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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048983

Facility Name: Fairview Care Center Of Joliet

Address: 222 North Hammes (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: 02/13/07

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 01/01/11 to 12/31/11 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: 01/01/11 Ending: 12/31/11

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	29,984	2,282	14,379	46,645	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,984	2,282	14,379	46,645	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.95%

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 1/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2007 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 8,089

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

* 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: 01/01/11 Ending: 12/31/11

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	230,791	28,918	22,165	281,874		281,874	(7,851)	274,023			1
2	Food Purchase		231,735		231,735		231,735	(113)	231,622			2
3	Housekeeping	178,455	20,243		198,698		198,698		198,698			3
4	Laundry	63,528	21,861		85,389		85,389		85,389			4
5	Heat and Other Utilities			216,610	216,610		216,610	1,640	218,250			5
6	Maintenance	71,888	165	131,176	203,229		203,229	9,597	212,826			6
7	Other (specify):*							1,912	1,912			7
8	TOTAL General Services	544,662	302,922	369,951	1,217,535		1,217,535	5,185	1,222,720			8
	B. Health Care and Programs											
9	Medical Director			20,000	20,000		20,000		20,000			9
10	Nursing and Medical Records	2,249,177	241,217	102,552	2,592,946		2,592,946	(27,934)	2,565,012			10
10a	Therapy	9,694			9,694		9,694		9,694			10a
11	Activities	97,087	5,288	3,630	106,005		106,005		106,005			11
12	Social Services	75,962		4,035	79,997		79,997		79,997			12
13	CNA Training											13
14	Program Transportation							4,134	4,134			14
15	Other (specify):*							8,026	8,026			15
16	TOTAL Health Care and Programs	2,431,920	246,505	130,217	2,808,642		2,808,642	(15,774)	2,792,868			16
	C. General Administration											
17	Administrative	135,859		66,098	201,957		201,957	28,529	230,486			17
18	Directors Fees											18
19	Professional Services			271,857	271,857		271,857	(171,001)	100,856			19
20	Dues, Fees, Subscriptions & Promotions			83,150	83,150		83,150	(20,980)	62,170			20
21	Clerical & General Office Expenses	121,545	776	276,614	398,935		398,935	(120,473)	278,462			21
22	Employee Benefits & Payroll Taxes			640,986	640,986		640,986		640,986			22
23	Inservice Training & Education											23
24	Travel and Seminar			999	999		999	1,511	2,510			24
25	Other Admin. Staff Transportation			1,019	1,019		1,019	3,778	4,797			25
26	Insurance-Prop.Liab.Malpractice			209,309	209,309		209,309	2,281	211,590			26
27	Other (specify):*							28,742	28,742			27
28	TOTAL General Administration	257,404	776	1,550,032	1,808,212		1,808,212	(247,612)	1,560,600			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,233,986	550,203	2,050,200	5,834,389		5,834,389	(258,202)	5,576,187			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: 01/01/11 Ending: 12/31/11

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			220,806	220,806		220,806	36,904	257,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,988	61,988		61,988	5,734	67,722			32
33	Real Estate Taxes			111,773	111,773		111,773	3,135	114,908			33
34	Rent-Facility & Grounds			1,074,485	1,074,485		1,074,485	(14,000)	1,060,485			34
35	Rent-Equipment & Vehicles			15,066	15,066		15,066	9,322	24,388			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,484,118	1,484,118		1,484,118	41,095	1,525,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		533,802	807,236	1,341,038		1,341,038		1,341,038			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):*	104,333		385,395	489,728		489,728	(489,728)	(0)			43
44	**TOTAL Special Cost Centers**	104,333	533,802	1,303,774	1,941,909		1,941,909	(489,728)	1,452,181			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,338,319	1,084,005	4,838,092	9,260,416		9,260,416	(706,835)	8,553,581			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: 01/01/11 Ending: 12/31/11

