3, 8, and 9) Col 5					129.80

RECONCILIATION OF COSTS

Schedule/ Line #	Total (1)	Adjustments Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
12. B1/26	col 3 344,850	col 4 -102,350	col 5 242,500	col 7 242,500
13. B2/56	col 3 2,583,707	col 4 539	col 5 2,584,246	col 7 2,584,246
14. C/93	col 3 1,680,989	col 4 94,677	col 5 1,775,666	col 7 1,775,666
15. D *	col 3 243,603	col 4 -39,805	col 5 203,798	col 7 203,798
16. Totals	\$ 4,853,149 (A)	\$ -46,939 (B)	\$ 4,806,210	\$ 4,806,210
17. Less Non-Reimbursable from Schedule C Page 3 line 92 Page 3 line 92			col 5 (153,143)	col 7 (153,143)
18. Total Reimbursable			\$ 4,653,067 (C)	\$ 4,653,067 (C)

- \* Summary of Schedule D lines 11, 13 and 19
- (A) Agrees to Total Expenses per Working Trial Balance
- (B) Agrees to Total of Attachment 2, line 40, Column 4, and Schedule A-2, lines 7 and 12, column 5.
- (C) Agrees to Schedule A-3, line 10, Column 3

NOTE: All cost data should be rounded to the nearest whole dollar.

## OTHER PROTECTED COST CENTER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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OTHER PROTECTED COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>MEDICAL SUPPLIES</b>								
1. Medical Supplies - medicare billable	6000		0	0	0	0	1.0000	0
2. Medical Supplies - medicare non-billable	6001		31,308	31,308	0	31,308	1.0000	31,308
3. Oxygen - Emergency stand-by	6003		0	0	0	0	1.0000	0
4. Medical Minor Equip. - medicare billable	6005		0	0	0	0	1.0000	0
5. Medical Minor Equip. - medicare non-billable	6006		0	0	0	0	1.0000	0
6. TOTAL Medical Supplies (sum of lines 1 through 5)			31,308	31,308	0	31,308		31,308
<b>PRIOR AUTHORIZED MEDICAL EQUIPMENT</b>								
7. Prior Authorized Medical Equipment	6010		0	0	0	0	1.0000	0
<b>UTILITY EXPENSES</b>								
8. Heat, Light, Power	6020		149,597	149,597	0	149,597	1.0000	149,597
9. Water and Sewage	6030	0	15,099	15,099	0	15,099	1.0000	15,099
10. Trash and Refuse Removal	6040		7,327	7,327	0	7,327	1.0000	7,327
11. Hazardous Medical Waste Collection	6050		1,076	1,076	0	1,076	1.0000	1,076
12. TOTAL Utility Costs		0	173,099	173,099	0	173,099		173,099
<b>PROPERTY TAXES</b>								
13. Real Estate Taxes	6060		1,593	1,593	0	1,593	1.0000	1,593
14. Personal Property Taxes	6070		0	0	0	0	1.0000	0
15. Franchise Tax (Attach FT 1120)	6080		0	0	0	0	1.0000	0
16. TOTAL Property Taxes (sum of lines 13 through 15)			1,593	1,593	0	1,593		1,593
<b>GOVERNMENT MANDATED FEES</b>								
17. Government Mandated Assessments/Fees	6090		0	0	0	0	1.0000	0
17a. Franchise Permit Fees	6091		138,850	138,850	-102,350	36,500	1.0000	36,500
17b. Total Government Mandated Fees (sum of lines 17 and 17a)			138,850	138,850	-102,350	36,500		36,500
<b>** HOME OFFICE COSTS **</b>								
18. **Home Office Costs/Other Protected**	6095		0	0	0	0	1.0000	0
<b>NFs and ICFs-MR PAYROLL TAXES, FRINGE BENEFITS &amp; STAFF DEVELOP. (other protected Costs)</b>								
19. Payroll Taxes - Other Protected	6054		0	0	0	0	1.0000	0
20. Workers Compensation - Other Protected	6055		0	0	0	0	1.0000	0
21. Employee Fringe Benefits - Other Protected	6056		0	0	0	0	1.0000	0
22. EAP Administrator - Other Protected	6057	0	0	0	0	0	1.0000	0
23. Self Funded Programs Admn. - Other Protected	6058	0	0	0	0	0	1.0000	0
24. Staff Development - Other Protected	6059	0	0	0	0	0	1.0000	0
25. TOTAL Payroll Taxes, Fringe Benefits, &		0	0	0	0	0		0
26. TOTAL Other Protected Costs		0	344,850	344,850	-102,350	242,500		242,500

**\*\* HOME OFFICE COSTS INSTRUCTIONS \*\***

Home office costs are to be entered on line 18 only. They are not to be distributed to any other line on this schedule.

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>NURSING AND HABILITATION/REHABILITATION</b>								
1. Medical Director	6100	0	0	0	0	0	1.0000	0
2. Director of Nursing	6105	58,807	0	58,807	0	58,807	1.0000	58,807
3. RN Charge Nurse	6110	0	0	0	0	0	1.0000	0
4. LPN Charge Nurse	6115	0	0	0	0	0	1.0000	0
5. Registered Nurse	6120	256,580	0	256,580	0	256,580	1.0000	256,580
6. Licensed Practical Nurse	6125	519,203	0	519,203	0	519,203	1.0000	519,203
7. Nurse Aides	6130	1,052,396		1,052,396	0	1,052,396	1.0000	1,052,396
8. Activity Director	6135	28,590	0	28,590	0	28,590	1.0000	28,590
9. Activity Staff	6140	0	0	0	0	0	1.0000	0
10. Recreational Therapist for NFs	6145	0	0	0	0	0	1.0000	0
11. Program Specialist for ICFs-MR	6150	0	0	0	0	0	1.0000	0
12. Program Director	6155	0	0	0	0	0	1.0000	0
13. Habilitation Supervisor for NFs	6160	113,500	0	113,500	0	113,500	1.0000	113,500
14. Habilitation Supervisor for ICFs-MR	6165	0	0	0	0	0	1.0000	0
15. Habilitation Staff	6170	0	0	0	0	0	1.0000	0
16. Psychologist	6175	0	0	0	0	0	1.0000	0
17. Psychology Assistant	6180	0	0	0	0	0	1.0000	0
18. Respiratory Therapist	6185	0	0	0	0	0	1.0000	0
19. Social Work/Counseling	6190	0	0	0	0	0	1.0000	0
20. Social Services/Pastoral Care	6195	69,699	0	69,699	0	69,699	1.0000	69,699
21. Qualified Mental Retardation Professional	6200	0	0	0	0	0	1.0000	0
22. Quality Assurance	6205	20,954	0	20,954	0	20,954	1.0000	20,954
23. Consulting and Management Fees-Direct Care	6210		0	0	0	0	1.0000	0
24. Other Direct Care - Specify Below	6220	0	0	0	0	0	1.0000	0
25. Home Office Costs/Direct Care	6230	0	0	0	0	0	1.0000	0
26. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 25)		2,119,729	0	2,119,729	0	2,119,729		2,119,729
<b>PURCHASED NURSING SERVICES</b>								
27. Registered Nurse Purchased Nursing	6300		0	0	0	0	1.0000	0
28. Licensed Practical Nurse Purchased Nursing	6310		0	0	0	0	1.0000	0
29. Nurse Aides Purchased Nursing	6320		0	0	0	0	1.0000	0
30. TOTAL Purchased Nursing (sum of lines 27 through 29)			0	0	0	0		0

