		FOR BHF USE					

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048983

Facility Name: Fairview Care Center of Joliet

Address: 222 North Hammes Avenue (Number) Joliet (City) 60435 (Zip Code)

County: Will

Telephone Number: (815) 725-0443 **Fax #** (815) 725-1079

HFS ID Number:

Date of Initial License for Current Owners: 02/13/2007

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,206	1,308	14,356	43,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,206	1,308	14,356	43,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.21%

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]

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 01/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 8,173

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: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	230,379	27,320	21,505	279,204		279,204	(4,524)	274,680			1
2	Food Purchase		226,816		226,816		226,816	(68)	226,748			2
3	Housekeeping	201,173	19,033		220,206		220,206		220,206			3
4	Laundry	53,828	17,081		70,909		70,909		70,909			4
5	Heat and Other Utilities			198,082	198,082		198,082	2,143	200,225			5
6	Maintenance	65,960		112,890	178,850		178,850	9,623	188,473			6
7	Other (specify):*							2,797	2,797			7
8	TOTAL General Services	551,340	290,250	332,477	1,174,067		1,174,067	9,971	1,184,038			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,752,417	195,826	41,805	1,990,048		1,990,048	32,830	2,022,878			10
10a	Therapy	17,506			17,506		17,506		17,506			10a
11	Activities	102,772	2,800	2,957	108,529		108,529		108,529			11
12	Social Services	90,303		5,810	96,113		96,113	369	96,482			12
13	CNA Training											13
14	Program Transportation			268	268		268	4,118	4,386			14
15	Other (specify):*							8,008	8,008			15
16	TOTAL Health Care and Programs	1,962,998	198,626	74,840	2,236,464		2,236,464	45,324	2,281,788			16
	C. General Administration											
17	Administrative	134,573		43,200	177,773		177,773	26,683	204,456			17
18	Directors Fees											18
19	Professional Services			238,149	238,149		238,149	(159,424)	78,725			19
20	Dues, Fees, Subscriptions & Promotions			67,393	67,393		67,393	(49,639)	17,754			20
21	Clerical & General Office Expenses	115,192	1,194	242,334	358,720		358,720	(66,126)	292,594			21
22	Employee Benefits & Payroll Taxes			465,584	465,584		465,584		465,584			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,274	1,274		1,274	1,891	3,165			24
25	Other Admin. Staff Transportation			1,745	1,745		1,745	3,048	4,793			25
26	Insurance-Prop.Liab.Malpractice			182,473	182,473		182,473	(13,267)	169,206			26
27	Other (specify):*							28,061	28,061			27
28	TOTAL General Administration	249,765	1,194	1,242,152	1,493,111		1,493,111	(228,771)	1,264,340			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,764,103	490,070	1,649,469	4,903,642		4,903,642	(173,476)	4,730,166			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet #0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			139,682	139,682		139,682	5,217	144,899			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,041	56,041		56,041	6,986	63,027			32
33	Real Estate Taxes			98,397	98,397		98,397	4,012	102,409			33
34	Rent-Facility & Grounds			1,009,890	1,009,890		1,009,890	(20,084)	989,806			34
35	Rent-Equipment & Vehicles			12,245	12,245		12,245	9,419	21,664			35
36	Other (specify):*											36
37	TOTAL Ownership			1,316,255	1,316,255		1,316,255	5,551	1,321,806			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		433,014	751,109	1,184,123		1,184,123		1,184,123			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*	114,601		309,200	423,801		423,801	(423,801)				43
44	TOTAL Special Cost Centers	114,601	433,014	1,171,452	1,719,067		1,719,067	(423,801)	1,295,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,878,704	923,084	4,137,176	7,938,964		7,938,964	(591,726)	7,347,238			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Reference	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	(8,489)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,721)	30		9
10	Interest and Other Investment Income	(1,341)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		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				18
19	Entertainment	(7,098)	21		19
20	Contributions	(11,296)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(161,509)	21		24
25	Fund Raising, Advertising and Promotional	(31,719)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,006)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(440,277)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (671,524)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,798		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,798		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (591,726)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview Care Center of Joliet

