

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0024992

Facility Name: FAIRVIEW NURSING CENTER

Address: 602 EAST JACKSON DUQUOIN 62832
Number City Zip Code

County: PERRY

Telephone Number: 618-542-3441 Fax # 618-542-6351

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY Telephone Number: (618) 549-8331
JAMESTOWN MANAGEMENT Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number FAIRVIEW NURSING CENTER# 0024992 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	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>20</u>	Skilled (SNF)	<u>20</u>	<u>7,320</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>56</u>	Intermediate (ICF)	<u>56</u>	<u>20,496</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,816</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,002</u>	<u>1,152</u>	<u>2,315</u>	<u>4,469</u>	8
9	SNF/PED					9
10	ICF	<u>8,648</u>	<u>3,866</u>		<u>12,514</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,650</u>	<u>5,018</u>	<u>2,315</u>	<u>16,983</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.05%

D. How many bed-hold days during this year were paid by the Department?

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

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 11/10/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 20 and days of care provided 2,315Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2011

Fiscal Year: _____

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

	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	109,997	5,599	6,018	121,614		121,614		121,614		1
2	Food Purchase		77,547		77,547	5,445	82,992	(245)	82,747		2
3	Housekeeping	60,380	9,920		70,300	424	70,724		70,724		3
4	Laundry	48,162	4,406		52,568		52,568		52,568		4
5	Heat and Other Utilities			53,964	53,964	625	54,589		54,589		5
6	Maintenance	28,723	12,344	41,046	82,113		82,113		82,113		6
7	Other (specify):*										7
8	TOTAL General Services	247,262	109,816	101,028	458,106	6,494	464,600	(245)	464,355		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	671,598	22,554	48,887	743,039	(2,677)	740,362		740,362		10
10a	Therapy										10a
11	Activities	36,345	2,655	1,495	40,495	(1,828)	38,667		38,667		11
12	Social Services	22,324		1,495	23,819		23,819		23,819		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	730,267	25,209	53,077	808,553	(4,505)	804,048		804,048		16
	C. General Administration										
17	Administrative	53,042		8,001	61,043	33,111	94,154		94,154		17
18	Directors Fees										18
19	Professional Services			169,565	169,565	(82,757)	86,808	(85,589)	1,219		19
20	Dues, Fees, Subscriptions & Promotions			11,076	11,076	169	11,245	(6,422)	4,823		20
21	Clerical & General Office Expenses	27,757	7,030	7,802	42,589	23,182	65,771	(1,027)	64,744		21
22	Employee Benefits & Payroll Taxes			144,924	144,924	9,834	154,758		154,758		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,832	3,832	215	4,047		4,047		24
25	Other Admin. Staff Transportation					2,023	2,023		2,023		25
26	Insurance-Prop.Liab.Malpractice			46,053	46,053	2,009	48,062		48,062		26
27	Other (specify):*										27
28	TOTAL General Administration	80,799	7,030	391,253	479,082	(12,214)	466,868	(93,038)	373,830		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,058,328	142,055	545,358	1,745,741	(10,225)	1,735,516	(93,283)	1,642,233		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			28,563	28,563	3,749	32,312	8,145	40,457			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			19,707	19,707	1,425	21,132		21,132			33
34	Rent-Facility & Grounds			44,214	44,214	5,051	49,265	(44,214)	5,051			34
35	Rent-Equipment & Vehicles			1,405	1,405		1,405		1,405			35
36	Other (specify):*											36
37	TOTAL Ownership			93,889	93,889	10,225	104,114	(36,069)	68,045			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,075	192,151	264,226		264,226		264,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,060	130,060		130,060		130,060			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		72,075	322,211	394,286		394,286		394,286			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,058,328	214,130	961,458	2,233,916		2,233,916	(129,352)	2,104,564			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,766)	30		9
10	Interest and Other Investment Income	(694)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(327)	21		18
19	Entertainment				19
20	Contributions	(700)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,168)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,254)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,154)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(119,198)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (119,198)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (129,352)		37