Line 24 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 24 columns 1 & 2		

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Provider Name <b>FAIRLAWN HAVEN</b>	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002 Through: 12/31/2002
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DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>NURSING FACILITY ONLY</b>								
<b>NURSE AIDE TRAINING</b>								
31. In-House Trainer Wages	6400	5,086	0	5,086	0	5,086	1.0000	5,086
32. Classroom Wages: Nurse Aides	6410	0		0	0	0	1.0000	0
33. Clinical Wages: Nurse Aides	6420	0		0	0	0	1.0000	0
34. Books and Supplies	6430		0	0	0	0	1.0000	0
35. Transportation	6440		0	0	0	0	1.0000	0
36. Tuition Payments	6450		0	0	0	0	1.0000	0
37. Tuition Reimbursement	6455		0	0	0	0	1.0000	0
38. Contractual Payments to Other NFs	6460		0	0	0	0	1.0000	0
39. Registration Fees/Application Fees	6470		1,424	1,424	539	1,963	1.0000	1,963
40. Employee Fringe Benefits	6490		661	661	0	661	1.0000	661
41. TOTAL Nurse Aide Training - NFs (sum of lines 31 through 40)		5,086	2,085	7,171	539	7,710		7,710
<b>ICF-MR FACILITIES ONLY</b>								
<b>DIRECT CARE THERAPIES</b>								
42. Physical Therapist ICF-MR	6600	0	0	0	0	0	1.0000	0
43. Physical Therapy Assistant ICF-MR	6605	0	0	0	0	0	1.0000	0
44. Occupational Therapist ICF-MR	6610	0	0	0	0	0	1.0000	0
45. Occupational Therapy Assistant ICF-MR	6615	0	0	0	0	0	1.0000	0
46. Speech Therapist ICF-MR	6620	0	0	0	0	0	1.0000	0
47. Audiologist ICF-MR	6630	0	0	0	0	0	1.0000	0
48. TOTAL Direct Care Therapies ICF-MR (sum of lines 42 through 47)		0	0	0	0	0		0
<b>NFs and ICFs-MR</b>								
<b>PAYROLL TAXES, FRINGE BENEFITS, &amp; STAFF DEVELOP. (No Purchased Nursing)</b>								
49. Payroll Taxes - Direct Care	6510		167,739	167,739	0	167,739	1.0000	167,739
50. Workers Compensation - Direct Care	6520		8,691	8,691	0	8,691	1.0000	8,691
51. Employee Fringe Benefits - Direct Care	6530		279,141	279,141	0	279,141	1.0000	279,141
52. EAP Administrator - Direct Care	6535	0	0	0	0	0	1.0000	0
53. Self Funded Programs Admin. - Direct Care	6540	0	0	0	0	0	1.0000	0
54. Staff Development - Direct Care	6550	0	1,236	1,236	0	1,236	1.0000	1,236
55. TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 49 thru 54)		0	456,807	456,807	0	456,807		456,807
56. TOTAL Reimbursable Direct Care Cost (sum of lines 26, 30, 41, 48 and 55)		2,124,815	458,892	2,583,707	539	2,584,246		2,584,246

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal.  
Note: All cost data should be rounded to the nearest whole dollar.

INDIRECT CARE COST CENTER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002 Through: 12/31/2002
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INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>DIETARY COST</b>								
1. Dietitian	7000	0	88	88	0	88	1.0000	88
2. Food Service Supervisor	7005	31,273	0	31,273	0	31,273	1.0000	31,273
3. Dietary Personnel	7015	289,796	0	289,796	0	289,796	1.0000	289,796
4. Dietary Supplies and Expenses	7025		28,803	28,803	0	28,803	1.0000	28,803
5. Dietary Minor Equipment	7030		0	0	0	0	1.0000	0
6. Dietary Maintenance and Repair	7035		0	0	0	0	1.0000	0
7. Food In-Facility	7040		169,209	169,209	-6,208	163,001	1.0000	163,001
8. Food Out-of-Facility (see * footnote)	7041		0	0	0	0	1.0000	0
9. Employee Meals	7045		0	0	0	0	1.0000	0
10. Contract Meals/Contract Meals Personnel	7050		0	0	0	0	1.0000	0
11. Enterals: Medicare Billable	7055		0	0	0	0	1.0000	0
11a. Enterals: Medicare Non-Billable	7056		0	0	0	0	1.0000	0
12. Payroll Taxes - Dietary	7060		25,346	25,346	0	25,346	1.0000	25,346
13. Workers' Compensation - Dietary	7065		1,313	1,313	0	1,313	1.0000	1,313
14. Employee Fringe Benefits - Dietary	7070		32,744	32,744	0	32,744	1.0000	32,744
15. EAP Administrator - Dietary	7075	0	0	0	0	0	1.0000	0
16. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	1.0000	0
17. Staff Development - Dietary	7090	0	22	22	0	22	1.0000	22
18. TOTAL Dietary (sum of lines 1 through 17)		321,069	257,525	578,594	-6,208	572,386		572,386
<b>MEDICAL, HABILITATION, PHARM. &amp; INCONTINENCE SUPPLIES</b>								
19. Habilitation Supplies	7100		36,910	36,910	0	36,910	1.0000	36,910
20. Medical/Habilitation Records	7105	36,835	1,326	38,161	0	38,161	1.0000	38,161
21. Pharmaceutical Consultant	7110	0	3,573	3,573	0	3,573	1.0000	3,573
22. Incontinence Supplies	7115		69,297	69,297	0	69,297	1.0000	69,297
23. Personal Care - Supplies	7120		16,232	16,232	-42	16,190	1.0000	16,190
24. Program Supplies	7125		16,124	16,124	-1,423	14,701	1.0000	14,701
25. TOTAL Habilitation, Pharmaceutical & Incontinence (sum of lines 19 through 24)		36,835	143,462	180,297	-1,465	178,832		178,832
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>								
26. Administrator	7200	65,737	0	65,737	0	65,737	1.0000	65,737
27. Other Administrative Personnel	7210	63,572	0	63,572	0	63,572	1.0000	63,572
28. Consulting and Management Fees - Indirect	7215		0	0	0	0	1.0000	0
29. Office and Administrative Supplies	7220		14,772	14,772	0	14,772	1.0000	14,772
30. Communications	7225		8,713	8,713	0	8,713	1.0000	8,713
31. Security Services	7230	0	731	731	0	731	1.0000	731
32. Travel and Entertainment	7235		3,145	3,145	0	3,145	1.0000	3,145
33. SUB-TOTAL (sum of lines 26 through 32)		129,309	27,361	156,670	0	156,670		156,670

\*Footnote Total Number of meals purchased

Food Out-of-Facility	0
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\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal.  
Note: All cost data should be rounded to the nearest whole dollar.