ID# 0048983

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft & Damage Loss	$ (900)	21	1
2	Bank Charges	(22,500)	21	2
3	Advertising & Promotion Payroll	(100,382)	43	3
4	Marketing Wage	(14,219)	43	4
5	COPE Dues	(7,426)	20	5
6	Non-Allowable Legal	(4,977)	19	6
7	Capitalized R&M	(6,542)	06	7
8	Other Income - Insurance Refund	(15,781)	26	8
9	Other Income	(328)	21	9
10	Non-Allowable Management Fees	(286,500)	43	10
11	Additional R&M	19,278	06	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**	(440,277)		49

Fairview Care Center of Joliet

ID# 0048983

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Fairview Care Center of Joliet **#** 0048983 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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				(4,524)								(4,524)	1
2	Food Purchase	(68)											(68)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,143									2,143	5
6	Maintenance	4,247		5,282		94							9,623	6
7	Other (specify):*			828	1,969								2,797	7
8	**TOTAL General Services**	4,179		8,253	(2,555)	94							9,971	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				32,830								32,830	10
10a	Therapy													10a
11	Activities													11
12	Social Services				369								369	12
13	CNA Training													13
14	Program Transportation				4,118								4,118	14
15	Other (specify):*				8,008								8,008	15
16	**TOTAL Health Care and Programs**				45,324								45,324	16
	C. General Administration													
17	Administrative			14,858	11,825								26,683	17
18	Directors Fees													18
19	Professional Services	(4,977)		(139,921)	(17,950)	3,424							(159,424)	19
20	Fees, Subscriptions & Promotions	(50,441)		526	97	180							(49,639)	20
21	Clerical & General Office Expenses	(199,341)		119,229	13,906	81							(66,126)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			636	1,255								1,891	24
25	Other Admin. Staff Transportation			2,669	379								3,048	25
26	Insurance-Prop.Liab.Malpractice	(15,781)		2,514									(13,267)	26
27	Other (specify):*			24,350	3,711								28,061	27
28	**TOTAL General Administration**	(270,540)		24,861	13,223	3,684							(228,771)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(266,361)		33,114	55,993	3,778							(173,476)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Fairview Care Center of Joliet** **#** **0048983** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,721)		6,157	69	1,712							5,217	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,341)		42		8,285							6,986	32
33	Real Estate Taxes			3,811		201							4,012	33
34	Rent-Facility & Grounds			(1,274)		(18,810)							(20,084)	34
35	Rent-Equipment & Vehicles			2,299	7,120								9,419	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(4,062)		11,036	7,189	(8,612)							5,551	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(401,101)			(22,700)								(423,801)	43
44	**TOTAL Special Cost Centers**	(401,101)			(22,700)								(423,801)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(671,524)		44,150	40,482	(4,834)							(591,726)	45

