

		FOR BHF USE					

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

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 Du Quoin 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: Larry Templin Telephone Number: (630) 361-2868
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 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
	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	20	Skilled (SNF)	20	7,320	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	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			1,438	1,438	8
9	SNF/PED					9
10	ICF	10,928	5,627		16,555	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,928	5,627	1,438	17,993	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.69%

SEE ACCOUNTANTS' PREPARATION REPORT

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? Yes

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

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

I. On what date did you start providing long term care at this location? Date started 11/10/1970

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

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 20 and days of care provided 1,340

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	118,678	6,057	5,675	130,410		130,410	4,133	134,543			1
2	Food Purchase		85,611		85,611		85,611		85,611			2
3	Housekeeping	61,126	12,095		73,221		73,221	3,026	76,247			3
4	Laundry	41,414	7,086		48,500		48,500		48,500			4
5	Heat and Other Utilities			63,158	63,158		63,158	1,186	64,344			5
6	Maintenance	43,524	27,621	49,767	120,912		120,912		120,912			6
7	Other (specify):* Waste Rem/Alloc Em			1,889	1,889		1,889	354	2,243			7
8	TOTAL General Services	264,742	138,470	120,489	523,701		523,701	8,699	532,400			8
	B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600			9
10	Nursing and Medical Records	741,088	30,112	111,403	882,603		882,603		882,603			10
10a	Therapy											10a
11	Activities	47,106	3,740	2,042	52,888		52,888	(1,805)	51,083			11
12	Social Services	25,351		1,457	26,808		26,808		26,808			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	813,545	33,852	117,502	964,899		964,899	(1,805)	963,094			16
	C. General Administration											
17	Administrative	65,325		182,527	247,852		247,852	(152,666)	95,186			17
18	Directors Fees											18
19	Professional Services			1,612	1,612		1,612	9,694	11,306			19
20	Dues, Fees, Subscriptions & Promotions			6,419	6,419		6,419	316	6,735			20
21	Clerical & General Office Expenses	24,188	8,755	10,921	43,864		43,864	120,750	164,614			21
22	Employee Benefits & Payroll Taxes			140,775	140,775		140,775		140,775			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,157	1,157		1,157		1,157			24
25	Other Admin. Staff Transportation			1,501	1,501		1,501	1,567	3,068			25
26	Insurance-Prop.Liab.Malpractice			51,555	51,555		51,555	4,931	56,486			26
27	Other (specify):* Alloc. Emp Ben.							13,370	13,370			27
28	TOTAL General Administration	89,513	8,755	396,467	494,735		494,735	(2,038)	492,697			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,167,800	181,077	634,458	1,983,335		1,983,335	4,856	1,988,191			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			29,437	29,437		29,437	(3,538)	25,899			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			19,160	19,160		19,160	6,941	26,101			33
34	Rent-Facility & Grounds			12,840	12,840		12,840	2,239	15,079			34
35	Rent-Equipment & Vehicles			2,637	2,637		2,637		2,637			35
36	Other (specify):*											36
37	TOTAL Ownership			64,074	64,074		64,074	5,642	69,716			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,325	154,687	202,012		202,012		202,012			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,834	147,834		147,834		147,834			42
43	Other (specify):* See Att Sch 4A			25,022	25,022		25,022	(11,987)	13,035			43
44	TOTAL Special Cost Centers		47,325	327,543	374,868		374,868	(11,987)	362,881			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,167,800	228,402	1,026,075	2,422,277		2,422,277	(1,489)	2,420,788			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Fairview Nursing Center

Period Beginning 1/1/16
Period End 12/31/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			10,867	10,867		10,867		10,867			
	Radiology Expenses			2,168	2,168		2,168		2,168			
	Non-Allowable Expenses			11,987	11,987		11,987	(11,987)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	25,022	25,022	0	25,022	(11,987)	13,035			