INDIRECT CARE COST CENTER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>								
34. Laundry/Housekeeping Supervisor	7240	26,567	0	26,567	0	26,567	1.0000	26,567
35. Housckeping	7245	184,727	28,057	212,784	0	212,784	1.0000	212,784
36. Laundry and Linen	7250	80,852	11,124	91,976	0	91,976	1.0000	91,976
37. Universal Precaution Supplies	7255		9,198	9,198	0	9,198	1.0000	9,198
38. Legal Services	7260		0	0	0	0	1.0000	0
39. Accounting	7265	0	15,310	15,310	0	15,310	1.0000	15,310
40. Dues, Subscriptions and Licenses	7270		13,108	13,108	0	13,108	1.0000	13,108
41. Interest - Other	7275		0	0	0	0	1.0000	0
42. Insurance	7280		62,973	62,973	0	62,973	1.0000	62,973
43. Data Services	7285	0	3,472	3,472	0	3,472	1.0000	3,472
44. Help Wanted/Informational Advertising	7290		182	182	0	182	1.0000	182
45. Amortization of Start-Up Costs	7295		0	0	0	0	1.0000	0
46. Amortization of Organizational Costs	7300		0	0	0	0	1.0000	0
47. Other Indirect Care - Specify below	7305	0	0	0	0	0	1.0000	0
48. ** Home Office Costs/Indirect Care **	7310	0	0	0	0	0	1.0000	0
49. TOTAL Admin. & General Services (sum of lines 34 thru 48 and 33)		421,455	170,785	592,240	0	592,240		592,240
<b>MAINTENANCE AND MINOR EQUIPMENT</b>								
50. Plant Operations/Maintenance Supervisor	7320	40,386	0	40,386	0	40,386	1.0000	40,386
51. Plant Operations and Maintenance	7330	50,217	0	50,217	0	50,217	1.0000	50,217
52. Repair and Maintenance	7340		70,027	70,027	0	70,027	1.0000	70,027
53. Minor Equipment	7350		0	0	0	0	1.0000	0
54. Leased Equipment	7400		0	0	0	0	1.0000	0
55. TOTAL Maintenance and Minor Equipment (sum of lines 50 through 54)		90,603	70,027	160,630	0	160,630		160,630
<b>PAYROLL TAXES, FRINGE BENEFITS, &amp; STAFF DEVELOPMENT</b>								
56. Payroll Taxes - Indirect Care	7500		43,331	43,331	0	43,331	1.0000	43,331
57. Workers' Compensation - Indirect Care	7510		2,245	2,245	0	2,245	1.0000	2,245
58. Employee Fringe Benefits - Indirect Care	7520		71,580	71,580	0	71,580	1.0000	71,580
59. EAP Administrator - Indirect Care	7525	0	0	0	0	0	1.0000	0
60. Self Funded Prog. Admin. - Indirect Care	7530	0	0	0	0	0	1.0000	0
61. Staff Development - Indirect Care	7535	0	1,279	1,279	0	1,279	1.0000	1,279
62. TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 56 thru 61)		0	118,435	118,435	0	118,435		118,435
63. TOTAL Reimbursable Indirect Care Cost (sum of lines 18, 25, 49, 55 and 62)		869,962	760,234	1,630,196	-7,673	1,622,523		1,622,523

\*\* Home office costs are to be entered on line 48 only. They are not to be distributed to any other line on this schedule \*\*

Line 47 Other Indirect Care - Specify below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 47. Columns 1 & 2		

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal

Note: All cost data should be rounded to the nearest whole dollar

INDIRECT CARE COST CENTER

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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NON REIMBURSABLE EXPENSES	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc Ratio *** (6)	Allocated Adjust. Total (Col 5 * Col 6) (7)
<b>NURSING FACILITIES ONLY NON-REIMBURSABLE EXPENSES</b>								
64. Physical Therapist - NF	6600	0	0	0	0	0	1.0000	0
65. Physical Therapy Assistant - NF	6605	0	0	0	0	0	1.0000	0
66. Occupational Therapist - NF	6610	0	0	0	0	0	1.0000	0
67. Occupational Therapist Assistant - NF	6615	0	0	0	0	0	1.0000	0
68. Speech Therapist - NF	6620	0	0	0	0	0	1.0000	0
69. Audiologist - NF	6630	0	0	0	0	0	1.0000	0
70. Payroll Taxes - Therapy - NF	6640		0	0	0	0	1.0000	0
71. Workers' Compensation - Therapy - NF	6650		0	0	0	0	1.0000	0
72. Employee Fringe Benefits - Therapy - NF	6660		0	0	0	0	1.0000	0
73. EAP Administrator - Therapy - NF	6665	0	0	0	0	0	1.0000	0
74. Self Funded Program Admin. - Therapy - NF	6670	0	0	0	0	0	1.0000	0
75. Staff Development - Therapy - NF	6680	0	0	0	0	0	1.0000	0
76. TOTAL Non-Reimbursable NF's Only (sum of lines 64 through 75)		0	0	0	0	0		0
<b>NURSING FACILITIES &amp; ICFs-MR NON-REIMBURSABLE EXPENSES</b>								
77. Legend Drugs	9705		7,577	7,577	0	7,577	1.0000	7,577
78. Radiology	9710		0	0	0	0	1.0000	0
79. Laboratory	9715		0	0	0	0	1.0000	0
80. Oxygen	9720		0	0	0	0	1.0000	0
81. Other Non-Reimbursable - Specify Below	9725	0	2,428	2,428	102,350	104,778	1.0000	104,778
82. Late Fees, Fines or Penalties	9730		0	0	0	0	1.0000	0
83. Federal Income Tax	9735		0	0	0	0	1.0000	0
84. State Income Tax	9740		1,084	1,084	0	1,084	1.0000	1,084
85. Local Income Tax	9745		0	0	0	0	1.0000	0
86. Insurance - Officers Life	9750		0	0	0	0	1.0000	0
87. Promotional Advertising and Marketing	9755	8,490	0	8,490	0	8,490	1.0000	8,490
88. Contributions and Donations	9760		31,214	31,214	0	31,214	1.0000	31,214
89. Bad Debt	9765		0	0	0	0	1.0000	0
90. Parenteral Nutrition Therapy	9770		0	0	0	0	1.0000	0
91. TOTAL Non-Reimbursable NFs and ICFs-MR (sum of lines 77 thru 90)		8,490	42,303	50,793	102,350	153,143		153,143
92. TOTAL Non-Reimbursable NFs and ICFs-MR (sum of lines 76 and 91)		8,490	42,303	50,793	102,350	153,143		153,143
93. TOTAL Indirect Care Cost Reimbursable and Non-Reimbursable (sum of lines 63 and 92)		878,452	802,537	1,680,989	94,677	1,775,666		1,775,666

Line 81 Other Non-Reimbursable - Specify below

Account Title	Salary Column 1	Other Column 2
Non-allowable P/T, W/C, & Frin	0	1,702
Non-Resident Related Expenses	0	726
Totals must tie to line 81 Columns 1 & 2	0	2,428

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal

Note: All cost data should be rounded to the nearest whole dollar

ADMINISTRATORS COMPENSATION

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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SECTION A:

Name of Individual Steven Ringenberg	Administrator License Number* 2777	Social Security Number 339-42-3259
Relationship to Provider: Is the administrator an owner/relative? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
1. Basic percentage allowance		100%
2. Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years)	<u>10</u> Times 4 =	40%
3. Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate is not obtained)	<u>6</u> Times 5 =	30%
3.1 Was baccalaureate degree obtained?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
4. Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)		
a. Accounting	<u>0</u>	
b. Maintenance	<u>0</u>	
c. Housekeeping	<u>0</u>	
d. Other, specify	<u>0</u>	
e. Other, specify	<u>0</u>	
Total Duties	<u>0</u> Times 4 =	0%
5. County Adjustment (see instructions)		0%
6. Ownership Points (see instructions)		0%
7. Subtotal of lines 1 through 6		170%
8. Allowance Percentage (enter line 7, not to exceed 150%)		150%

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Paid Weekly		Compensation		
Beginning Date (MM/DD/YYYY) (1)	Ending Date (MM/DD/YYYY) (2)	Hrs. **	%	Account Number ***	Column Number	Amount
(1)	(2)	(3)	(4)	(5)	(6)	(7)
01/01/2002	12/31/2002	34.00	85.00	7200	7	65,737
TOTAL COMPENSATION						65,737

\* QMRP'S AND ADMINISTRATORS OF HOSPITAL BASED LTCF'S REPORT SOCIAL SECURITY NUMBER.