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

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

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

1 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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)	
15	V	5	UTILITIES	$	YAM MANAGEMENT, LLC	100.00%	$ 2,143	$ 2,143	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	5,282	5,282	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	828	828	17
18	V	17	ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	10,531	10,531	18
19	V	17	ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	4,327	4,327	19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	9,546	9,546	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	526	526	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	119,229	119,229	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	636	636	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	2,669	2,669	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,514	2,514	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	24,350	24,350	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	6,157	6,157	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	42	42	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	3,811	3,811	29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	22,226	22,226	30
31	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,323	1,323	31
32	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	976	976	32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	111,144	YAM MANAGEMENT, LLC	100.00%		(111,144)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	23,500	YAM MANAGEMENT, LLC	100.00%		(23,500)	37
38	V	19	DATA PROCESSING	2,323	YAM MANAGEMENT, LLC	100.00%		(2,323)	38
39	Total			$ 172,967			$ 217,117	$ * 44,150	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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)	
15	V	01	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 16,981	$ 16,981	15
16	V	07	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,969	1,969	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	63,841	63,841	17
18	V	12	SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	369	369	18
19	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,118	4,118	19
20	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	8,008	8,008	20
21	V	17	ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	13,025	13,025	21
22	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	326	326	22
23	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	97	97	23
24	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	13,906	13,906	24
25	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	1,255	1,255	25
26	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	379	379	26
27	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,711	3,711	27
28	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	69	69	28
29	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	7,120	7,120	29
30	V								30
31	V								31
32	V								32
33	V	01	Dietary Consultant	21,505				(21,505)	33
34	V	10	RN Consultant	31,011				(31,011)	34
35	V	17	DIR. OF OPERATIONS CONSULT	1,200				(1,200)	35
36	V	19	DATA PROCESSING FEES	18,276				(18,276)	36
37	V	43	MARKETING	22,700				(22,700)	37
38	V								38
39	Total			$ 94,692			$ 135,174	$ * 40,482	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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)	
15	V	6	REPAIRS & MAINTENANCE	$	8131 N. MONTICELLO, LLC	100.00%	$ 94	$ 94	15
16	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		3,424	3,424	16
17	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		180	180	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		81	81	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,712	1,712	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		8,285	8,285	20
21	V	33	REAL ESTATE TAXES	3,811	8131 N. MONTICELLO, LLC		4,012	201	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	18,810	8131 N. MONTICELLO, LLC			(18,810)	26
27	V								27
28	V								28
29	V								29
30	V								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			$ 22,621			$ 17,787	$ * (4,834)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	54.65%	See Attached	5.1	13%	Mgmt. Fees	$ 42,000	17-3	1
2	Jay Meystel	Owner	Administrative	2%	See Attached	2.6	7%	Alloc. Salary	7,284	17-7	2
3	Joel Meystel	Owner	Administrative	1%	See Attached	2.6	13%	Alloc. Salary	3,247	17-7	3
4	Meir Meystel	Relative	Administrator	0%	None	16.67	100%	Salary	18,766	17-1	4
5	Shimon Meystel	Relative	Clerical	0%	See Attached	5.1	13%	Alloc. Salary	1,725	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 73,022		13

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

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: YAM MANAGEMENT, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	5	UTILITIES	AVAIL. BED DAYS	579,474	16	$ 16,764	$	74,095	$ 2,143	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	74,095	5,282	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478		74,095	828	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	74,095	10,531	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	74,095	4,327	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656		74,095	9,546	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114		74,095	526	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	74,095	119,229	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974		74,095	636	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872		74,095	2,669	10
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661		74,095	2,514	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434		74,095	24,350	12
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156		74,095	6,157	13
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331		74,095	42	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806		74,095	3,811	15
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825		74,095	22,226	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347		74,095	1,323	17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632		74,095	976	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,698,015	$ 987,832		$ 217,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: YAM CONSULTING, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	6	DIETARY	AVAIL. BED DAYS	579,474	16	$ 132,801	$ 123,648	74,095	$ 16,981	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		74,095	1,969	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	74,095	63,841	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	74,095	369	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		74,095	4,118	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		74,095	8,008	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	74,095	13,025	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		74,095	326	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		74,095	97	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	74,095	13,906	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		74,095	1,255	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		74,095	379	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		74,095	3,711	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		74,095	69	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		74,095	7,120	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,057,162	$ 813,692		$ 135,174	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: 8131 N. MONTICELLO LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	6	REPAIRS & MAINTENANCE	PATIENT DAYS	579,474	16	$ 732	$	74,095	$ 94	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	16	26,780		74,095	3,424	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	16	1,405		74,095	180	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	16	630		74,095	81	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	16	13,389		74,095	1,712	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	16	64,796		74,095	8,285	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	16	31,375		74,095	4,012	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 139,107	$		$ 17,787	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	The Private Bank		X	Line of Credit			$	$ 766,473		6.0000	$ 47,632	1
2	The Private Bank		X	Improvements				43,750	04/09/11	6.0000	8,409	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocated from YAM Mgmt	X									42	6
7	Alloc. From 8131 Monticello	X									8,285	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 810,223			$ 64,368	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,341)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,341)	14
15	TOTALS (line 9+line14)						$	$ 810,223			$ 63,027	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	93,000	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.)	$	98,209	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,209	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	97,200	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.	$	102,409	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	89,159	9
2007	89,612	10
2008	90,848	11
2009	94,197	12