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(5,193)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(324)	43		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	(1,944)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,389)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,949)	43		28
29	Other-Attach Schedule See Page 5A	(3,627)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,426)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,937		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,937		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,489)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,441)	21	1
2	Resident Funeral Flowers	(381)	43	2
3	Offset Activity Income Against Expense	(1,805)	11	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	(3,627)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 12,840	Fairview Residential Center Land Trust	39.70%	\$	\$ (12,840)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 12,840			\$	\$ * (12,840)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Jamestown Management Company	100.00%	\$ 4,133	\$ 4,133	15
16	V	3	Housekeeping		Jamestown Management Company	100.00%	3,026	3,026	16
17	V	5	Utilities		Jamestown Management Company	100.00%	1,186	1,186	17
18	V	7	Emp Ben-Gen Serv Alloc		Jamestown Management Company	100.00%	354	354	18
19	V	17	Administrative	182,527	Jamestown Management Company	100.00%	29,861	(152,666)	19
20	V	19	Professional Services		Jamestown Management Company	100.00%	9,694	9,694	20
21	V	20	Licenses & Dues		Jamestown Management Company	100.00%	316	316	21
22	V	21	Clerical & Office Wages		Jamestown Management Company	100.00%	17,551	17,551	22
23	V	21	Clerical & Office Wages		Jamestown Management Company	100.00%	99,183	99,183	23
24	V	21	Clerical & Office Expense		Jamestown Management Company	100.00%	5,457	5,457	24
25	V	25	Auto Expense		Jamestown Management Company	100.00%	1,567	1,567	25
26	V	26	General Insurance		Jamestown Management Company	100.00%	4,931	4,931	26
27	V	27	Emp Ben-G&A Alloc		Jamestown Management Company	100.00%	13,370	13,370	27
28	V	30	Depreciation		Jamestown Management Company	100.00%	1,655	1,655	28
29	V	33	Real Estate Taxes		Jamestown Management Company	100.00%	6,941	6,941	29
30	V	34	Rent		Jamestown Management Company	100.00%	15,079	15,079	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 182,527			\$ 214,304	\$ * 31,777	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL 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	Lucinda Bain	46.97			Jamestown Mgmt	Carbondale, IL	Mgmt Co.	1
2	Coletta McClary	46.97			Fairview Residential	DuQuoin, IL	Land Trust	2
3	Kristin McClary Powers	1.01			Land Trust			3
4	James David McClary	1.01						4
5	Sara Glitzer	1.01						5
6	Marcia McClary Kell	1.01						6
7	David Brent Bain	1.01						7
8	Susan Beth Helsley	1.01						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kristin McClary Powers	Managing Partner	Administrative	1.01	See Sch 7A	16.57	41.44	Salary	\$ 29,861	L17, C7	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	\$ 29,861		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Fairview Nursing Center

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 7A
VII Related Parties - Page 7, Section C
Summary of Owner's Compensation Allocated by Facility

	Allocation Units	Allocated Salary	Allocated Hours/Week	% of Hours/Week
<u>Kristin McClary Powers</u>				
	440,612	72,083	40.00	100.00%
Fairview	182,527	29,861	16.57	41.43%
Freeburg	185,466	30,342	16.84	42.09%
Fair Acres	3,000	491	0.27	0.68%
Pope County	1,465	240	0.13	0.33%
New Athens	68,154	11,150	6.19	15.47%
	440,612	72,083	40.00	100.00%

Note: The only facility related to Jamestown Management is Fairview Nursing Center

Facility Name & ID Number Fairview Nursing Center# 0024992

Report Period Beginning:

1/1/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

Jamestown Management Corporation

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Management Fee Rev.	440,612	5	\$ 9,975	\$ 9,375	182,527	\$ 4,133	1
2	3	Housekeeping	Management Fee Rev.	440,612	5	7,304		182,527	3,026	2
3	5	Utilities	Management Fee Rev.	440,612	5	2,862		182,527	1,186	3
4	7	Emp Ben-Gen Serv Alloc	Management Fee Rev.	440,612	5	854		182,527	354	4
5	17	Administrative	Management Fee Rev.	440,612	5	72,083	72,083	182,527	29,861	5
6	19	Professional Services	Management Fee Rev.	440,612	5	23,400		182,527	9,694	6
7	20	Licenses & Dues	Management Fee Rev.	440,612	5	764		182,527	316	7
8	21	Clerical & Office Wages	Management Fee Rev.	440,612	5	42,368	42,368	182,527	17,551	8
9	21	Clerical & Office Wages	Management Fee Rev.	440,612	5	239,425	239,425	182,527	99,183	9
10	21	Clerical & Office Expense	Management Fee Rev.	440,612	5	13,177		182,527	5,457	10
11	25	Auto Expense	Management Fee Rev.	440,612	5	3,783		182,527	1,567	11
12	26	General Insurance	Management Fee Rev.	440,612	5	11,904		182,527	4,931	12
13	27	Emp Ben-G&A Alloc	Management Fee Rev.	440,612	5	32,275		182,527	13,370	13
14	30	Depreciation	Management Fee Rev.	440,612	5	3,994		182,527	1,655	14
15	33	Real Estate Taxes	Management Fee Rev.	440,612	5	16,756		182,527	6,941	15
16	34	Rent	Management Fee Rev.	440,612	5	36,400		182,527	15,079	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 517,324	\$ 363,251		\$ 214,304	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

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

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

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

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

B. Real Estate Taxes

[illegible]

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Center COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT Brenda Cullum

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 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 1-61-0270-100	Long Term Care Property	\$ 19,160.30	\$ 19,160.30
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 19,160.30	\$ 19,160.30

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

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

A. Square Feet: 14,640

B. General Construction Type: Exterior Brick Frame Wood & Concrete 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).

N/A

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	76,320	1968	\$ 3,996	1
2					2
3	TOTALS	76,320		\$ 3,996	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42			1968	\$ 94,863	\$	40	\$	\$	94,863	4
5				1968	61,381		20			61,381	5
6				1970	3,953		20			3,953	6
7	18			1970	26,047		38			26,047	7
8	16			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	Activity Room			1986	15,306		20			15,306	13
14	Activity 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			1990	13,831	439	25		(439)	13,831	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 Units			1996	1,071		10			1,071	32
33	Installed Service Cable			1997	7,666		15			7,666	33
34	A/c Units			1998	698		10			698	34
35	Hot Water Heater			1998	2,985		15			2,985	35
36	Overbed Lighting			1998	8,932		15			8,932	36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

1/1/16

Ending:

12/31/16

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			3,599	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		(124)	3,917	44
45	Building Addition	1998	239,137		15			239,137	45
46	Parking Lot	1998	13,916		15			13,916	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	Entrance Sign	1999	1,000		5			1,000	55
56	Paint Windoe 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	1999	3,952		5			3,952	59
60	To Refurbish The Building								60
61	Awnings	1999	420		5			420	61
62	Labor & Materials To Remove Existing Wall & Rebuild New	1999	8,559		10			8,559	62
63	Wall Relocate Plumbing & Electrical Services, Install								63
64	Cabinetry, & Countertops And Installed New Flooring. Labor								64
65	&Materials To Gut An Existing Bathroom & Rehab Room To								65
66	Create 2 New Bathrooms &Storage Area For Housekeeping								66
67	& Datary (To Ve Complete In 2000). Labor & Materials								67
68	To Install New Cabinets, Relocated Plumbing & Electrical,								68
69	Repair Drywall & Paint The Breakroom.								69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 682		\$	\$ (682)	\$ 834,312	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 834,312	\$ 682		\$	\$ (682)	\$ 834,312	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 Existing Wall In Order To Conver	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	103	15	102	(1)	3,075	10
11	Reinforce & Raise Sinking Floor On B Wing	2001	7,380	246	15	246		7,380	11
12	Gut Beauty Shop Area & Construct A New Handicapped	2001	16,165	535	15	534	(1)	16,165	12
13	Bathroom. New Wiring, Plumbing, Flooring, Shower, Toilet,								13
14	Sink, Door, Sprinkler Heads, Cubicle Tracks, & Curtains &								14
15	Cove Base.								15
16	Sewer Repair To 3 Bed Ward Bathroom. Removed Concrete &	2001	2,800	89	15	89		2,800	16
17	Replaced Deteriorated Sewer Line, Install New Line, & New								17
18	Clean Out & Pour New Floor								18
19	Relocate Beauty Shop Top Pt Area. Installed Lines, Clean Out &	2001	1,223	34	15	34		1,223	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	237	15	237		7,124	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	9	15	9		386	28
29	Install 2 Sprinkler Heads In Store Room & Water Heater Closet	2001	338	5	15	5		338	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	\$ 1,940		\$ 1,256	\$ (684)	\$ 920,094	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 920,094	\$ 1,940		\$ 1,256	\$ (684)	\$ 920,094	1
2	Install Grease Trap & Wet Well	2002	13,224		10			13,224	2
3	Replaced Rusted Out Main Line In B Hallway &	2002	3,494		10			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		10			1,706	5
6	A Hall Bathroom								6
7	Repair Roof Over Front Dining Room & Activity Room	2002	8,230		10			8,230	7
8	Landscaping Of Courtyard	2004	1,109		10			1,109	8
9	Remove, Repair, & Install Tile Flooring In Dining Room	2005	7,222		10			7,222	9
10	Replace Tile In Hall, TV Room & Small Hallway	2008	3,310		10	331	331	2,814	10
11	Replace Roof Over Kitchen & Dining Room & Repairs To	2009	7,615	545	10	762	217	5,715	11
12	A & B Halls								12
13	5'x6' Entrance Sign	2009	1,599		5			1,599	13
14	Repair Flat Roof Area On Back Of Building	2010	5,980	399	15	399		2,593	14
15	Demo & Install Ductwork On Back Of Building	2010	3,792	253	15	253		1,644	15
16	Installed Fire Rated Carpet On Walls	2011	6,126		5	614	614	6,126	16
17	Seal & Stripe Parking Lot	2011	1,380		5	138	138	1,380	17
18	Install 400 Amp Breaker Box & New Disconnect	2011	4,395		20	220	220	1,210	18
19	Replace 139 Sprinkler Heads	2012	17,509	584	15	1,167	583	5,252	19
20	Replace Roof On East And West Wings	2013	20,139	672		1,343	671	4,700	20
21	Install Fire Sprinkler System On C Wing	2013	11,700	390		468	78	1,638	21
22									22
23	Replaced B Wing Roof	2014	19,305	644	15	1,287	643	3,218	23
24	Replaced Sprinkler System throughout the Building	2014	79,900	2,525	25	320	(2,205)	800	24
25	except Medicare C Wing								25
26	Replaced Admin Section Roof	2014	9,490	316	15	633	317	1,582	26
27	Cost Reduction-Sprinkler System (See Line 24)	2015	(2,100)		25	(84)	(84)	(168)	27
28	Storage Shed	2015	8,271	393	10	827	434	1,241	28
29	Install Vinyl Wallcovering and Crash Rails-C Wing	2015	7,052	863	10	75	(788)	428	29
30	Replace Flooring/Walltiles in C Wing Large Bathroom	2015	4,672	572	10	467	(105)	701	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,165,214	\$ 10,096		\$ 10,476	\$ 380	\$ 997,552	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,165,214	\$ 10,096		\$ 10,476	\$ 380	\$ 997,552	1
2	Install Security System	2016	7,815	4,466	7	1,116	(3,350)	1,116	2
3	Install Rooftop A/C Heater-C Wing Roof	2016	5,200	2,972	7	743	(2,229)	743	3
4	Install New Water Line/Tankless Water Heater-Laundry	2016	4,203	2,401	7	600	(1,801)	600	4
5	Therapy Room Imp-Replace Flooring, Cabinets, Countertops								5
6	Blinds, Track Lighting, Patched and Painted Walls	2016	5,972	3,085	15	398	(2,687)	398	6
7	Beauty Shop/Bathroom Imp-Replace Flooring, New Water								7
8	Lines, Sink, Toilet, Electrical Upgrades, Exhaust Fan	2016	7,233	3,737	15	482	(3,255)	482	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,195,637	\$ 26,757		\$ 13,815	\$ (12,942)	\$ 1,000,891	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$88,223	\$1,073	\$8,822	\$7,749	5-15 Yrs	\$56,960	71
72	Current Year Purchases	2,811	1,607	1,607		7 Years	1,607	72
73	Fully Depreciated Assets	293,229					293,229	73
74	Allocated from Management Company			1,655	1,655			74
75	TOTALS	\$384,263	\$2,680	\$12,084	\$9,404		\$351,796	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				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,583,896	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$29,437	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$25,899	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,538)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,352,687	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Management Company				15,079			5
6								6
7	TOTAL				\$ 15,079			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 2,637 Description: See Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Fairview Nursing Center