\*\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 7 IS ALLOCATED, HOURS WORKED MUST BE ALLOCATED USING THE SAME RATIO.

\*\*\* THIS SCHEDULE MUST BE COMPLETED FOR ALL ADMINISTRATORS REGARDLESS OF WHETHER THE ADMINISTRATOR'S SALARY IS REPORTED IN ACCOUNT NUMBER

**OWNERS'/RELATIVES' COMPENSATION  
OTHER THAN COMPENSATION FOR FACILITY ADMINISTRATOR DUTIES**

Provider Name <b>FAIRLAWN HAVEN</b>	Medicaid Provider Number <b>0010302</b>	Reporting Period From: <b>01/01/2002</b> Through: <b>12/31/2002</b>
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Instructions: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed.

Detail owners and/or relatives compensation included on ODHS 2524, Schedules B-1, B-2 and C net of applicable column 4 adjustments.

Individual's Name (1)	Social Security Number (2)	Position Number ** (3)	Relationship to Owner (4)	Years of Exper. (5)	Dates of Employment During this Reporting Period		Paid Weekly Compensation					
					Beginning (6)	Ending (7)	Hrs. * (8)	% (9)	Account Number (10)	Col. No. (11)	Amount (12)	

\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 12 IS ALLOCATED, HOURS WORKED MUST BE ALLOCATED USING THE SAME RATIO.

\*\* SEE COST REPORT INSTRUCTIONS PAGES 22, 23, AND 24 FOR POSITION NUMBERS.



COST OF SERVICES FROM RELATED ORGANIZATIONS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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1. In the amount of costs to be reimbursed by the Ohio Medical Assistance Program, are any costs included which are a result of transactions with a related organization? \*  
 \_\_\_ Yes                      X No                      If Yes, complete item 2

2. Does this cost report include payments to related parties in excess of the costs to the related party?  
 \_\_\_ Yes                      X No                      If Yes, complete the table below

Name of Owner (1)	Social Security Number (2)	Name of Related Organization (3)	Federal ID. Number (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Organization (9)

\* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-20

COST OF SERVICES FROM RELATED ORGANIZATIONS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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3. List each individual who owns, in whole or in part, any mortgage or deed of trust, of the facility or of any property or asset of the provider.  
 (All individuals owning greater than 10% of the land or building, and/or greater than 5% of non-real estate business, etc., must be identified by name and Social Security Number.) \*

Name	Social Security Number	Name	Social Security Number

4. Is this facility a partnership?         Yes        X   No      If Yes, list each partner.  
 Is this facility a corporation?        X   Yes        —   No      If Yes, list each corporate officer or director. \*\*

Name	Social Security Number	Job Title
Calvin Britsch	100-00-0000	President
James Gautsche	200-00-0000	Vice President
Frieda Sauder	300-00-0000	Secretary
David Lersch, Sr.	400-00-0000	Treasurer

5. List all other facilities that have ownership, either direct or indirect, in common with this facility.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

\* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-20

\*\* FOR CORPORATE OFFICERS OR DIRECTORS NOT IDENTIFIED IN 1, 2, OR 3 ABOVE AND WHO HAVE NOT RECEIVED COMPENSATION FOR PERFORMING THE DUTIES OF CORPORATE OFFICER OR DIRECTOR, NEED NOT REPORT THEIR SOCIAL SECURITY NUMBER.

COST OF SERVICES FROM RELATED ORGANIZATIONS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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5. Continued

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

\*\* FOR CORPORATE OFFICERS OR DIRECTORS NOT IDENTIFIED IN 1, 2, OR 3 ABOVE AND WHO HAVE NOT RECEIVED COMPENSATION FOR PERFORMING THE DUTIES OF CORPORATE OFFICER OR DIRECTOR, NEED NOT REPORT THEIR SOCIAL SECURITY NUMBER.

COST OF SERVICES FROM RELATED ORGANIZATIONS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?  
 \_\_\_ Yes    X No    If yes, list names below

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Human Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, or the Department of Industrial Relations within the previous twelve months?  
 \_\_\_ Yes    X No    If yes, list names below.

Name	Social Security Number	Name	Social Security Number

8. List all contracts in effect during the cost report period for which the imputed value or cost of the service from any individual or organization is twenty-five thousand dollars or more in a twelve month period.

Contractor Name	Contract Amount	Goods or Services Provided

CAPITAL COST CENTER

Provider Name <b>FAIRLAWN HAVEN</b>	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002 Through: 12/31/2002
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All ICFs-MR need only use group (A).

NFs that did not change provider agreement on or after 7/01/93 need only use group (A).

NFs that did change provider agreement on or after 7/01/93 use groups (A) and (B).

**GROUP A ASSETS ACQUIRED**

(1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
1. Depreciation - Building	8010	29,467	-1,473	27,994	1.0000	27,994
2. Amortization - Land Improvements	8020	6,726	0	6,726	1.0000	6,726
3. Amortization - Leasehold Improvements	8030	0	0	0	1.0000	0
4. Depreciation - Equipment	8040	44,589	0	44,589	1.0000	44,589
5. Depreciation - Transportation Equipment	8050	5,989	0	5,989	1.0000	5,989
6. Lease and Rent - Building	8060	0	0	0	1.0000	0
7. Lease and Rent - Equipment	8065	0	0	0	1.0000	0
8. Interest Exp. - Prop., Plant and Equip.	8070	51,867	-34,110	17,757	1.0000	17,757
9. Amortization of Financing Costs	8080	0	0	0	1.0000	0
10. ** Home Office Costs/Capital Cost **	8090	0	0	0	1.0000	0
<b>11. TOTAL Cost of Ownership Group A</b>		<b>138,638</b>	<b>-35,583</b>	<b>103,055</b>		<b>103,055</b>

\*\* Home Office Costs are to be entered on line 10 only. They are not to be distributed to any other line in Group A. \*\*

**GROUP A RENOVATIONS**

RENOVATIONS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
12. Depreciation/Amort and Interest	8500,8570,8580	104,965	-4,222	100,743	1.0000	100,743
<b>13. TOTAL RENOVATIONS GROUP A</b>		<b>104,965</b>	<b>-4,222</b>	<b>100,743</b>		<b>100,743</b>

**GROUP B ASSETS ACQUIRED THROUGH A CHANGE OF PROVIDER AGREEMENT**

NFs, other than leased facilities, that changed Provider Agreement on or after 7/01/93 use this group to report expenses incurred through a change of provider agreement on or after 7/01/93. Leased nursing facilities that changed provider agreement on or after 5/27/92 use this group to report expenses incurred through a change of provider agreement on or after 5/27/92.

[Use column (4) to adjust reported costs to the allowable costs as defined in OAC 5101:3-3-51.6.]

OWNERSHIP COST CENTER (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
14. Depreciation - Building	8110	0	0	0	1.00	0
15. Depreciation - Equipment	8140	0	0	0	1.00	0
16. Interest Exp. - Prop., Plant and Equip.	8170	0	0	0	1.00	0
17. Amortization of Financing Costs	8180	0	0	0	1.00	0
18. Lease Expense	8195	0	0	0	1.00	0
<b>19. TOTAL Cost of Ownership Group B</b>		<b>0</b>	<b>0</b>	<b>0</b>		<b>0</b>

\*\*\* If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Provider Name <b>FAIRLAWN HAVEN</b>	Medicaid Provider Number <b>0010302</b>	Reporting Period From: <b>1/1/2002</b> Through: <b>12/31/2002</b>
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All ICFs-MR need only use group (A).

NFs that did not change provider agreement on or after 7/01/93 need only use group (A).

