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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0024992

Facility Name: Fairview Nursing Center

Address: 602 East Jackson (Number) Du Quoin (City) 62832 (Zip Code)

County: Perry

Telephone Number: (618) 542-3441 **Fax #** (618) 542-6351

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	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			1,221	1,221	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	9,489	6,015		15,504	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,489	6,015	1,221	16,725	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.29%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 11/10/1970

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,005

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	112,929	7,471	5,651	126,051		126,051		126,051			1
2	Food Purchase		84,417		84,417		84,417	(503)	83,914			2
3	Housekeeping	63,951	10,938		74,889		74,889		74,889			3
4	Laundry	43,186	6,872		50,058		50,058		50,058			4
5	Heat and Other Utilities			59,597	59,597		59,597		59,597			5
6	Maintenance	49,450	35,470	34,681	119,601		119,601		119,601			6
7	Other (specify):* Waste Removal			1,827	1,827		1,827		1,827			7
8	TOTAL General Services	269,516	145,168	101,756	516,440		516,440	(503)	515,937			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	673,295	27,860	134,749	835,904		835,904		835,904			10
10a	Therapy											10a
11	Activities	47,851	1,085	1,380	50,316		50,316	(1,686)	48,630			11
12	Social Services	25,523		1,266	26,789		26,789		26,789			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	746,669	28,945	137,395	913,009		913,009	(1,686)	911,323			16
	C. General Administration											
17	Administrative	65,536		61,664	127,200		127,200		127,200			17
18	Directors Fees											18
19	Professional Services			93,345	93,345		93,345		93,345			19
20	Dues, Fees, Subscriptions & Promotions			18,641	18,641		18,641	(14,276)	4,365			20
21	Clerical & General Office Expenses	52,849	7,834	34,519	95,202		95,202		95,202			21
22	Employee Benefits & Payroll Taxes			125,657	125,657		125,657		125,657			22
23	Inservice Training & Education			100	100		100		100			23
24	Travel and Seminar			303	303		303		303			24
25	Other Admin. Staff Transportation			1,610	1,610		1,610		1,610			25
26	Insurance-Prop.Liab.Malpractice			50,075	50,075		50,075		50,075			26
27	Other (specify):*											27
28	TOTAL General Administration	118,385	7,834	385,914	512,133		512,133	(14,276)	497,857			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,134,570	181,947	625,065	1,941,582		1,941,582	(16,465)	1,925,117			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center #0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			15,175	15,175		15,175	10,037	25,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			20,005	20,005		20,005		20,005			33
34	Rent-Facility & Grounds			12,840	12,840		12,840	(12,840)				34
35	Rent-Equipment & Vehicles			882	882		882		882			35
36	Other (specify):*											36
37	**TOTAL Ownership**			48,902	48,902		48,902	(2,803)	46,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,275	188,868	230,143		230,143	(1,756)	228,387			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,018	136,018		136,018		136,018			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		41,275	324,886	366,161		366,161	(1,756)	364,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,134,570	223,222	998,853	2,356,645		2,356,645	(21,024)	2,335,621			45

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(503)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,037	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,756)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,118)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,844)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,184)		$	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)	(12,840)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (12,840)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (21,024)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Fairview Nursing Center

ID# 0024992

Report Period Beginning: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IDPH License	$ (1,158)	20	1
2	Offset Activity Income Against Expense	(1,686)	11	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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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**	(2,844)		49

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
1	V	34	Rent	$ 12,840	Fairview Residential Center Land Trust	39.70%	$	$ (12,840)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 12,840			$	$ * (12,840)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Lucinda Bain	46.97			Fairview Residential	DuQuoin, IL	Land Trust	1
2	Coletta McClary	46.97			Land Trust			2
3	Kristin McClary Powers	1.01						3
4	James David McClary	1.01						4
5	Sarah Glitzer	1.01						5
6	Marcia McClary Silen	1.01						6
7	David Brent Bain	1.01						7
8	Susan Beth Helsley	1.01						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	Section N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		N/A				$	$		$	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' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	Section N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center **#** 0024992 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 19,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 19,505	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 20,000	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.		$ 20,005	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	19,067	8
	2013	19,020	9
	2014	19,237	10
	2015	19,160	11
	2016	19,505	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Center COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-61-0270-100	Long Term Care Property	$ 19,504.60	$ 19,504.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,504.60	$ 19,504.60