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	(14,601)	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	29,479	30		9
10	Interest and Other Investment Income	(318)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	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	(7,648)	21		18
19	Entertainment	(5,655)	21		19
20	Contributions	(8,880)	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	(181,467)	21		24
25	Fund Raising, Advertising and Promotional	(6,511)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,734)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,568)	20		28
29	Other-Attach Schedule	(497,479)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (698,496)		$	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)	(8,339)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,339)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (706,835)		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: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft & Damage Loss	$ (4)	21	1
2	Bank Charges	(26,988)	21	2
3	Advertising & Promotion Payroll	(104,333)	43	3
4	Marketing Expense	(15,395)	43	4
5	COPE Dues	(4,888)	20	5
6	Non-Allowable Legal	(10,547)	19	6
7	Other Income	(1,608)	21	7
8	Non-Allowable Management Fees	(354,000)	43	8
9	Additional R&M	21,410	06	9
10	Non- Allowable Fee	(1,126)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(497,479)		49

Fairview Care Center Of Joliet

ID# 0048983

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary				(7,851)								(7,851)	1
2	Food Purchase	(113)											(113)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,640									1,640	5
6	Maintenance	6,809		2,788									9,597	6
7	Other (specify):*			197	1,715								1,912	7
8	**TOTAL General Services**	6,696		4,625	(6,136)								5,185	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(27,934)								(27,934)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				4,134								4,134	14
15	Other (specify):*				8,026								8,026	15
16	**TOTAL Health Care and Programs**				(15,774)								(15,774)	16
	C. General Administration													
17	Administrative			38,484	(9,955)								28,529	17
18	Directors Fees													18
19	Professional Services	(10,547)		(148,343)	(12,669)	558							(171,001)	19
20	Fees, Subscriptions & Promotions	(21,847)		708	92	67							(20,980)	20
21	Clerical & General Office Expenses	(228,231)		96,090	11,560	108							(120,473)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,095	416								1,511	24
25	Other Admin. Staff Transportation			3,184	594								3,778	25
26	Insurance-Prop.Liab.Malpractice			2,281									2,281	26
27	Other (specify):*			25,472	3,270								28,742	27
28	**TOTAL General Administration**	(260,624)		18,971	(6,692)	733							(247,612)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(253,929)		23,596	(28,602)	733							(258,202)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	29,479		1,792	73	5,560							36,904	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(318)		108		5,944							5,734	32
33	Real Estate Taxes			5,008		(1,873)							3,135	33
34	Rent-Facility & Grounds			2,829		(16,829)							(14,000)	34
35	Rent-Equipment & Vehicles			2,642	6,680								9,322	35
36	Other (specify):*													36
37	**TOTAL Ownership**	29,161		12,379	6,753	(7,198)							41,095	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):*	(473,728)			(16,000)								(489,728)	43
44	**TOTAL Special Cost Centers**	(473,728)			(16,000)								(489,728)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(698,496)		35,975	(37,849)	(6,465)							(706,835)	45

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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.**

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 1,640	$ 1,640	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,788	2,788	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	197	197	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	38,484	38,484	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,873	2,873	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	708	708	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	96,090	96,090	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	1,095	1,095	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	3,184	3,184	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,281	2,281	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	25,472	25,472	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,792	1,792	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	108	108	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	5,008	5,008	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	16,829	16,829	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,952	1,952	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	690	690	31
32	V				YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V	19	OTHER PROFESSIONAL FEES	2,000	YAM MANAGEMENT, LLC	100.00%		(2,000)	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	14,000	YAM MANAGEMENT, LLC	100.00%		(14,000)	37
38	V	19	DATA PROCESSING	2,072				(2,072)	38
39	Total			$ 165,216			$ 201,191	$ * 35,975	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: 01/01/11 Ending: 12/31/11