2010 Accrual = $94,197 x 1.032% = $97,200

8131 N. Monticello Allocation = $4,012

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Care Center of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0048983

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-304-025-000	Long Term Care Property	$ 94,196.60	$ 94,196.60
2.	Allocated from 8131 N. Monticello	Home Office Allocation	$ 30,331.21	$ 3,878.33
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 124,527.81	$ 98,074.93

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? X YES _____ NO

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Care Center of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0048983

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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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

*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 Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		161,508	1,757		2,566	809	2,814	68
69	Financial Statement Depreciation			139,682			(139,682)		69
70	TOTAL (lines 4 thru 69)		$ 161,508	$ 141,439		$ 2,566	$ (138,873)	$ 2,814	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 161,508	$ 141,439		$ 2,566	$ (138,873)	$ 2,814	1
2	Long Elevator & Machine Co Inv #10110049 - Replaced Existing S	2007	2,960		20	148	148	530	2
3	Econocare - 1St Floor Dining Room	2007	16,550		20	1,103	1,103	3,770	3
4	Econocare - 1St Floor Dining Room	2007	10,009		20			10,009	4
5	Seco Refrigeration Inv.. 4769-146 - Install New Unit 1St Floor Lob	2007	16,985		20	1,415	1,415	4,600	5
6	Seco Refrigeration	2007	8,796		20	733	733	2,321	6
7	Atlas Construction - 2Nd Floor Oxygen Room	2007	3,590		20	239	239	748	7
8	Bailey'S Carpet	2007	2,945		20	421	421	1,332	8
9	Seco Refrigeration Inv. 3610-150 - Boiler Section Replacement	2007	7,319		20	610	610	1,932	9
10	On-Line Communications #8319 - Nurse Call System 1St Floor &	2008	7,394		20	493	493	1,438	10
11	Judicial Receivers Corp. #111841 - Rehab 1St Floor Shower Room	2008	16,985		20	1,699	1,699	5,096	11
12	Judicial Receivers Corp #111842 - Rehab 1St Floor Men'S Visitor	2008	4,067		20	407	407	1,220	12
13	Judicial Receivers Corp #111843 - Rehab 1St Floor Women'S Visi	2008	3,824		20	382	382	1,147	13
14	Champion Roofing #15723	2008	77,806		20	7,781	7,781	21,397	14
15	Econocare #3220 - Kitchen Tiles	2008	15,027		20	751	751	1,941	15
16	Dgtell New Data Cables	2008	2,600		20	260	260	650	16
17	Champion Roofing #16326	2008	36,250		20	3,625	3,625	8,760	17
18	Fox Valley Sprinkler System	2008	12,240		20	1,224	1,224	2,958	18
19	Sendra Service - 4" Gate Valve	2008	3,385		20	339	339	790	19
20	Lozano Electric	2008	3,675		20	368	368	858	20
21	Lozano Electric	2008	12,000		20	1,200	1,200	3,000	21
22	Champion Roofing #16017	2008	36,250		20	3,625	3,625	9,063	22
23	Econocare Resident Room Improvements - Flooring, Light Fixture	2008	40,921		20	4,092	4,092	8,866	23
24	Econocare Lobby Improvements - Flooring, Window Treatments	2008	8,530		20	853	853	1,848	24
25	Nico Plumbing 4" Lining Kitchen Piping	2008	26,400		20	2,640	2,640	5,500	25
26	Nico Plumbing - Kitchen Improvements	2009	3,652		20	365	365	700	26
27	On-Line Communications - Nurse Call	2009	11,629		20	2,326	2,326	4,652	27
28	Econocare - Double Doors And Wall	2009	7,204		20	720	720	1,201	28
29	Econocare - Elevator	2009	10,013		20	501	501	834	29
30	Econocare - Tiles & Other Improvements	2009	16,718		20	1,672	1,672	2,786	30
31	Champion - Coping Metal & A/C Ducts	2009	17,300		20	1,730	1,730	2,739	31
32	Nico Plumbing - Insulated Water Valves	2009	3,550		20	355	355	562	32
33	Seco Refrigeration - 3 Roof Top Units	2009	18,800		20	1,880	1,880	2,977	33