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

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

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

STATE OF ILLINOIS
FAIRVIEW NURSING CENTER

Report Period Beginning: ID# 0024992
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(245)	0	0	0	0	0	0	0	0	0	0	(245)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(245)	0	0	0	0	0	0	0	0	0	0	(245)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(85,589)	0	0	0	0	0	0	0	0	0	(85,589)	19
20	Fees, Subscriptions & Promotions	(6,422)	0	0	0	0	0	0	0	0	0	0	(6,422)	20
21	Clerical & General Office Expenses	(1,027)	0	0	0	0	0	0	0	0	0	0	(1,027)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,449)	(85,589)	0	0	0	0	0	0	0	0	0	(93,038)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(7,694)	(85,589)	0	0	0	0	0	0	0	0	0	(93,283)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,766)	9,911	0	0	0	0	0	0	0	0	0	8,145	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(694)	694	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(44,214)	0	0	0	0	0	0	0	0	0	(44,214)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,460)	(33,609)	0	0	0	0	0	0	0	0	0	(36,069)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(10,154)	(119,198)	0	0	0	0	0	0	0	0	0	(129,352)	45

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
LUCINDA BAIN	46.97	FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	Carbondale	Management
COLETTA SUE MCCLARY	46.97	CANTERBURY MANOR NURSING HOME	WATERLOO	Fairview Residential	DuQuoin	Owns Building
KRISTIN MCCLARY POWERS	1.01			Land Trust		
JAMES DAVID MCCLARY	1.01					
SARAH J. GLITZER	1.01					
MARCIA MCCLARY KELL	1.01					
DAVID BRENT BAIN	1.01					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	\$ 168,578	JAMESTOWN MANAGEMENT CORPORATION	100.00%	\$ 82,989	\$ (85,589)	1
2	V	30	DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%	9,911	9,911	2
3	V	34	RENT	44,214	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%		(44,214)	3
4	V	32	INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%	694	694	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			\$ 212,792			\$ 93,594	\$ * (119,198)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SUSAN BETH HELSLEY	1.01						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

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT.***								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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

X

NO

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

Name of Related Organization

Jamestown Management Corp

Street Address

1001 East Main Bldg 4a

City / State / Zip Code

Carbondale, IL 62901

Phone Number

(618) 549-8331

Fax Number

(618) 549-0133

	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	3	HOUSEKEEPING	HOURS OF SERVICE	13,531		\$ 7,128	\$	2,589	\$ 1,364	1
2	5	UTILITIES	HOURS OF SERVICE	13,531		3,269		2,589	625	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,320		173,045	173,045	1,592	33,111	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,531		1,213		2,589	232	4
5	20	LICENSE & DUES	HOURS OF SERVICE	13,531		883		2,589	169	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,211		106,884	106,884	997	20,450	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	13,531		14,280		2,589	2,732	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	13,531		51,397		2,589	9,834	8
9	24	SEMINARS	HOURS OF SERVICE	8,320		1,124		1,592	215	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320		10,575		1,592	2,023	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,531		10,501		2,589	2,009	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,531		19,596		2,589	3,749	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,531		7,447		2,589	1,425	13
14	34	RENT	HOURS OF SERVICE	13,531		26,400		2,589	5,051	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 433,742	\$ 279,929		\$ 82,989	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	FAIRVIEW NURSING CENTE	X		FINANCE CONSTRUCTION	\$3,922.00	3/1/07	\$ 220,000	\$	09/01/2012	0.0600	\$ 694	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,922.00		\$ 220,000	\$			\$ 694	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 220,000	\$			\$ 694	15	

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.	\$	18,500		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	18,707		2
3. Under or (over) accrual (line 2 minus line 1).	\$	207		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	19,500		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	19,707		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007	14,904	8	
	2008	15,731	9	
	2009	16,796	10	
	2010	18,006	11	
	2011	18,707	12	
Line 7 does not include the Jamestown allocation from page 8 SCH VIII \$1425.				
Real estate taxes on page 4 line 33 should reconcile to line 7 \$19707 + Jamestown allocation of \$1425 = \$21132.				