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	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 14,314	$ 14,314	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,715	1,715	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	64,466	64,466	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,134	4,134	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	8,026	8,026	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	21,143	21,143	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	5,607	5,607	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	92	92	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	11,560	11,560	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	416	416	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	594	594	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,270	3,270	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	73	73	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	6,680	6,680	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	22,165	YAM CONSULTING, LLC	100.00%		(22,165)	33
34	V	10	NURSE CONSULTING	92,400	YAM CONSULTING, LLC	100.00%		(92,400)	34
35	V	17	DIR. OF OPERATIONS CONSULT	31,098	YAM CONSULTING, LLC	100.00%		(31,098)	35
36	V	19	DATA PROCESSING FEES	18,276	YAM CONSULTING, LLC	100.00%		(18,276)	36
37	V	43	MARKETING	16,000	YAM CONSULTING, LLC	100.00%		(16,000)	37
38	V								38
39	Total			$ 179,939			$ 142,090	$ * (37,849)	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: 01/01/11 Ending: 12/31/11

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	19	PROFESSIONAL FEES	$	8131 N. MONTICELLO, LLC	100.00%	$ 558	$ 558	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		67	67	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		108	108	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		5,560	5,560	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		5,944	5,944	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,135	3,135	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	16,829	8131 N. MONTICELLO, LLC			(16,829)	26
27	V	33	REAL ESTATE TAXES	5,008	8131 N. MONTICELLO, LLC			(5,008)	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			$ 21,837			$ 15,372	$ * (6,465)	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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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.**

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	1219 LIMITED PARTNERSHIP	8.200%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 LIMITED PARTNERSHIP	8.200%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	350 LIMITED PARTNERSHIP	10.700%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	42170 LIMITED PARTNERSHIP	8.200%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON				4
5	GARY BIDER	0.800%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	ISADORE MEYSTEL REVOCABLE TRUST	2.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	JAY MEYSTEL TRUST	2.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JOEL MEYSTEL	1.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9	MARLEE ASSOCIATES, LLC	2.250%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	YOSEF MEYSTEL	56.650%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			ROCKFORD NUR. & REHAB	ROCKFORD				14
15			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	56.65%	See Attached	4.3	10.75%	Mgmt. Fees	$ 35,000	17-3	1
2	Jay Meystel	Owner	Administrative	2.00%	See Attached	2.2	5.50%	Alloc. Salary	6,527	17-7	2
3	Joel Meystel	Owner	Administrative	1.00%	See Attached	2.2	11.00%	Alloc. Salary	2,485	17-7	3
4											4
5											5
6											6
7											7
8	Where applicable, the amounts reported on this page have been adjusted from the acutal costs to reflect only amounts anticipated to be considered allowable										8
9	by the IL dept of HFS.										9
10											10
11											11
12											12
13								TOTAL	$ 44,012		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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	686,836	17	$ 15,204	$	74,095	$ 1,640	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	74,095	2,788	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		74,095	197	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	74,095	38,484	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		74,095	2,873	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		74,095	708	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	74,095	96,090	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		74,095	1,095	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		74,095	3,184	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		74,095	2,281	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		74,095	25,472	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		74,095	1,792	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		74,095	108	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		74,095	5,008	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		74,095	16,829	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		74,095	1,952	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		74,095	690	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,864,985	$ 1,200,907		$ 201,191	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1	DIETARY	AVAIL. BED DAYS	686,836	17	$ 132,684	$ 123,698	74,095	$ 14,314	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		74,095	1,715	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	74,095	64,466	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		74,095	4,134	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		74,095	8,026	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	74,095	21,143	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		74,095	5,607	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		74,095	92	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	74,095	11,560	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		74,095	416	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		74,095	594	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		74,095	3,270	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		74,095	73	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		74,095	6,680	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,317,116	$ 1,008,809		$ 142,090	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	$ 5,168	$	20,440	$ 558	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		20,440	67	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		20,440	108	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		20,440	5,560	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		20,440	5,944	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		20,440	3,135	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					$ 142,495	$		$ 15,372	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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** 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	The Private Bank		X	Line of Credit			$	$ 832,130		6.0000	$ 57,649	1
2	The Private Bank		X	Improvements				60,000	4/9/11	6.0000	4,339	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 892,130			$ 61,988	9
	B. Non-Facility Related*											
10	Interest Income		X								(318)	10
11	Allocated from YAM Management		X								108	11
12	Allocated from 8131 N. Monticello		X								5,944	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 5,734	14
15	TOTALS (line 9+line14)						$	$ 892,130			$ 67,722	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: 01/01/11 Ending: 12/31/11