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,640 B. General Construction Type: Exterior Brick Frame Wood & Concrete Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1968	$ 94,863	$	40	$	$	$ 94,863	4
5				1968	61,381		20			61,381	5
6				1970	3,953		20			3,953	6
7	18			1970	26,047		38			26,047	7
8	16			1976	177,922		30			177,922	8
	Improvement Type**										
9	Fire Alarm			1981	1,190		10			1,190	9
10	Sewer Line			1982	1,056		10			1,056	10
11	Plumbing Improvements			1984	1,193		10			1,193	11
12	Roof & Landscaping			1984	1,488		10			1,488	12
13	Activity Room			1986	15,306		20			15,306	13
14	Activity Room			1987	5,223		20			5,223	14
15	Roof & Landscaping			1987	9,775		10			9,775	15
16	Parking Lot			1987	18,960		15			18,960	16
17	Security System			1988	2,583		15			2,583	17
18	Renovations			1989	2,723		15			2,723	18
19	Hot Water Heater			1990	4,128		15			4,128	19
20	6 Wall A/C Units			1990	7,205		8			7,205	20
21	Landscaping			1990	495		10			495	21
22	Showers/cubicle Tracks			1990	8,459	119	15		(119)	8,459	22
23	Roof			1990	13,831	439	25		(439)	13,831	23
24	Telephone			1991	3,274		20			3,274	24
25	Water Heater			1991	1,945		15			1,945	25
26	Emergency Lights			1992	960		15			960	26
27	Seal & Stripe Parking Lot			1994	1,421		5			1,421	27
28	Emergency Lights			1995	994		15			994	28
29	Hot Water Heater			1995	7,433		15			7,433	29
30	Subpanels & Circuits Installed to A/C			1996	2,394		10			2,394	30
31	Pt A/C Unit			1996	1,163		10			1,163	31
32	A/C Units			1996	1,071		10			1,071	32
33	Installed Service Cable			1997	7,666	128	15		(128)	7,666	33
34	A/C Units			1998	698		10			698	34
35	Hot Water Heater			1998	2,985		15			2,985	35
36	Overbed Lighting			1998	8,932		15			8,932	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	Carpet	1998	$ 588	$	5	$	$	$ 588	37
38	Install Baseboard Heating	1998	3,599		15			3,599	38
39	Cabinets & Countertops	1998	708		5			708	39
40	Wallpaper & Installation	1998	9,457		5			9,457	40
41	Painting	1998	11,779		5			11,779	41
42	Trim, Pictures, Mirrors, Permanent Decoraive Fixtures	1998	2,007		5			2,007	42
43	Floor Cove Base	1998	901		5			901	43
44	Morton Storage Building	1998	3,917	124	15		(124)	3,917	44
45	Building Addition	1998	239,137		15			239,137	45
46	Parking Lot	1998	13,916		15			13,916	46
47	Flooring - Adjustment to 1998 Building Addition	1999	737		5			737	47
48	Door alarm System	1999	6,691		10			6,691	48
49	Wallpaper & Painting	1999	8,314		5			8,314	49
50	Install Bookcase In Admin Office	1999	333		10			333	50
51	Landscaping	1999	5,931		10			5,931	51
52	Seal Coated and Striped Parking Lot	1999	1,646		8			1,646	52
53	Install Telephones in Breakroom & Dining	1999	777		5			777	53
54	Move Phone Lines	1999	328		5			328	54
55	Entrance Sign	1999	1,000		5			1,000	55
56	Paint Window Grids	1999	175		5			175	56
57	Installation of Flooring	1999	8,949		10			8,949	57
58	Fountain & Light	1999	1,774		5			1,774	58
59	Balance of Trim, Mirrors, Permanent Decorative Fixtures	1999	3,952		5			3,952	59
60	To Refurbish The Building								60
61	Awnings	1999	420		5			420	61
62	Labor & Materials To Remove Existing Wall & Rebuild New	1999	8,559		10			8,559	62
63	Wall Relocate Plumbing & Electrical Services, Install								63
64	Cabinetry, & Countertops And Installed New Flooring, Labor								64
65	& Materials To Gut An Existing Bathroom & Rehab Room To								65
66	Create 2 New Bathrooms & Storage Area For Housekeeping								66
67	& Dietary(To Be Complete in 2000). Labor & Materials								67
68	To Install New Cabinets, Relocated Plumbing & Electrical,								68
69	Repair Drywall & Paint the Breakroom.								69
70	TOTAL (lines 4 thru 69)		$ 834,312	$ 810		$	$ (810)	$ 834,312	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 834,312	$ 810		$	$ (810)	$ 834,312	1
2	Labor & Materials To Complete 1999 Bathroom Project	2000	20,296		10			20,296	2
3	Installed Ceramic Tile, Sinks, Toilet Stool, Showers, And								3