NFs that did change provider agreement on or after 7/01/93 use groups (A) and (B).

**GROUP A**

**ASSETS ACQUIRED**

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
1. Land	01/01/1964	22,367	-11,799	10,568		10,568	
2. Buildings	01/01/1964	2,887,796	25,878	2,913,674	1,404,328	1,509,346	29,467
3. Land Improvements	01/01/1964	107,581	0	107,581	93,727	13,854	6,726
4. Leasehold Improvements		0	0	0	0	0	0
5. Equipment	01/01/1964	766,548	58,828	825,376	533,873	291,503	44,589
6. Transportation	03/01/1982	65,526	0	65,526	59,537	5,989	5,989
7. Financing Costs		0	0	0	0	0	0
<b>8. TOTAL</b>		<b>3,849,818</b>	<b>72,907</b>	<b>3,922,725</b>	<b>2,091,465</b>	<b>1,831,260</b>	<b>86,771</b>

Has there been any change in the original historical cost of capital assets?

YES

NO

If yes, submit complete detail.

**GROUP A**

**RENOVATIONS**

Complete for renovations in use during cost report period reimbursable under OAC Rules 5101:3-3-51 and 5101:3-3-84.

(1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Project Cost End of Period (Col 1 + Col 2) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 3 - Col 4) (6)	Depreciation/Amortization this Period (7)	Interest this Period (8)	**Total Columns 6 and 7 (9)
9.	1,962,942	0	1,962,942	695,446	1,267,496	104,965	0	104,965
<b>10. TOTAL</b>	<b>1,962,942</b>	<b>0</b>	<b>1,962,942</b>	<b>695,446</b>	<b>1,267,496</b>	<b>104,965</b>	<b>0</b>	<b>104,965</b>

\*\* Transfer TOTAL of column 9 to Schedule D, column 3, line 12.

**GROUP B**

**ASSETS ACQUIRED THROUGH A CHANGE OF PROVIDER AGREEMENT**

NFs, other than leased facilities, that changed Provider Agreement on or after 7/01/93 use this group to report expenses incurred through a change of provider agreement on or after 7/01/93.

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
11. Land		0				0	
12. Buildings		0			0	0	0
13. Equipment		0			0	0	0
14. Financing Costs		0			0	0	0
<b>15. TOTAL</b>		<b>0</b>			<b>0</b>	<b>0</b>	<b>0</b>

Has there been any change in the original historical cost of capital assets?

YES

NO

If yes, submit complete detail.



## BALANCE SHEET

Provider Name FAIRLAWN HAVEN		Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
<b>CURRENT ASSETS</b>		Chart of Account	BALANCE PER BOOKS	
			Beginning of Period	End of Period
1.	Petty Cash	1001	208	208
2.	Cash In Banks - General Account	1010	1,393,538	1,842,251
3.	Accounts Receivable	1030	160,114	212,168
4.	Allowance For Uncollectible Accounts	1040	0	0
5.	Notes Receivable	1050	0	0
6.	Allowance For Uncollectible Notes Receivable	1060	0	0
7.	Other Receivables	1070	0	0
8.	Cost Settlement	1080	0	0
9.	Inventories	1090	0	0
10.	Prepaid Expenses	1100	8,049	100,624
11.	Short-Term Investments	1110	0	0
12.	Special Expenses	1120	0	0
13.	Total Current Assets (sum of lines 1 through 12)		1,561,909	2,155,251
<b>PROPERTY, PLANT AND EQUIPMENT</b>				
14.	Property, Plant and Equipment	1200	3,849,818	3,922,725
15.	Accumulated Depreciation and Amortization	1250	-2,004,695	-2,091,465
16.	Renovations	1300	1,962,942	1,962,942
17.	Accumulated Depreciation and Amortization - Renovations	1350	-590,481	-695,446
18.	Total Property, Plant and Equipment (sum of lines 14 through 17)		3,217,584	3,098,756
<b>OTHER ASSETS</b>				
19.	Non-Current Investments	1400	0	0
20.	Deposits	1410	1,000	1,000
21.	Due From Owners / Officers (to Sch. E-1, pg. 1 of 2, line 2)	1420	0	0
22.	Deferred Charges and Other Assets	1430	905,592	872,397
23.	Notes Receivable - Long-Term	1440	0	0
24.	Total Other Assets (sum of lines 19 through 23)		906,592	873,397
25.	Total Assets (sum of lines 13, 18 and 24)		5,686,085	6,127,404
<b>CURRENT LIABILITIES (Report credit balances as positive amount)</b>				
26.	Accounts Payable	2010	62,134	59,577
27.	Cost Settlements	2020	2,355	0
28.	Notes Payable	2030	0	0
29.	Current Portion of Long-Term Debt	2040	0	0
30.	Accrued Compensation	2050	213,305	241,719
31.	Payroll Related Withholdings and Liabilities	2060	11,606	11,809
32.	Taxes Payable	2080	30,360	39,560
33.	Other Liabilities, specify; Employee Insurance & Memorials	2090	23,703	22,178
34.	Total Current Liabilities (sum of lines 26 through 33)		343,463	374,843
<b>LONG-TERM LIABILITIES (Report credit balances as positive amount)</b>				
35.	Long-Term Debt	2410	1,059,056	1,024,409
36.	Related Party Loans - Interest Allowable	2420	0	0
37.	Related Party Loans - Interest Non-Allowable(to Sch E-1, pg 1 of 2, line	2430	0	0
38.	Non-Interest Bearing Loans From Owners(to Sch E-1, pg1 of 2, line 4)	2440	0	0
39.	Deferred Liabilities	2450	0	0
40.	Total Long-Term Liabilities (sum of lines 35 through 39)		1,059,056	1,024,409
41.	Total Liabilities (sum of lines 34 and 40)		1,402,519	1,399,252
42.	Capital (line 25 less line 41) (to Sch E-1, pg. 1 of 2, line 1)	3000	4,283,566	4,728,152
43.	Total Liabilities and Capital (must equal line 25)		5,686,085	6,127,404

## RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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REIMBURSABLE EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch E, line 42)	4,283,566	4,728,152
2. Due From Owners/Officers (from Sch E, line 21)	0	0
3. Related Party Loans - Interest Non-Allowable (from Sch E, line 3)	0	0
4. Non-Interest Bearing Loans From Related Party (from Sch E, line	0	0
5. Equity in Assets Leased From Related Party (attach detail)	0	0
6. Home Office Equity (attach detail)	0	0
7. Cash Surrender Value of Life Insurance Policy	0	0
8. Other, Specify	0	0
9. Other, Specify	0	0
10. Other, Specify	0	0
11. Other, Specify	0	0
12. Other, Specify	0	0
13. Other, Specify	0	0
14. Other, Specify	0	0
15. Other, Specify	0	0
16. Other, Specify	0	0
17. Other, Specify	0	0
18. Other, Specify	0	0
19. Other, Specify	0	0
20. Other, Specify	0	0
21. Other, Specify	0	0
22. Total Reimbursable Equity (column 1 to E-1, page 2 of 2, column	4,283,566	4,728,152

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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Month (1)	Reimbursable Equity Beginning of Period (2)	Capital Investments During Period (3)	Gain (Loss) On Disposal of Assets (4)	Withdrawals, or Dividend Distribution (5)	Other Increase / (Decrease) (6)	Increases or (Decreases) Due to Operations (7)	Reimbursable Equity Capital End of Month (net total of columns 2-7) (8)
23. January	0	0	0	0	0	0	0
24. February	0	0	0	0	0	0	0
25. March	0	0	0	0	0	0	0
26. April	0	0	0	0	0	0	0
27. May	0	0	0	0	0	0	0
28. June	0	0	0	0	0	0	0
29. July	0	0	0	0	0	0	0
30. August	0	0	0	0	0	0	0
31. September	0	0	0	0	0	0	0
32. October	0	0	0	0	0	0	0
33. November	0	0	0	0	0	0	0
34. December	0	0	0	0	0	0	0
35. TOTAL							0
36. Return on Equity	1 0	2 / 12	3* X 0.07298		4 / 35,848	=	5** 0.00
(Ref. Sch. A-3, line 12 col. 5)							

\* Estimate Only

\*\* Maximum Return on Equity is \$1.00 (see instructions)

INSTRUCTIONS FOR COMPLETING LINE NUMBER 36

- Column # 1 Enter amount from Schedule E-1 line 35 column 8.
- Column # 2 Enter number of months in reporting period.
- Column # 4 Enter allowable capital days from Schedule A line 6.2 column 1.
- Column # 5 Enter result of the previous calculations or \$1.00 whichever is less.
- Column # 8 If result is negative figure enter "0" lines 23-34. Do not enter less than zero.