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
FAIRVIEW NURSING CENTER

COUNTY
PERRY

FACILITY IDPH LICENSE NUMBER
0024992

CONTACT PERSON REGARDING THIS REPORT
ROGER W. BAGLEY

TELEPHONE
(618) 549-8331
FAX #:
(618) 549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	1-61-0270-100	SEC 17 TWP 06 RNG 01 S SW SW	\$ 18,707.00	\$ 18,707.00
2.		NE E 215'0	\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 18,707.00	\$ 18,707.00

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 X NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

A. Square Feet: 14,640

B. General Construction Type: Exterior BRICK

Frame WOOD & CONCRET

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING	76,320	1968	\$ 3,996	1
2					2
3	TOTALS	76,320		\$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1968	1968	\$ 94,863	\$	40	\$	\$	94,863	4
5			1968	1968	61,381		20			61,381	5
6			1970	1970	3,953		20			3,953	6
7	18		1970	1970	26,047		38			26,047	7
8	16		1976	1976	177,922		30			177,922	8
	Improvement Type**										
9	FIRE ALARM			1981	1,190		10			1,190	9
10	SEWER LINE			1982	1,056		10			1,056	10
11	PLUMBING IMPROVEMENTS			1984	1,193		10			1,193	11
12	ROOF & LANDSCAPING			1984	1,488		10			1,488	12
13	ACIVITY ROOM			1986	15,306		20			15,306	13
14	ACIVITY ROOM			1987	5,223		20			5,223	14
15	ROOF & LANDSCAPING			1987	9,775		10			9,775	15
16	PARKING LOT			1987	18,960		15			18,960	16
17	SECURITY SYSTEM			1988	2,583		15			2,583	17
18	RENOVATIONS			1989	2,723		15			2,723	18
19	HOT WATER HEATER			1990	4,128		15			4,128	19
20	6 WALL A/C UNITS			1990	7,205		8			7,205	20
21	LANDSCAPING			1990	495		10			495	21
22	SHOWERS/CUBICLE TRACKS			1990	8,459	119	15		(119)	8,459	22
23	ROOF & LANDSCAPING			1990	13,831	439	25	553	114	12,443	23
24	TELEPHONE			1991	3,274		20			3,274	24
25	WATER HEATER			1991	1,945		15			1,945	25
26	EMERGENCY LIGHTS			1992	960		15			960	26
27	SEAL & STRIPE PARKING LOT			1994	1,421		5			1,421	27
28	EMERGENCY LIGHTS			1995	994		15			994	28
29	HOT WATER HEATER			1995	7,433		15			7,433	29
30	SUBPANELS & CIRCUITS INSTALLED TO A/C			1996	2,394		10			2,394	30
31	PT A/C UNIT			1996	1,163		10			1,163	31
32	A/C UNIT			1996	1,071		10			1,075	32
33	INSTALLED SERVICE CABLE			1997	7,666	128	15	256	128	7,666	33
34	A/C UNITS			1998	698		10			698	34
35	HOT WATER HEATER			1998	2,985		15	199	199	2,886	35
36	OVERBED LIGHTING			1998	8,932		15	595		8,628	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CARPET	1998	\$ 588	\$	5	\$	\$	\$ 588	37
38	INSTALL BASEBOARD HEATING	1998	3,599		15	240	240	3,480	38
39	CABINETS & COUNTERTOPS	1998	708		5			708	39
40	WALLPAPER & INSTALLATION	1998	9,457		5			9,457	40
41	PAINTING	1998	11,779		5			11,779	41
42	Trim, pictures, mirrors, permanent decorative fixtures	1998	2,007		5			2,007	42
43	FLOOR COVE BASE	1998	901		5			901	43
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	3,524	44
45	BUILDING ADDITION	1998	239,137		15	15,942	15,942	215,217	45
46	PARKING LOT	1998	13,916		15	928	928	13,456	46
47	FLOORING - ADJUSTMENT TO 1998 BUILDING ADDITION	1999	737		5			737	47
48	DOOR ALARM SYSTEM	1999	6,691		10			6,691	48
49	WALLPAPER & PAINTING	1999	8,314		5			8,314	49
50	INSTALL BOOKCASE IN ADMIN OFFICE	1999	333		10			333	50
51	LANDSCAPING	1999	5,931		10			5,931	51
52	SEAL COATED AND STRIPED PARKING LOT	1999	1,646		8			1,646	52
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777		5			777	53
54	MOVE PHONE LINES	1999	328		5			328	54
55	ENTANCE SIGN	1999	1,000		5			1,000	55
56	PAINT WINDOW GRIDS	1999	175		5			175	56
57	INSTALLATION OF FLOORING	1999	8,949		10			8,949	57
58	FOUNTAIN & LIGHT	1999	1,774		5			1,774	58
59	Balance of trim, mirrors, permanent decorative fixtures to refurbish the building	1999	3,952		5			3,952	59
60									60
61	AWINIGS	1999	420		5			420	61
62	Labor & materials to remove existing wall & rebuild new wall relocate plumbing & electrical services, install cabinetry, & countertops and installed new flooring. Labor & materials to gut an existing bathroom and rehab room to create 2 new bathrooms and storage area for housekeeping and deatary (to be complete in 2000). Labor & materials to install new cabinets, relocated plumbing & electrical, repair drywall & paint the breakroom.	1999	8,559		10			8,559	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 810		\$ 18,974	\$ 17,569	\$ 807,633	70