4	Lighting Fixtures								4
5	Labor & Materials To Remove Existing Wall In Order To	2000	11,212		10			11,212	5
6	Convert Storage Room into a Resident Room. Removed Existing								6
7	Closets, Installedd Shower Area, Relocated Doors, Electrical,								7
8	& Plumbing Services, Repaired & Painted Drywall &								8
9	Relocated Call Lights								9
10	Excavate & Replace Driveway Asphalt & Fill In Cracks with Tar	2001	3,075		15			3,075	10
11	Reinforce & Raise Sinking Floor On B Wing	2001	7,380		15			7,380	11
12	Gut Beauty Shop Area & Construct A New Handicapped	2001	16,165		15			16,165	12
13	Bathroom. New Wiring, Plumbing, Flooring, Shower, Toilet,								13
14	Sink, Door, Sprinkler Heads, Bubicle Tracks, & Curtains &								14
15	Cove Base.								15
16	Sewer Repair To 3 Bed Ward Bathroom. Removed Concrete &	2001	2,800		15			2,800	16
17	Replaced Deteriorated Sewer Line, Install New Line, & New								17
18	Clean Out& Pour New Floor								18
19	Relocate Beauty Shop To Pt Area. Installed Lines, Clean Out &	2001	1,223		15			1,223	19
20	Shut Off Walves, Drill & Knock Out Outside Brick Wall, Install								20
21	Fan, Finish Drywall, Paint, Install Tile On Drywall, Install								21
22	Sink & Shelves								22
23	Convet Existing Bathroom To Handicapped Bathroom	2001	7,124		15			7,124	23
24	Remove Tile, Install Box For Call Lights, Tear Out &								24
25	Reconstruct Showers, Tile Wall & Showers, Install Handrails								25
26	In Tub & Showers, Hang Tracks & Curtains, Put New Lever								26
27	Hand Door Lever								27
28	Add Fan to Isolation Room For Medicare Compliance	2001	386		15			386	28
29	Install 2 Sprinkler Heads In Store Room & Water Heater Closet	2001	338		15			338	29
30	Upgrade Emergency Lighting & Moved Annunciator Panel	2001	15,138		10			15,138	30
31	& Smoke Detector								31
32	Upgraded Nurses Call Station	2001	645		10			645	32
33									33
34	TOTAL (lines 1 thru 33)		$ 920,094	$ 810		$	$ (810)	$ 920,094	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 920,094	$ 810		$	$ (810)	$ 920,094	1
2	Install Grease Trap & Wet Well	2002	13,224		10			13,224	2
3	Replaced Rusted Out Main Line In B Hallway&	2002	3,494		10			3,494	3
4	Reinstalled Drain To Connect To Mainline In B Hall Bath								4
5	Removed Old Flooring & Replaced With Ceramic Tile In	2002	1,706		10			1,706	5
6	A Hall Bathroom								6
7	Repair Roof Over Front Dining Room & Activity Room	2002	8,230		10			8,230	7
8	Landscaping Off Courtyard	2004	1,109		10			1,109	8
9	Remove, Repair & Install Tile Flooring In Dining Room	2005	7,222		10			7,222	9
10	Replace Tile In Hall, TV Room & Small Hallway	2008	3,310		10	331	331	3,145	10
11	Replace Roof Over Kitchen & Dining Room & Repairs To	2009	7,615		10	761	761	6,477	11
12	A & B Halls								12
13	5'x6' Entrance Sign	2009	1,599		5			1,599	13
14	Repair Flat Roof Area On Back Of Building	2010	5,980	399	15	399		2,992	14
15	Demo & Inatall Ductwork On Back Of Building	2010	3,792	253	15	253		1,895	15
16	Installed Fire Rated Carpet On Walls	2011	6,126		5			6,126	16
17	Seal & Stripe Parking Lot	2011	1,380		5			1,380	17
18	Install 400 Amp Breaker Box & New Disconnect	2011	4,395		20	220	220	1,430	18
19	Replace 139 Sprinkler Heads	2012	17,509	584	15	1,167	583	6,419	19
20	Replace Roof On East And West Wings	2013	20,139	671	20	1,343	672	6,043	20
21	Install Fire Sprinkler System On C Wing	2013	11,700	390	25	468	78	2,106	21
22									22
23	Replaced B Wing Roof	2014	19,305	643	15	1,287	644	4,505	23
24	Replaced Sprinkler System throughout the Building	2014	79,900	2,523	25	3,196	673	3,996	24
25	except Medicare C Wing								25
26	Replaced Admin Section Roof	2014	9,490	316	15	633	317	2,215	26
27	Cost Reduction - Sprinkler System (See Line 24)	2015	(2,100)		25	(84)	(84)	(252)	27
28	Storage Shed	2015	8,271	354	10	827	473	2,068	28
29	Install Vinyl Wallcovering and Crash Rails-C Wing	2015	7,052	616	10	705	89	1,133	29