## REVENUE TRIAL BALANCE

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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Revenue Account Name	Chart of Account	Total	Adjustments Increase (Decrease)	Adjusted Total (Col. 2 + Col. 3)
	(1)	(2)	(3)	(4)
<b>ROUTINE SERVICE - ROOM AND BOARD</b>				
1. Private	5010	2,357,265	0	2,357,265
2. Medicare	5011	0	0	0
3. Medicaid	5012	2,550,198	0	2,550,198
4. Veterans	5013	0	0	0
5. Other	5014	0	0	0
6. TOTAL (lines 1 through 5)		4,907,463	0	4,907,463
<b>DEDUCTIONS FROM REVENUES</b>				
7. Contractual Allowance-Medicare	5710	0	0	0
8. Contractual Allowance-Medicaid	5720	13,353	0	13,353
9. Contractual Allowance-Other	5730	-17,605	0	-17,605
10. Charity Allowance	5740	0	0	0
11. TOTAL (lines 7 through 10)		-4,252	0	-4,252
<b>THERAPY SERVICES</b>				
12. Physical Therapy	5020	0	0	0
13. Occupational Therapy	5030	0	0	0
14. Speech Therapy	5040	0	0	0
15. Audiology Therapy	5050	0	0	0
16. Respiratory Therapy	5060	0	0	0
17. TOTAL (lines 12 through 16)		0	0	0
<b>MEDICAL SUPPLIES</b>				
18. Medicare (To Sch A- 2)	5070-1	0	0	0
19. Medicare (To Sch A- 3)	5070-2	0	0	0
20. Private (To Sch A- 4)	5070-3	0	0	0
21. Medicare (To Sch A- 5)	5070-4	0	0	0
22. Veterans (To Sch A- 6)	5070-5	0	0	0
23. Other (To Sch A- 6)	5070-6	0	0	0
24. Medicaid (To Sch A- 7)	5070-7	0	0	0
25. Medical Supplies-Routine	5080	0	0	0
26. TOTAL (lines 18 through 25)		0	0	0
<b>MEDICAL MINOR EQUIPMENT</b>				
27. Medicare (To Sch. A- 2)	5090-1	0	0	0
28. Medicare (To Sch. A- 3)	5090-2	0	0	0
29. Private (To Sch. A- 4)	5090-3	0	0	0
30. Medicare (To Sch. A- 5)	5090-4	0	0	0
31. Veterans (To Sch. A- 6)	5090-5	0	0	0
32. Other (To Sch. A- 6)	5090-6	0	0	0
33. Medicaid (To Sch. A- 7)	5090-7	0	0	0
34. Medical Minor Equipment-Routine	5100	0	0	0
35. TOTAL (Lines 27 through 34)		0	0	0

REVENUE TRIAL BALANCE

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>ENTERAL NUTRITION THERAPY</b>				
36. Medicare (To Sch. A-2, Line 3a, Col. 2)	5110-1	0	0	0
37. Medicare (To Sch. A-2, Line 3a, Col. 3)	5110-2	0	0	0
38. Private (To Sch. A-2, Line 3a, Col. 4)	5110-3	0	0	0
39. Medicare (To Sch. A-2, Line 3a, Col. 5)	5110-4	0	0	0
40. Veterans (To Sch. A-2, Line 3a, Col. 6)	5110-5	0	0	0
41. Other (To Sch. A-2, Line 3a, Col. 6)	5110-6	0	0	0
42. Medicaid (To Sch. A-2, Line 3a, Col. 7)	5110-7	0	0	0
43. Enteral Nutrition Therapy - Routine	5120	0	0	0
44. TOTAL (lines 36 through 43)		0	0	0
<b>OTHER ANCILLARY SERVICE</b>				
45. Habilitation Supplies	5130	0	0	0
46. Incontinence Supply	5140	0	0	0
47. Personal Care	5150	0	0	0
48. Laundry Service - Routine	5160	0	0	0
49. TOTAL (lines 45 through 48)		0	0	0
<b>OTHER SERVICES</b>				
50. Dry Cleaning Service	5310	0	0	0
51. Communications	5320	0	0	0
52. Meals	5330	0	0	0
53. Barber and Beauty	5340	-876	0	-876
54. Personal Purchases - Residents	5350	42	-42	0
55. Radiology	5360	0	0	0
56. Laboratory	5370	0	0	0
57. Oxygen	5380	0	0	0
58. Legend Drugs	5390	0	0	0
59. Other - Specify Below	5400	7,952	-1,423	6,529
60. TOTAL (lines 50 through 59)		7,118	-1,465	5,653

Line 59 Other - Specify below

Account Title	Amount
Activities Income	1,423
Non-Patient Care Rel	-252
Duplex Sale Income	6,781
Total must tie to line 59, column 2	7,952

## REVENUE TRIAL BALANCE

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>NON-OPERATING</b>				
61. Management Services	5510	16,231	0	16,231
62. Cash Discounts	5520	0	0	0
63. Rebates and Refunds	5530	0	0	0
64. Gift Shop	5540	0	0	0
65. Vending Machine Revenues	5550	6,208	-6,208	0
66. Vending Machine Commissions	5555	0	0	0
67. Rental - Space	5560	0	0	0
68. Rental - Equipment	5570	0	0	0
69. Rental - Other	5580	0	0	0
70. Interest Income - Working Capital	5590	34,110	-34,110	0
71. Interest Income - Restricted Funds	5600	1,902	0	1,902
72. Interest Income - Funded Depreciation	5610	30,237	0	30,237
73. Interest Income - Related Party Revenue	5620	0	0	0
74. Interest Income - Contributions	5625	0	0	0
75. Endowments	5630	0	0	0
76. Gain/Loss on Disposal of Assets	5640	0	0	0
77. Gain/Loss on Sale of Investments	5650	0	0	0
78. Nurse Aide Training Program Revenue	5660	-539	539	0
79. Unrestricted Contributions	5670	226,204	0	226,204
80. TOTAL (lines 61 through 79)		314,353	-39,779	274,574
81. TOTAL (SUM OF LINES 6, 11, 17, 26, 35, 44, 49, 60 AND 80)		5,224,682	-41,244	5,183,438