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

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 834,312	\$ 810		\$ 18,974	\$ 18,164	\$ 807,633	1
2	Labor & materials to complete 1999 bathroom project	2000	20,296		10			20,296	2
3	Installed ceramic tile, sinks, toilet stool, showers, and								3
4	lighting fixtures.								4
5	Labor & materials to remove esisting wall in order to convert	2000	11,212		10			11,212	5
6	storage room into a resident room. Removed existing								6
7	closets, installed shower area, relocated doors, electrical,								7
8	& plumbing services, repaired & painted drywall &								8
9	relocated call lights								9
10	Excavate & replace driveway asphalt & fill in cracks with tar	2001	3,075	205	15	205		2,358	10
11	Reinforce & raise sinking floor on B wing	2001	7,380	492	15	492		5,658	11
12	Gut beauty shop area & construct a new handicapped	2001	16,165	1,078	15	1,078		12,397	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet,								13
14	sink, door, spinkler heads, cubicle tracks, & curtains &								14
15	cove base.								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete &	2001	2,800	187	15	187		2,150	16
17	replaced deteriorated sewer line, install new line, & new								17
18	clean out & pour now floor.								18
19	Relocate beauty shop to PT area. Installed lines, clean out &	2001	1,223	82	15	82		943	19
20	shut off valves, drill & knock out outside brick wall, install								20
21	fan, finish drywall, paint, install tile on drywall, install								21
22	sink & shelves								22
23	Convert existing bathroom to handicapped bathroom.	2001	7,124	475	15	475		5,462	23
24	Remove tile, install box for call lights, tear out &								24
25	reconstruct showers, tile wall & showers, install handrails								25
26	in tub & showers, hang tracks & curtains, put new lever								26
27	hand door lever.								27
28	Add fan to isolation room for Medicare compliance.	2001	386	26	15	26		299	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	23	15	23		264	29
30	Upgrade emergency lighting & moved annunciator panel	2001	15,138		10			15,138	30
31	& smoke detector								31
32	Upgraded nurses call station	2001	645		10			645	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 920,094	\$ 3,378		\$ 21,542	\$ 18,164	\$ 884,455	34

**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 12B, Carried Forward		\$ 920,094	\$ 3,378		\$ 21,542	\$ 18,164	\$ 884,455	1
2	Install grease trap & wet well	2002	13,224	665	10	665		13,224	2
3	Replaced rusted out main line in B hallway &	2002	3,494	178	10	178		3,494	3
4	reinstalled drain to connect to mainline in B hall bath								4
5	Removed old flooring & replaced with ceramic tile in	2002	1,706	82	10	82		1,706	5
6	A hall bathroom								6
7	Repair roof over front dining room & activity room	2002	8,230	411	10	411		8,230	7
8	LANDSCAPING OF COURTYARD	2004	1,109	111	10	111		943	8
9	Remove, repair, & install tile flooring in dining room	2005	7,222	722	10	722		5,415	9
10	Replace tile in hall, TV room & small hallway	2008	3,310		10	331	331	1,490	10
11	Replace roof over kithcen & dining room & repairs to	2009	7,615	1,087	10	762	(325)	2,667	11
12	A & B halls								12
13	5'x6' entrance sign	2009	1,599		5	320	320	1,120	13
14	Repair flat roof area on back of building	2010	5,980	399	15	399		997	14
15	Demo & install ductwork on back of building	2010	3,792	253	15	253		632	15
16	Installed fire rated carpet on walls	2011	6,126		5	1,225	1,225	1,837	16
17	Seal & stripe parking lot	2011	1,380		5	276	276	414	17
18	Install 400 amp breaker box & new disconnect	2011	4,395		20	220	220	330	18
19	Replace 139 sprinkler heads	2012	17,509	9,047	15	584	(8,463)	584	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,006,785	\$ 16,333		\$ 28,081	\$ 11,748	\$ 927,538	34