30	Replace Flooring/Wall tiles ni C Wing Large Bathroom	2015	4,672	409	10	467	58	1,168	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,165,214	$ 7,968		$ 11,973	$ 4,005	$ 1,009,524	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,165,214	$ 7,968		$ 11,973	$ 4,005	$ 1,009,524	1
2	Install Security System	2016	7,815	957	7	1,116	159	2,232	2
3	Install Rooftop A/C Heater-C Wing Roof	2016	5,200	637	7	743	106	1,486	3
4	Install New Water Line/Tankless Water Heater-Laundry	2016	4,203	515	7	600	85	1,200	4
5	Therapy Room Imp-Replace Flooring, Cabinets, Countertops								5
6	Blilnds, Track Lighting, Patched & Painted Walls	2016	5,972	398	15	398		796	6
7	Beauty Shop/Bathroom Imp-Replace Floornig, New Water								7
8	Lines, Sinks, Toilet, Electrical Upgrades, Exhaust Fan	2016	7,233	482	15	482		964	8
9	Water Heater & Installation	2017	4,676	779	5	468	(311)	468	9
10	Wall Repairs, Paint Ceiling, and Handrails	2017	7,502	375	15	375		375	10
11	3 Door Cooler	2017	3,154	158	10	158		158	11
12	Paint, Flooring & Installation for Dining Room	2017	21,586	720	10	720		720	12
13	Flooring & Installation for A-Wing Bathrooms	2017	3,137	70	15	70		70	13
14	Wander Guard Alarm	2017	3,022	108	7	108		108	14
15	Wash Basin, Shower System, Vanity for A-Wing	2017	3,995	67	15	67		67	15
16	Sliding Doors & Cabinets for Dining & Activity	2017	3,874		15	129	129	129	16
17	New Doors for A-Wing Offices	2017	2,278	63	15	76	13	76	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,248,861	$ 13,297		$ 17,483	$ 4,186	$ 1,018,373	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 59,435	$ 1,784	$ 7,635	$ 5,851	5-15 Yrs	$ 33,693	71
72	Current Year Purchases	6,335	94	94		7-10 Yrs	94	72
73	Fully Depreciated Assets	325,738					325,738	73
74								74
75	TOTALS	$ 391,508	$ 1,878	$ 7,729	$ 5,851		$ 359,525	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,644,365	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,175	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,212	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,037	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,377,898	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 Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ 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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 882 Description: Storage
    (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	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				32,131		32,131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39,2					9,144		9,144	12
13	Other (specify): Therapy, Lab, X-Ray	39,3				188,868			188,868	13
14	TOTAL			$		$ 188,868	$ 41,275		$ 230,143	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Fairview Nursing Center **#** 0024992 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 410,203	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	776,491		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	65,353		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,804		7
8	Accounts Receivable (owners or related parties)	9,000		8
9	Other(specify): Capital	13,300		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,283,151	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	11,688		14
15	Leasehold Improvements, at Historical Cost	425,247		15
16	Equipment, at Historical Cost	523,880		16
17	Accumulated Depreciation (book methods)	(816,798)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 144,017	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,427,168	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,451	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,966		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	49,759		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 199,360	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 199,360	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,227,808	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,427,168	