## ADJUSTMENT TO TRIAL BALANCE

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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Description	Revenue Chart of Account # (1)	Salary Increase (Decrease) (2)	Other Increase (Decrease) (3)	Total Increase (Decrease) (Col. 2 + Col. 3) (4)	Expense Chart of Account # (5)	Revenue Reference Attachment 1 Line (6)
1. Meals	5330	0	0	0		52
2. Barber and Beauty	5340	0	0	0		53
3. Vending Machine Revenues	5550	0	-6,208	-6,208	7040	65
4. Interest Income - Working Capital	5590	0	-34,110	-34,110	8070	70
5. Nurse Aide Training Program Revenue	5660	0	539	539	6470	78
6. Other Income-Activities	5400	0	-1,423	-1,423	7125	59
7. H.B. 94 Add-on		0	102,350	102,350	9725	
8. H.B. 94 Add-on		0	-102,350	-102,350	6091	
9. Personal Purchases - Residents	5350	0	-42	-42	7120	54
10. Assisted Living Bldg Deprec		0	-1,473	-1,473	8010	
11. Assisted Living Renov Deprec		0	-4,222	-4,222	8500	
12. A-2 Offset (Line 7, Col 2)		0	0	0	6000	
13. A-2 Offset (Line 7, Col 3)		0	0	0	6005	
14. A-2 Offset (Line 7, Col 4)		0	0	0	7055	
15. A-2 Offset (Line 12, Col 5)		0	0	0	7305	
16. TOTAL		0	-46,939	-46,939		

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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As per the Cost Report instructions, any documentation required by the Department, or needed to clarify individual line items (or groupings) must be submitted as hard copy and labeled as an Exhibit. To facilitate the reporting and review process of this submitted Cost Report (including Exhibits) the Department requires that Exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and will be labeled accordingly. Exhibits 3 and 4, if needed, will also be labeled accordingly. In certain situations, if Exhibits 3 and 4 are not applicable the corresponding Exhibit number shall not be used. Any other additional Exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

**Please attach one copy of the following:**

Exhibit 1. Facility trial balance that detail the general ledger account names as of December 31, 19CY

IF THE RECOMMENDED CHART OF ACCOUNTS PER OAC 5101 3-3-201 IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT. (One copy with each cost report is required.)

Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)

Exhibit 3. Home office trial balances and the allocation work sheets that are required to show how the home office trial balance is allocated to each individual facility's cost report. Include: Account groupings for each home office account. The allocation procedures are pursuant to HCFA 15-1 Chapter 21, section 2150 through section 2153. (If applicable - One copy with each Cost Report is required.)

Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported. (If applicable - One copy with each Cost Report is required)

Exhibit 5. Any other documentation which you feel is necessary to explain your cost(s) You must identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8 col. 4.

Failure to cross-reference exhibits, to the applicable Cost Report schedule, line, and column, may qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to OAC Rule 5101:3-3-20.

## PAID NON-MEDICAID LEAVE DAYS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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## INSTRUCTIONS

Record monthly the Non-Medicaid leave days paid for by payers other than ODHS. Paid Non-Medicaid leave days are hospital, therapeutic, or any other leave day paid for by a Non-Medicaid resident. Non-Medicaid leave days are counted as inpatient days proportionate to the Non-Medicaid per diem rate paid.

MONTH	TOTAL PAID NON-MEDICAID LEAVE DAYS
JANUARY	8
FEBRUARY	2
MARCH	12
APRIL	3
MAY	4
JUNE	21
JULY	12
AUGUST	2
SEPTEMBER	9
OCTOBER	10
NOVEMBER	47
DECEMBER	24
TOTAL	154

Percentage of per diem rate paid by Non-Medicaid residents for leave days

100.00

NURSE AIDE TRAINING STATISTICAL INFORMATION

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through: 12/31/2002
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ONLY NURSING FACILITIES MUST COMPLETE THIS ATTACHMENT

Description	JANUARY 1 through MARCH 31 (1)	APRIL 1 through JUNE 30 (2)	JULY 1 through SEPTEMBER 30 (3)	OCTOBER 1 through DECEMBER 31 (4)	TOTAL (col. 1 thru 4) (5)
<b>SECTION A: NURSE AIDE CONTINUING EDUCATION</b>					
1. Number of nurse aides completing continuing education	0	0	0	59	59

SECTION B: NUMBER OF AIDES TRAINED	NUMBER OF NURSE AIDES				
	TRAINED IN THIS FACILITY		TRAINED IN OTHER LTCF's (3)	TRAINED FROM OTHER SOURCES (4)	TOTAL (Sum of col. 1 - 4) (5)
	Your Facility Nurse Aides (1)	Other Facilities Nurse Aides (2)			
2. Number of aides who completed training during cost report period.	20	0	1	0	21
3. Number of aides who dropped out of training during cost report period.	5	0	0	0	5
4. Total aides (sum of lines 2 and 3)	25	0	1	0	26
5. Total number of state approved nurse aides on your payroll at the end of the cost report period.					66
6. Total number of state approved nurse aides, excluding line 5, at the end of the cost report period.					66

## WAGE AND HOURS SURVEY

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through 12/31/2002
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## INSTRUCTIONS:

REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED.

Column (C): Enter wages (net of adjustments) paid to facility personnel (This must agree with the sum of column 1 on schedules B-1, B-2, C and attachment 2, column 2).

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with Schedule C-2).

Column (E): Column (C) minus Column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus Column (G).

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owner Wages Paid (D)	Total Non-Owner Wages Paid (E)	Total Hours Paid (F)	Owner Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>OTHER PROTECTED COSTS</b>							
1. Water and Sewage	6030	0	0	0	0	0	0
1a. EAP Administrator - Other Protected	6057	0	0	0	0	0	0
1b. Self Funded Programs Admin. - Other Protected	6058	0	0	0	0	0	0
1c. Staff Development - Other Protected	6059	0	0	0	0	0	0
1d. TOTAL Other Protected Costs Sum of lines (1 through 1c)		0	0	0	0	0	0
<b>DIRECT CARE NURSING AND HABILITATION/REHABILITATION</b>							
2. Medical Director	6100	0	0	0	0	0	0
3. Director of Nursing	6105	58,807	0	58,807	2,193	0	2,193
4. RN Charge Nurse	6110	0	0	0	0	0	0
5. LPN Charge Nurse	6115	0	0	0	0	0	0
6. Registered Nurse	6120	256,580	0	256,580	12,664	0	12,664
7. Licensed Practical Nurse	6125	519,203	0	519,203	30,257	0	30,257
8. Nurse Aides	6130	1,052,396	0	1,052,396	102,174	0	102,174
9. Activity Director	6135	28,590	0	28,590	2,148	0	2,148
10. Activity Staff	6140	0	0	0	0	0	0
11. Recreational Therapist for NFs	6145	0	0	0	0	0	0
12. Program Specialist for ICFs-MR	6150	0	0	0	0	0	0
13. Program Director	6155	0	0	0	0	0	0
14. Habilitation Supervisor for NFs	6160	113,500	0	113,500	5,851	0	5,851
15. Habilitation Supervisor for ICFs-MR	6165	0	0	0	0	0	0
16. Habilitation Staff	6170	0	0	0	0	0	0
17. Psychologist	6175	0	0	0	0	0	0
18. Psychology Assistant	6180	0	0	0	0	0	0
19. Respiratory Therapist	6185	0	0	0	0	0	0
20. Social Work/Counseling	6190	0	0	0	0	0	0
21. Social Services/Pastoral Care	6195	69,699	0	69,699	3,380	0	3,380
22. Qualified Mental Retardation Professional	6200	0	0	0	0	0	0
23. Quality Assurance	6205	20,954	0	20,954	921	0	921
24. Other Direct Care (salary)	6220	0	0	0	0	0	0
25. Home Office Costs/Direct Care (salary)	6230	0	0	0	0	0	0
26. TOTAL Nursing and Habilitation/ (sum of lines 2 through 25)		2,119,729	0	2,119,729	159,588	0	159,588
27. TOTAL Page 1 (sum of lines 1d and 26)		2,119,729	0	2,119,729	159,588	0	159,588