**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	\$ 74,720	\$	\$ 7,959	\$ 7,959	various	\$ 40,575	71
72	Current Year Purchases	12,230	12,230	668	(11,562)	various	668	72
73	Fully Depreciated Assets	273,095					273,095	73
74								74
75	TOTALS	\$ 360,045	\$ 12,230	\$ 8,627	\$ (3,603)		\$ 314,338	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	JAMESTOWN ALLOCATION			\$	\$ 3,749	\$ 3,749	\$		\$ 33,698	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 3,749	\$ 3,749	\$		\$ 33,698	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)	\$ 1,370,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,312	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,457	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,275,574	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:
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.

YESNO

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

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy: YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$1,405

Description: STORAGE 187; DISHMACHINE 788; WOUND VAC 405; ICE MACHINE 25

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

WE ONLY HIRE TRAINED AIDs.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(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.

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	36/3;39/2	hrs	\$	1,236	\$ 64,927	\$ 155	1,236	\$ 65,082	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		107	10,565	33	107	10,598	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		1,698	98,866	267	1,698	99,133	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				63,803		63,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med sup, tube feed, oxygen Other (specify): lab, xray, other	39/2 39/3				17,793	7,817		25,610	13
14	TOTAL			\$	3,041	\$ 192,151	\$ 72,075	3,041	\$ 264,226	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 104,361	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,230,046		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	38,820		5
6	Prepaid Insurance	679		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INVESTMENT	6,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,379,906	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	212,078		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	476,109		16
17	Accumulated Depreciation (book methods)	(648,841)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 39,346	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,419,252	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,857	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,616		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,677		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	6,412		36
37	ACCRUED LICENSE BED TAX	45,610		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 166,672	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 166,672	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,252,580	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,419,252	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,142,726	1
2	Restatements (describe):		2
3	2011 IL REPLACEMENT TAX	(1,038)	3
4	ADJ 2011 DPA RATE INC 5/11 -12/11	47,844	4
5	ADJ 2011 ADDITIONAL OCCUPIED BED TAX 7/11-12/11	(47,667)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,141,865	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,717	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) EXCESS SALARIES ELIMINATED	(16,002)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 110,715	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,252,580	24 *

* This must agree with page 17, line 47.