34	TOTAL (lines 1 thru 33)		$ 626,882	$ 141,439		$ 46,522	$ (94,917)	$ 119,038	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 626,882	$ 141,439		$ 46,522	$ (94,917)	$ 119,038	1
2	Econocare - Nurses Stations & Other	2009	24,865		20	2,487	2,487	3,937	2
3	Power Transformer	2009	4,786		20	957	957	1,436	3
4	Water Supply Repair Band	2009	2,714		20	271	271	407	4
5	Dialysis Rm Project - Moshe Calamaro Architect Fees	2009	3,490		20	349	349	465	5
6	Dialysis Rm Project - City Of Joliet Building Permits	2009	3,873		20	387	387	516	6
7	Seco Walk-In Freezer Door	2009	2,936		20	294	294	367	7
8	Econocare Wallcovering, Handrails, Bumpers	2009	59,176		20	5,918	5,918	7,397	8
9	Rjv Woods Remodeling-Carpentry, Electric, Flooring, Demo, Dry	2009	50,020		20	10,022	10,022	11,692	9
10	Peter Pro Floor Hardwood Flooring	2009	4,800		20	480	480	560	10
11	Peter Pro Floor Hardwood Flooring	2009	4,800		20	480	480	560	11
12	Performance Blend Valve	2009	21,225		20	2,123	2,123	2,653	12
13	Hvac Buildout For Dialysis Room	2009	14,250		20	1,425	1,425	1,781	13
14	Pph Co Plumbing Improvements	2009	43,891		20	4,389	4,389	5,486	14
15	Painting Sofit	2009	10,000		20	500	500	875	15
16	Elevator Renovation	2009	3,955		20	198	198	313	16
17	Sprinkler Repair	2009	5,750		20	288	288	335	17
18	Rjv Woods Remodeling-Carpentry, Electric, Flooring, Demo, Dry	2009	50,200		20	2,510	2,510	2,510	18
19	Electrical Improvements - Tie Ins & Runs For Lighting	2009	90,000		20	4,500	4,500	4,500	19
20	Display Case Installation	2010	5,272		20	1,054	1,054	1,054	20
21	Universal Elevator Valve	2010	3,140		20	92	92	92	21
22	Econocare Panel Lamination & Signs	2010	5,383		20	538	538	538	22
23	Dgtell Camera And Installation	2010	15,447		20	257	257	257	23
24	Econocare Wallcovering	2010	43,922		20	2,196	2,196	2,196	24
25	Econocare Tile Installation	2010	35,000		20	1,750	1,750	1,750	25
26	Econocare Carpeting	2010	13,879		20	496	496	496	26
27	Econocare Kitchen Cabinetry & Wall Protection	2010	24,060		20	602	602	602	27
28	Econocare Vinyl Tile Installation	2010	37,557		20	626	626	626	28
29	Repairs To Ventilator/Hot Water Tank	2010	2,692		20	135	135	135	29
30	Remove Asphalt, Repair Storm Sewer Catch Basin, Patch Asphalt	2010	3,850		20	193	193	193	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,217,815	$ 141,439		$ 92,037	$ (49,402)	$ 172,769	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 1,217,815	$ 141,439		$ 92,037	$ (49,402)	$ 172,769	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
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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)		$ 1,217,815	$ 141,439		$ 92,037	$ (49,402)	$ 172,769	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12D, Carried Forward		$ 1,217,815	$ 141,439		$ 92,037	$ (49,402)	$ 172,769	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,217,815	$ 141,439		$ 92,037	$ (49,402)	$ 172,769	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information Continued		$	$		$	$	$	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	113,932	1,207	39	1,205	(2)	1,205	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from 8131 N. Monticello	2010	39,609	505	20	1,066	561	1,066	10
11									11
12	Allocated from YAM Management	2007	2,736	8	20	137	129	428	12
13	Allocated from YAM Management	2008	188	2	20	8	6		13
14	Allocated from YAM Management	2009	831	10	20	35	25		14
15	Allocated from YAM Management	2010	4,212	25	20	115	90	115	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 161,508	$ 1,757		$ 2,566	$ 809	$ 2,814	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 312,368	$ 1,765	$ 45,664	$ 43,899	10	$ 127,575	71
72	Current Year Purchases	109,828	4,070	6,659	2,589	10	6,659	72
73	Fully Depreciated Assets	3,233				10	3,233	73
74								74
75	TOTALS	$ 425,429	$ 5,835	$ 52,323	$ 46,488		$ 137,467	75