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:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 97,200	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.)		$ 105,308	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,108	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 106,800	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.		$ 114,908	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	89,159	8
	2007	89,612	9
	2008	90,848	10
	2009	94,197	11
	2010	102,173	12

2011 Accrual = $102,173 x 1.05 = $106,800

Allocated from 8131 N. Monticello - $3,135

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(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	$ 102,172.86	$ 102,172.76
2.	10-23-325-045-0000	Home office allocation	$ 35,987.49	$ 3,400.83
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 138,160.35	$ 105,573.59

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Allocated from 8131 N. Monticello			$ 9,601	1
2					2
3	TOTALS			$ 9,601	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	69,154		20	4,670	4,670	29,912	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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)		111,572	5,917		3,940	(1,977)	5,812	68
69	Financial Statement Depreciation			220,806			(220,806)		69
70	TOTAL (lines 4 thru 69)		$ 180,726	$ 226,723		$ 8,610	$ (218,113)	$ 35,724	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 180,726	$ 226,723		$ 8,610	$ (218,113)	$ 35,724	1
2	On-Line Communications #8319 - Nurse Call System 1St Floor &	2008	7,394		20	493	493	1,931	2
3	Judicial Receivers Corp. #111841 - Rehab 1St Floor Shower Room	2008	16,985		20	1,699	1,699	6,794	3
4	Judicial Receivers Corp #111842 - Rehab 1St Floor Men'S Visitor	2008	4,067		20	407	407	1,627	4
5	Judicial Receivers Corp #111843 - Rehab 1St Floor Women'S Visi	2008	3,824		20	382	382	1,530	5
6	Champion Roofing #15723	2008	77,806		20	7,781	7,781	29,177	6
7	Econocare #3220 - Kitchen Tiles	2008	15,027		20	751	751	2,692	7
8	Dgtell New Data Cables	2008	2,600		20	260	260	910	8
9	Champion Roofing #16326	2008	36,250		20	3,625	3,625	12,385	9
10	Fox Valley Sprinkler System	2008	12,240		20	1,224	1,224	4,182	10
11	Sendra Service - 4" Gate Valve	2008	3,385		20	339	339	1,128	11
12	Lozano Electric	2008	3,675		20	368	368	1,225	12
13	Lozano Electric	2008	12,000		20	1,200	1,200	4,200	13
14	Champion Roofing #16017	2008	36,250		20	3,625	3,625	12,688	14
15	Econocare Resident Room Improvements - Flooring, Light Fixture	2008	40,921		20	4,092	4,092	12,958	15
16	Econocare Lobby Improvements - Flooring, Window Treatments	2008	8,530		20	853	853	2,701	16
17	Nico Plumbing 4" Lining Kitchen Piping	2008	26,400		20	2,640	2,640	8,140	17
18	Nico Plumbing - Kitchen Improvements	2009	3,652		20	365	365	1,065	18
19	On-Line Communications - Nurse Call	2009	11,629		20	2,326	2,326	6,977	19
20	Econocare - Double Doors And Wall	2009	7,204		20	720	720	1,921	20
21	Econocare - Elevator	2009	10,013		20	501	501	1,335	21
22	Econocare - Tiles & Other Improvements	2009	16,718		20	1,672	1,672	4,458	22
23	Champion - Coping Metal & A/C Ducts	2009	17,300		20	1,730	1,730	4,469	23
24	Nico Plumbing - Insulated Water Valves	2009	3,550		20	355	355	917	24
25	Seco Refrigeration - 3 Roof Top Units	2009	18,800		20	1,880	1,880	4,857	25
26	Econocare - Nurses Stations & Other	2009	24,865		20	2,487	2,487	6,423	26
27	Power Transformer	2009	4,786		20	957	957	2,393	27
28	Water Supply Repair Band	2009	2,714		20	271	271	679	28
29	Dialysis Rm Project - Moshe Calamaro Architect Fees	2009	3,490		20	349	349	814	29
30	Dialysis Rm Project - City Of Joliet Building Permits	2009	3,873		20	387	387	904	30
31	Seco Walk-In Freezer Door	2009	2,936		20	294	294	661	31
32	Econocare Wallcovering, Handrails, Bumpers	2009	59,176		20	5,918	5,918	13,315	32
33	Rjv Woods Remodeling-Carpentry, Electric, Flooring, Demo, Dry	2009	10,020		20	1,002	1,002	2,171	33
34	TOTAL (lines 1 thru 33)		$ 688,806	$ 226,723		$ 59,561	$ (167,162)	$ 193,351	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 688,806	$ 226,723		$ 59,561	$ (167,162)	$ 193,351	1
2	Peter Pro Floor Hardwood Flooring	2009	4,800		20	480	480	1,040	2
3	Peter Pro Floor Hardwood Flooring	2009	4,800		20	480	480	1,040	3
4	Performance Blend Valve	2009	21,225		20	2,123	2,123	4,776	4
5	Hvac Buildout For Dialysis Room	2009	14,250		20	1,425	1,425	3,206	5
6	Pph Co Plumbing Improvements	2009	43,891		20	4,389	4,389	9,875	6
7	Painting Sofit	2009	10,000		20	500	500	1,375	7
8	Elevator Renovation	2009	3,955		20	198	198	511	8
9	Sprinkler Repair	2009	5,750		20	288	288	623	9
10	Electrical Improvements - Tie Ins & Runs For Lighting	2009	90,000		20	4,500	4,500	9,375	10