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,865,127	1
2	Discounts and Allowances for all Levels	112,033	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,977,160	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,540	6
7	Oxygen	50	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 362,590	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,665	19
20	Radiology and X-Ray	786	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,451	23
	D. Non-Operating Revenue		
24	Contributions	1,390	24
25	Interest and Other Investment Income***	3,042	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,432	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,360,633	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	458,106	31
32	Health Care	808,553	32
33	General Administration	479,082	33
	B. Capital Expense		
34	Ownership	93,889	34
	C. Ancillary Expense		
35	Special Cost Centers	264,226	35
36	Provider Participation Fee	130,060	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,233,916	40
41	Income before Income Taxes (line 30 minus line 40)**	126,717	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 126,717	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 939,388	44
45	Private Pay - Net Inpatient Revenue	607,957	45
46	Medicare - Net Inpatient Revenue	442,458	46
47	Other-(specify)	(13,222)	47
48	Other-(specify)	579	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,977,160	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. IL Replacement Tax
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,900	2,080	\$ 49,025	\$ 23.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,199	7,465	153,248	20.53	3
4	Licensed Practical Nurses	6,392	6,973	114,099	16.36	4
5	CNAs & Orderlies	32,967	35,202	355,226	10.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,637	2,811	36,345	12.93	9
10	Activity Assistants					10
11	Social Service Workers	1,737	1,952	22,324	11.44	11
12	Dietician					12
13	Food Service Supervisor	2,121	2,289	30,238	13.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,430	8,980	79,759	8.88	15
16	Dishwashers					16
17	Maintenance Workers	1,831	1,947	28,723	14.75	17
18	Housekeepers	5,717	6,050	60,380	9.98	18
19	Laundry	3,530	3,970	48,162	12.13	19
20	Administrator	1,792	2,080	53,042	25.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,908	2,080	27,757	13.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,161	83,879	\$ 1,058,328 *	\$ 12.62	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	99	\$ 6,018	1/3	35
36	Medical Director		1,200	9/3	36
37	Medical Records Consultant		100	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,680	10/3	39
40	Physical Therapy Consultant	1	46	10/3	40
41	Occupational Therapy Consultant	2	90	10/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,495	11/3	44
45	Social Service Consultant	22	1,495	12/3	45
46	Other(specify)				46
47	UTILIZATION REVIEW		1,200	10/3	47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 13,324		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13	\$ 630	10/3	50
51	Licensed Practical Nurses	1,291	43,579	10/3	51
52	Certified Nurse Assistants/Aides	75	1,562	10/3	52
53	TOTAL (lines 50 - 52)	1,379	\$ 45,771		53

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	
JENI ALLEN	ADMINISTRATOR	0	\$ 53,042	Workers' Compensation Insurance		\$ 30,564	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance		12,356	Advertising: Employee Recruitment	726	
				FICA Taxes		80,962	Health Care Worker Background Check		
				Employee Health Insurance		4,834	(Indicate # of checks performed 18)	216	
				Employee Meals			Patient Background Checks	51 612	
				Illinois Municipal Retirement Fund (IMRF)*			SUBSCRIPTIONS 265; INHAA 100	365	
				VACCINES		514	OTHER ADVERTISING	6,422	
				401K EXPENSE		10,023	CLIA	150	
				STAFF PARTIES, ATTENDANCE, AWARDS		5,671	CORP FEES	593	
				JAMESTOWN ALLOCATION		9,834	JAMESTOWN ALLOCATION	169	
							Less: Public Relations Expense	(5,168)	
							Non-allowable advertising	()	
							Yellow page advertising	(1,254)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 53,042	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,823
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	
BONUS TO MANAGEMENT COMPANY EMPLOYEES			\$ 8,001			\$	Out-of-State Travel	\$	
							In-State Travel	705	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	3,127	
C. Professional Services							JAMESTOWN ALLOCATION		
Vendor/Payee	Type		Amount				215		
JAMESTOWN MGMT CORP	MANAGEMENT		\$ 168,578						
BARNETT & LEVINE	ACCOUNTING		850				Entertainment Expense ()		
INNOVATIVE SOLUTIONS	BILLING		137				(agree to Sch. V, line 24, col. 8)		
							TOTAL		
							\$ 4,047		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
			\$ 169,565						

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2005	\$ 3,498		\$ 1,166	\$ 583	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,498		\$ 1,166	\$ 583	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 9 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,060
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? N/A
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A 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? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- 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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRVIEW NURSING CENTER INC

RECLASSIFICATION ON DPA COST REPORT

12/31/2012

PAGES 3 & 4 COLUMN 5

#0024992

LINE	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASE	3617	
10	NURSING & MEDICAL RECORDS		3617
	RECLASSIFY FOOD SUPPLEMENTS		
2	FOOD PURCHASES	1828	
11	NURSING & MEDICAL RECORDS		1828
	RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPT		
10	NURSING & MEDICAL RECORDS	940	
3	HOUSEKEEPING		940
	RECLASSIFY SOAP & SHAMPOO		
VARIOUS	VARIOUS LINE ITEMS	82989	
19	PROFESSIONAL SERVICES		82989
	RECLASSIFY SCHEDULE VIII FOR BREAKDWON		