WAGE AND HOURS SURVEY

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through 12/31/2002
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WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owner Wages Paid (D)	Total Non-Owner Wages Paid (E)	Total Hours Paid (F)	Owner Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>NURSING FACILITIES ONLY</b>							
<b>NURSE AIDE TRAINING</b>							
28. In-House Trainer Wages	6400	5,086	0	5,086	286	0	286
29. Classroom Wages: Nurse Aides	6410	0	0	0	0	0	0
30. Clinical Wages: Nurse Aides	6420	0	0	0	0	0	0
<b>31. TOTAL Nurse Aide Training - NFs</b> (sum of lines 28 through 30)		5,086	0	5,086	286	0	286
<b>ICF's-MR FACILITIES ONLY</b>							
<b>DIRECT CARE THERAPIES</b>							
32. Physical Therapist ICF-MR	6600	0	0	0	0	0	0
33. Physical Therapy Assistant ICF-MR	6605	0	0	0	0	0	0
34. Occupational Therapist ICF-MR	6610	0	0	0	0	0	0
35. Occupational Therapy Assistant ICF-MR	6615	0	0	0	0	0	0
36. Speech Therapist ICF-MR	6620	0	0	0	0	0	0
37. Audiologist ICF-MR	6630	0	0	0	0	0	0
<b>38. TOTAL Direct Care Therapies ICF-MR</b> (sum of lines 32 through 37)		0	0	0	0	0	0
<b>NFs and ICFs-MR</b>							
<b>PAYROLL TAX, FRINGE BEN., &amp; STAFF DEVELOPMENT (No Purchased Nursing)</b>							
39. EAP Administrator - Direct Care	6535	0	0	0	0	0	0
40. Self Funded Programs Admin. - Direct Care	6540	0	0	0	0	0	0
41. Staff Development - Direct Care	6550	0	0	0	0	0	0
<b>42. TOTAL Fringe Benefits and Staff</b> (sum of lines 39 through 41)		0	0	0	0	0	0
<b>DIETARY COST</b>							
43. Dietitian	7000	0	0	0	0	0	0
44. Food Service Supervisor	7005	31,273	0	31,273	2,081	0	2,081
45. Dietary Personnel	7015	289,796	0	289,796	30,666	0	30,666
46. EAP Administrator - Dietary	7075	0	0	0	0	0	0
47. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	0
48. Staff Development - Dietary	7090	0	0	0	0	0	0
<b>49. TOTAL Dietary Cost</b> (sum of lines 43 through 48)		321,069	0	321,069	32,747	0	32,747
<b>HABILITATION and PHARMACEUTICAL</b>							
50. Medical/Habilitation Records	7105	36,835	0	36,835	3,511	0	3,511
51. Pharmaceutical Consultant	7110	0	0	0	0	0	0
<b>52. TOTAL Habilitation, Pharmaceutical</b> (sum of lines 50 and 51)		36,835	0	36,835	3,511	0	3,511
<b>53. TOTAL Pages 2</b> (sum of lines 31, 38, 42, 49, and 52)		362,990	0	362,990	36,544	0	36,544

## WAGE AND HOURS SURVEY

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 1/1/2002	Through 12/31/2002
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WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owner Wages Paid (D)	Total Non-Owner Wages Paid (E)	Total Hours Paid (F)	Owner Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>							
54. Administrator	7200	65,737	0	65,737	1,795	0	1,795
55. Other Administrative Personnel	7210	63,572	0	63,572	4,671	0	4,671
56. Security Services (salary only)	7230	0	0	0	0	0	0
57. Laundry/Housekeeping Supervisor	7240	26,567	0	26,567	2,005	0	2,005
58. Housekeeping	7245	184,727	0	184,727	18,182	0	18,182
59. Laundry and Linen	7250	80,852	0	80,852	7,737	0	7,737
60. Accounting	7265	0	0	0	0	0	0
61. Data Services (salary only)	7285	0	0	0	0	0	0
62. Other Indirect Care (salary)	7305	0	0	0	0	0	0
63. Home Office Costs/Indirect Care (salary)	7310	0	0	0	0	0	0
<b>64. TOTAL Administrative and General Services</b> (sum of lines 54 through 63)		421,455	0	421,455	34,390	0	34,390
<b>MAINTENANCE AND MINOR EQUIPMENT</b>							
65. Plant Operations/Maintenance Supervisor	7320	40,386	0	40,386	2,081	0	2,081
66. Plant Operations and Maintenance	7330	50,217	0	50,217	4,424	0	4,424
<b>67. TOTAL Maintenance and Minor Equipment</b> (sum of lines 65 and 66)		90,603	0	90,603	6,505	0	6,505
<b>PAYROLL TAXES, FRINGE BENEFITS &amp; STAFF DEVELOPMENT</b>							
68. EAP Administrator - Indirect Care	7525	0	0	0	0	0	0
69. Self Funded Prog. Admin. - Indirect Care	7530	0	0	0	0	0	0
70. Staff Development - Indirect Care	7535	0	0	0	0	0	0
<b>71. TOTAL Payroll Taxes, Fringe Benefits, &amp;</b> (sum of lines 68 through 70)		0	0	0	0	0	0
<b>72. TOTAL Page 3</b> (sum of lines 64, 67 and 71)		512,058	0	512,058	40,895	0	40,895
<b>73. TOTAL Attachment 6</b> Pages 1, 2, and 3 (sum of lines 27, 53 and 72)		2,994,777	0	2,994,777	237,027	0	237,027

ADDENDUM FOR DISPUTED COSTS

Provider Name FAIRLAWN HAVEN	Medicaid Provider Number 0010302	Reporting Period From: 01/01/2002 Through: 12/31/2002
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INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code, section 5111.26, that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From:" columns, the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To:" columns, the schedule, line number, and reason you believe these costs should be reclassified.

Reclassification From:					Reclassification To:		
CURRENT COST CENTERS	Chart of Acct.	Salary Facility Employed (1)	Other/Contract Wages (2)	Adjusted/Allocated Total (3)	Schedule (4)	Line (5)	Reason (6)
<b>OTHER PROTECTED COSTS</b>							
1.		0	0	0			
2.		0	0	0			
3.		0	0	0			
4.		0	0	0			
5. TOTAL Other Protected Costs (sum of lines 1 through 4)		0	0	0			
<b>DIRECT CARE COST CENTER</b>							
6.		0	0	0			
7.		0	0	0			
8.		0	0	0			
9.		0	0	0			
10. TOTAL Direct Care Costs (sum of lines 6 through 9)		0	0	0			
<b>INDIRECT CARE COST CENTER</b>							
11.		0	0	0			
12.		0	0	0			
13.		0	0	0			
14.		0	0	0			
15. TOTAL Indirect Care Costs (sum of lines 11 through 14)		0	0	0			
<b>NON-REIMBURSABLE EXPENSES</b>							
16.		0	0	0			
17.		0	0	0			
18.		0	0	0			
19.		0	0	0			
20. TOTAL Non-Reimbursable Expenses (sum of lines 16 through 19)		0	0	0			
<b>CAPITAL COST CENTER</b>							
21.		0	0	0			
22.		0	0	0			
23.		0	0	0			
24.		0	0	0			
25. TOTAL Capital Cost (sum of lines 21 through 24)		0	0	0			
26. TOTAL COST CENTERS (sum of lines 5, 10, 15, 20, and 25)		0	0	0			