11	Display Case Installation	2010	5,272		20	1,054	1,054	2,109	11
12	Universal Elevator Valve	2010	3,140		20	157	157	249	12
13	Econocare Panel Lamination & Signs	2010	5,383		20	538	538	1,077	13
14	Dgtell Camera And Installation	2010	15,447		20	3,089	3,089	3,347	14
15	Econocare Wallcovering	2010	43,922		20	8,784	8,784	10,981	15
16	Econocare Tile Installation	2010	35,000		20	7,000	7,000	8,750	16
17	Econocare Carpeting	2010	13,879		20	1,983	1,983	2,478	17
18	Econocare Kitchen Cabinetry & Wall Protection	2010	24,060		20	2,406	2,406	3,008	18
19	Econocare Vinyl Tile Installation	2010	37,557		20	7,511	7,511	8,137	19
20	Repairs To Ventilator/Hot Water Tank	2010	2,692		20	135	135	258	20
21	Remove Asphalt, Repair Storm Sewer Catch Basin, Patch Asphalt	2010	3,850		20	193	193	273	21
22	Smoke Detectors, Annunciator, & Fire Alarm System	2011	5,575		20	836	836	836	22
23	Landmark - Automatic Door Operator	2011	7,500		20	438	438	438	23
24	Seco - Hot Water Tank Installation	2011	5,281		20	293	293	293	24
25	Notifier Fire Panel	2011	4,139		20	621	621	621	25
26	Elevator Furnishings And Installation	2011	3,663		20	61	61	61	26
27	Econocare Prefinished Door Installation	2011	61,932		20	1,548	1,548	1,548	27
28	2Nd Flr Resident Rooms-Cubicle Curtains,Panels,	2011	34,357		20	1,718	1,718	1,718	28
29	Resident Rm Bathrooms-Remove Old & Install New Flooring	2011	13,103		20	655	655	655	29
30	Resident Rooms-Remove Old Wallpaper & Paint	2011	8,840		20	442	442	442	30
31	200 Wing Corridor Nook-Wallcovering	2011	2,552		20	128	128	128	31
32	Wire Co-Axial Plugs And Recepticals	2011	4,320		20	432	432	432	32
33	Wire Co-Axial Plugs And Recepticals, Relocate Outlets	2011	3,480		20	174	174	174	33
34	TOTAL (lines 1 thru 33)		$ 1,232,419	$ 226,723		$ 114,139	$ (112,584)	$ 273,184	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,232,419	$ 226,723		$ 114,139	$ (112,584)	$ 273,184	1
2	New Therapy Room & New Lobby And Office Area	2011	1,196,757		20	59,838	59,838	59,838	2
3	Fire Caulking & Radient Dampers	2011	4,800		20	240	240	240	3
4	Prepare, Stain And Finish Crown Mouldings & Doors	2011	4,394		20	220	220	220	4
5	Sas Architects Fees,Permit, Ground Testing And Fire Sprinkler Fe	2011	143,315		20	7,166	7,166	7,166	5
6	Repair Water Fountain, Install Corner Guards, Replace Surface T	2011	3,428		20	171	171	171	6
7	Rekey And Reinstall Master Locks	2011	3,331		20	167	167	167	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)		$ 2,588,444	$ 226,723		$ 181,941	$ (44,782)	$ 340,986	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,588,444	$ 226,723		$ 181,941	$ (44,782)	$ 340,986	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,588,444	$ 226,723		$ 181,941	$ (44,782)	$ 340,986	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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22									22
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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									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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	74,601	2,219	39	1,913	(306)	2,790	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	3,554	356	20	356		452	9
10	Allocated from 8131 N. Monticello	2010	33,417	3,342	20	1,671	(1,671)	2,570	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 111,572	$ 5,917		$ 3,940	$ (1,977)	$ 5,812	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 398,729	$ 1,176	$ 66,390	$ 65,214	10	$ 178,243	71
72	Current Year Purchases	70,335	12	9,059	9,047	10	9,060	72
73	Fully Depreciated Assets	25,370				10	25,370	73
74								74
75	TOTALS	$ 494,435	$ 1,188	$ 75,449	$ 74,261		$ 212,673	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from YAM Managemer	2011	$ 2,901	$ 321	$ 321	$	5	$ 109	76
77										77
78										78
79										79
80	TOTALS			$ 2,901	$ 321	$ 321	$		$ 109	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)	$ 3,095,381	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,232	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 257,711	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,479	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 553,767	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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:		203		$ 1,060,485			3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 1,060,485 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 4,038 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	Facility		$	$ 11,718	17
18	Allocated from YAM Consulting			6,680	18
19	Allocated from YAM Management			1,952	19
20					20
21	TOTAL		$	$ 20,350	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: 01/01/11 Ending: 12/31/11