D. Vehicle Depreciation (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		Allocated from YAM Managemer	2010	$ 3,021	$ 346	$ 539	$ 193	5	$ 1,763	76
77										77
78										78
79										79
80	TOTALS			$ 3,021	$ 346	$ 539	$ 193		$ 1,763	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)	$ 1,646,265	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 147,620	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,899	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,721)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 311,999	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	Landlord Assets - CIP	$ 1,196,757	92
93	(Therapy room & lobby/office)		93
94			94
95		$ 1,196,757	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.

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Glenwood Real Estate, LLC
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:				$ 986,390			3
4	Additions							4
5	Allocated from YAM Management				3,415			5
6								6
7	TOTAL				$ 989,805 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: ☐ 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: $ 13,221 Description: See Attached Schedule
    (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	Allocated from YAM Management		$	$ 1,323	17
18	Allocated from YAM Consulting			7,120	18
19					19
20					20
21	TOTAL		$	$ 8,443	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' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - 03	hrs	$		$ 309,531	$		$ 309,531	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			92,765			92,765	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			345,614			345,614	4
5	Physician Care	39 - 03	visits			3,199			3,199	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				395,719		395,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						37,295		37,295	13
14	TOTAL			$		$ 751,109	$ 433,014		$ 1,184,123	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' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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	$ 284,017	$	1
2	Cash-Patient Deposits	2,712		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	858,853		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,022		6
7	Other Prepaid Expenses	1,126		7
8	Accounts Receivable (owners or related parties)	99,373		8
9	Other(specify): See Attached Schedule	266,991		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,538,094	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	918,274		15
16	Equipment, at Historical Cost	521,273		16
17	Accumulated Depreciation (book methods)	(319,081)		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): See Attached Schedule	701,448		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,821,914	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,360,008	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 777,894	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,091		28
29	Short-Term Notes Payable	810,223		29
30	Accrued Salaries Payable	42,030		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,535		31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	26,350		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,814,323	$	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	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,814,323	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,545,685	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,360,008	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,069,174	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,069,174	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,233	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	8,910	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(94,630)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Prior Period Adjustment**	149,998	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 476,511	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)**	$ 1,545,685	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,967,185	1
2	Discounts and Allowances for all Levels	(171,771)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,795,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,096,038	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,096,038	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	394,058	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,932	19
20	Radiology and X-Ray	6,230	20