IDPH License ID Number:

0024992

Fiscal Year End:

12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
C-PAP Machine	1,497
Vending Machine	164
Storage Shed	838
Dishwasher	138
Total - Line 16	2,637

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

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)

		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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	956	\$ 51,351	\$	956	\$ 51,351	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		546	37,628		546	37,628	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,166	65,708		1,166	65,708	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				35,948		35,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					11,377		11,377	12
13	Other (specify): _____									13
14	TOTAL			\$	2,668	\$ 154,687	\$ 47,325	2,668	\$ 202,012	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 33,827	\$ 33,827	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,543,533	1,543,533	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	95,061	95,061	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,007	7,007	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Capital</u>	13,300	13,300	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,692,728	\$ 1,692,728	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,996	13
14	Buildings, at Historical Cost	901,257	364,166	14
15	Leasehold Improvements, at Historical Cost		831,471	15
16	Equipment, at Historical Cost		384,263	16
17	Accumulated Depreciation (book methods)	(801,623)	(1,352,687)	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)	\$ 99,634	\$ 231,209	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,792,362	\$ 1,923,937	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,004	\$ 75,004	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,432	37,432	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,690	7,690	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,500	19,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	51,103	51,103	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 190,729	\$ 190,729	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)	\$ 190,729	\$ 190,729	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,601,633	\$ 1,733,208	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,792,362	\$ 1,923,937	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Fairview Nursing Center
IDPH License ID Number: 0024992
Fiscal Year End: 12/31/16

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After
		Consolidation
MANAGEMENT FEES PAY	14,264	14,264
INSURANCE	387	387
OTHER ACCRUED EXPENSE	519	519
401K LIABILITY	14,142	14,142
ACCR LIC BED TAX	15,254	15,254
ACCRUED RENT	535	535
PAYROLL WITHHOLDINGS	5,442	5,442
PRE TAX INSURANCE	560	560
Total - Line 36	51,103	51,103

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,577,630	1
2	Restatements (describe):		2
3	Post Closing Adjustments	(4,786)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,572,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,789	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 28,789	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)	\$ 1,601,633	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,049,634	1
2	Discounts and Allowances for all Levels	70,489	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,120,123	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	280,288	6
7	Oxygen	260	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 280,548	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	1,278	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,350	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,916	19
20	Radiology and X-Ray	2,609	20
21	Other Medical Services	2,280	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,433	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,716	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,716	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	3,246	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,246	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,451,066	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	523,701	31
32	Health Care	964,899	32
33	General Administration	494,735	33
	B. Capital Expense		
34	Ownership	64,074	34
	C. Ancillary Expense		
35	Special Cost Centers	227,034	35
36	Provider Participation Fee	147,834	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,422,277	40
41	Income before Income Taxes (line 30 minus line 40)**	28,789	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 28,789	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,229,991	44
45	Private Pay - Net Inpatient Revenue	778,207	45
46	Medicare - Net Inpatient Revenue	241,787	46
47	Other-(specify) Insurance	29,903	47
48	Other-(specify) Prior Year Adjustments	(159,765)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,120,123	49