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

STATE OF ILLINOIS

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$		$ 339,161	$		$ 339,161	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			99,939			99,939	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			359,232			359,232	4
5	Physician Care	39 - 03	visits			8,904			8,904	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				504,471		504,471	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						29,331		29,331	13
14	TOTAL			$		$ 807,236	$ 533,802		$ 1,341,038	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: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 25,510	$	1
2	Cash-Patient Deposits	17,446		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,459,667		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,328		6
7	Other Prepaid Expenses	2,100		7
8	Accounts Receivable (owners or related parties)	100,000		8
9	Other(specify): See Attached Schedule	105,133		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,807,184	$	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	1,401,449		15
16	Equipment, at Historical Cost	640,772		16
17	Accumulated Depreciation (book methods)	(539,887)		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	507,356		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,009,690	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,816,874	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 946,950	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,280		28
29	Short-Term Notes Payable	892,130		29
30	Accrued Salaries Payable	57,345		30
31	Accrued Taxes Payable (excluding real estate taxes)	55,978		31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,800		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	346,096		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,452,579	$	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)**	$ 2,452,579	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,364,295	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,816,874	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,545,685	1
2	Restatements (describe):		2
3	**Rounding Error**	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,545,689	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,731	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(246,125)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (181,394)	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)**	$ 1,364,295	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: 01/01/11 Ending: 12/31/11

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	$ 6,596,750	1
2	Discounts and Allowances for all Levels	(222,069)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,374,681	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,399,390	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,399,390	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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	476,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,858	19
20	Radiology and X-Ray	7,285	20
21	Other Medical Services	12,847	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 542,011	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 318	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,747	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,747	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,325,147	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,217,535	31
32	Health Care	2,808,642	32
33	General Administration	1,808,212	33
	B. Capital Expense		
34	Ownership	1,484,118	34
	C. Ancillary Expense		
35	Special Cost Centers	1,830,766	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)***	$ 9,260,416	40
41	**Income before Income Taxes (line 30 minus line 40)****	64,731	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 64,731	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: 01/01/11 Ending: 12/31/11