21	Other Medical Services	9,567	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 440,787	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,341	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,341	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17,617	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,617	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,351,197	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,174,067	31
32	Health Care	2,236,464	32
33	General Administration	1,493,111	33
	B. Capital Expense		
34	Ownership	1,316,255	34
	C. Ancillary Expense		
35	Special Cost Centers	1,607,924	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,938,964	40
41	**Income before Income Taxes (line 30 minus line 40)****	412,233	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 412,233	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,949	2,200	$ 99,211	$ 45.10	1
2	Assistant Director of Nursing	2,045	2,233	72,225	32.34	2
3	Registered Nurses	13,054	14,166	424,917	30.00	3
4	Licensed Practical Nurses	16,977	17,819	444,114	24.92	4
5	CNAs & Orderlies	50,472	53,815	567,459	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,452	1,558	17,506	11.24	8
9	Activity Director	2,013	2,102	31,785	15.12	9
10	Activity Assistants	7,086	7,537	70,987	9.42	10
11	Social Service Workers	4,277	4,694	90,303	19.24	11
12	Dietician					12
13	Food Service Supervisor	1,979	2,086	41,259	19.78	13
14	Head Cook	6,216	6,546	87,283	13.33	14
15	Cook Helpers/Assistants	10,390	11,190	101,837	9.10	15
16	Dishwashers					16
17	Maintenance Workers	4,111	4,547	65,960	14.51	17
18	Housekeepers	17,890	19,158	201,173	10.50	18
19	Laundry	3,664	4,335	53,828	12.42	19
20	Administrator	2,602	2,807	134,573	47.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,515	9,255	115,192	12.45	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	4,157	4,757	144,491	30.37	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,187	4,604	114,601	24.89	33
34	TOTAL (lines 1 - 33)	163,036	175,409	$ 2,878,704 *	$ 16.41	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	391	$ 21,505	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	514	32,061	10-03	38
39	Pharmacist Consultant	Monthly	9,744	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	2,957	11-03	44
45	Social Service Consultant	106	5,810	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,068	$ 96,077		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerald Mertes III	Administrator	0	$ 104,082
Meir Meystel	Administrator	0	18,766
Shalom Litchman	Administrator	0	11,725
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,573

B. Administrative - Other

Description	Amount
	$
Management Fees - YAM Management	42,000
Admin. Consulting - YAM Consulting	1,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 43,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Prospect Resources	Energy Consultant	$ 1,228
Personnel Planners	Unemployment Consulting	2,422
E-Health Data Solutions	Data Processing	6,755
See Attached	Legal	21,136
Frost, Ruttenberg & Rothblatt	Accounting	29,200
YAM Management	Bookkeeping/Accounting	147,144
YAM Consulting	Data Processing	18,276
Health Data Systems, Inc.	Data Processing	5,443
YAM Management	Data Processing	2,323
American Data	Data Processing	4,222
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 238,149

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,257
Unemployment Compensation Insurance	52,644
FICA Taxes	211,454
Employee Health Insurance	14,228
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	89,732
Union Pension Fund	22,401
401k Expense	1,335
Employee Benefits - Other	6,533
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,584

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	365
Health Care Worker Background Check	
(Indicate # of checks performed 328)	3,280
Patient Background Checks	
Dues & Subscriptions	15,254
Licenses & Permits	5,479
Allocated from YAM Management	526
Allocated from YAM Consulting	97
Allocated from 8131 N. Monticello	180
Less: Public Relations Expense	(7,426)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,755

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,274
Allocated from YAM Management	636
Allocated from YAM Consulting	1,255
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,165

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IAHCF: $2,436 ICLTC: $17,539.2**

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,495** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **111,143**
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. $ 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? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.