Note 1-This Entity is Cash Basis Tax Payer

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No- Note 1 If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Fairview Nursing Center

IDPH License ID Number:

0024992

Fiscal Year End:

12/31/16

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
OTHER INCOME	1,441
ACT & CONT INCOME	1,805
Total - Line 28	3,246

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	1,664	1,891	\$ 50,555	\$ 26.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,060	4,413	95,789	21.71	3
4	Licensed Practical Nurses	8,256	8,753	147,634	16.87	4
5	CNAs & Orderlies	38,575	41,202	447,110	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,165	3,510	47,106	13.42	10
11	Social Service Workers	1,845	2,007	25,351	12.63	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,140	30,543	14.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,800	9,375	88,135	9.40	15
16	Dishwashers					16
17	Maintenance Workers	2,529	2,670	43,524	16.30	17
18	Housekeepers	5,837	6,172	61,126	9.90	18
19	Laundry	2,917	3,104	41,414	13.34	19
20	Administrator	1,924	2,072	65,325	31.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,858	1,972	24,188	12.27	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)	83,305	89,281	\$ 1,167,800 *	\$ 13.08	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	74	\$ 5,675	L1,C3	35
36	Medical Director	Monthly	2,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	25	2,057	L10,C3	38
39	Pharmacist Consultant	Monthly	1,785	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,457	L11,C3	44
45	Social Service Consultant	22	1,457	L12,C3	45
46	Other(specify)				46
47	Utilization Review	Monthly	2,600	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	143	\$ 17,631		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	51	\$ 1,737	L10,C3	50
51	Licensed Practical Nurses	2,934	98,334	L10,C3	51
52	Certified Nurse Assistants/Aides	122	2,684	L10,C3	52
53	TOTAL (lines 50 - 52)	3,107	\$ 102,755		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number		Fairview Nursing Center		STATE OF ILLINOIS		Report Period Beginning:		1/1/16		Page 21	
				# 0024992		Ending:		12/31/16			
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Description		Amount		Description		Amount	
Randee Slover		Administrator	0	Workers' Compensation Insurance		\$ 18,676		IDPH License Fee		\$ 1,992	
				Unemployment Compensation Insurance		8,566		Advertising: Employee Recruitment		1,321	
				FICA Taxes		89,337		Health Care Worker Background Check			
				Employee Health Insurance				(Indicate # of checks performed 10)		450	
				Employee Meals				Patient Background Checks		53 483	
				Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous Licenses & Fees		1,619	
				Vaccines		504		Miscellaneous Dues & Subscriptions		554	
				Other Employee Benefits		5,016		Allocated from Management Co.		316	
				401(k) Expense		16,206					
				Christmas Gifts		2,470					
								Less: Public Relations Expense		()	
								Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 140,775		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,735	
(List each licensed administrator separately.)		\$ 65,325									
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	
Management Fees-See Page 6, Eliminated on P 3, C 7		\$ 182,527		N/A				Out-of-State Travel		\$	
								In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 182,527						Seminar Expense		1,157	
(Attach a copy of any management service agreement)											
C. Professional Services								Entertainment Expense		()	
Vendor/Payee		Type	Amount					(agree to Sch. V, line 24, col. 8)			
Barnett & Levine		Accounting	\$ 1,500					TOTAL		\$ 1,157	
Barrett Twomey Broom Hughes & Hoke, LLP		Legal	112								
TOTAL (agree to Schedule V, line 19, column 3)		\$ 1,612		TOTAL			\$				
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