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	1,430	1,516	$ 82,105	$ 54.16	1
2	Assistant Director of Nursing	1,321	1,448	49,261	34.02	2
3	Registered Nurses	18,706	19,445	575,322	29.59	3
4	Licensed Practical Nurses	24,300	25,775	674,135	26.15	4
5	CNAs & Orderlies	65,328	69,011	740,485	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	855	903	9,694	10.74	8
9	Activity Director	1,989	2,154	32,316	15.00	9
10	Activity Assistants	6,017	6,576	64,771	9.85	10
11	Social Service Workers	3,686	3,859	75,962	19.68	11
12	Dietician					12
13	Food Service Supervisor	1,926	2,064	41,048	19.89	13
14	Head Cook	6,938	7,655	92,445	12.08	14
15	Cook Helpers/Assistants	9,633	10,473	97,298	9.29	15
16	Dishwashers					16
17	Maintenance Workers	4,266	4,602	71,888	15.62	17
18	Housekeepers	14,784	16,648	178,455	10.72	18
19	Laundry	4,999	5,366	63,528	11.84	19
20	Administrator	2,390	2,596	113,244	43.62	20
21	Assistant Administrator	477	518	22,615	43.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,522	10,146	121,545	11.98	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	3,680	4,034	127,869	31.70	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,372	3,725	104,333	28.01	33
34	TOTAL (lines 1 - 33)	185,619	198,514	$ 3,338,319 *	$ 16.82	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	403	$ 22,165	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,490	92,400	10-03	38
39	Pharmacist Consultant	Monthly	10,152	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	70	3,630	11-03	44
45	Social Service Consultant	73	4,035	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,036	$ 152,382		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: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerald Mertes III (1/1/2011-3/14/2011)	Administrator	0	$ 27,518
Heather Bassett (3/15/2011-6/1/2011)	Administrator	0	21,293
JoMarie Silver (5/24/11-11/21/2011)	Administrator	0	59,405
Shalom Lichtman (11/22/2011-12/26/2011)	Administrator	0	5,028
Shalom Lichtman	Asst Admin	0	22,615
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,859

B. Administrative - Other

Description	Amount
Yosef Meystel-Management Fees	$ 35,000
Admin. Consulting- YAM Consulting	31,098
TOTAL (agree to Schedule V, line 17, col. 3)	$ 66,098
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Prospect Resources	Energy Consultant	$ 1,200
Personnel Planners	Unemployment Consulting	2,371
E-Health Data Solutions	Data Processing	3,302
See Attached	Legal	13,547
Frost, Ruttenberg & Rothblatt	Accounting	51,700
YAM Management	Bookkeeping/Accounting	147,144
YAM Consulting	Data Processing	18,276
Health Data Systems, Inc.	Data Processing	13,904
YAM Management	Data Processing	2,072
American Data	Data Processing	5,805
ADAR	Data Processing	4,647
See Supplemetal Schedule		7,890
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 271,857

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 155,434
Unemployment Compensation Insurance	84,118
FICA Taxes	255,381
Employee Health Insurance	110,708
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	22,080
401k Expense	1,701
Employee Benefits - Other	11,109
Employee Meals	455
TOTAL (agree to Schedule V, line 22, col.8)	$ 640,986

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	35,039
Health Care Worker Background Check	5,440
(Indicate # of checks performed 544)	
Patient Background Checks	
Dues & Subscriptions	17,194
Licenses & Permits	3,630
Allocated YAM Consulting	92
Allocated from YAM Management	708
See Supplemental Schedule	67
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,170

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	999
Allocated from YAM Consulting	416
Allocated from YAM Management	1,095
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,510

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center Of Joliet # 0048983 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	N/A		$		$	$	$	$	$	$	$	$	$
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:** 01/01/11 **Ending:** 12/31/11

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. **ILCLTC - $19,731**

(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. $ **7,533** 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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.