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Fairview Nursing Center **#** 0024992 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,601,633	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,601,633	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,473)	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	(91,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Reclass State Tax Payments**	2,148	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (373,825)	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)**	$ 1,227,808	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,014,478	1
2	Discounts and Allowances for all Levels	(214,047)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,800,431	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,402	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 252,402	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	503	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,485	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,355	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,343	23
	D. Non-Operating Revenue		
24	Contributions	1,686	24
25	Interest and Other Investment Income***	292	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,978	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	542	27
28	Miscellaneous	1,262	28
28a	Refunds	1,214	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,018	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,072,172	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	516,440	31
32	Health Care	913,009	32
33	General Administration	512,133	33
	B. Capital Expense		
34	Ownership	48,902	34
	C. Ancillary Expense		
35	Special Cost Centers	230,143	35
36	Provider Participation Fee	136,018	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,356,645	40
41	**Income before Income Taxes (line 30 minus line 40)****	(284,473)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (284,473)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,008,858	44
45	Private Pay - Net Inpatient Revenue	838,849	45
46	Medicare - Net Inpatient Revenue	194,858	46
47	Other-(specify) Insurance	26,249	47
48	Other-(specify) Discounts and Allowances	(268,383)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,800,431	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	1,821	2,111	$ 53,502	$ 25.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,911	4,320	92,967	21.52	3
4	Licensed Practical Nurses	7,127	7,724	136,488	17.67	4
5	CNAs & Orderlies	33,827	36,117	390,338	10.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,314	3,556	47,851	13.46	10
11	Social Service Workers	1,858	2,016	25,523	12.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,095	10,948	112,929	10.32	15
16	Dishwashers					16
17	Maintenance Workers	2,849	3,146	49,450	15.72	17
18	Housekeepers	6,312	6,574	63,951	9.73	18
19	Laundry	3,064	3,362	43,186	12.85	19
20	Administrator	2,000	2,089	65,536	31.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,848	2,980	52,849	17.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,026	84,943	$ 1,134,570 *	$ 13.36	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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	113	$ 5,651	1,3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,410	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,380	11,3	44
45	Social Service Consultant	19	1,266	12,3	45
46	Other(specify)				46
47	Utilization Review		687	10,3	47
48					48
49	TOTAL (lines 35 - 48)	153	$ 10,394		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	48	$ 2,198	10,3	50
51	Licensed Practical Nurses	3,349	118,368	10,3	51
52	Certified Nurse Assistants/Aides	529	12,086	10,3	52
53	TOTAL (lines 50 - 52)	3,926	$ 132,652		53

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Randee Slover	Administrator	0	$ 65,536
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 65,536

B. Administrative - Other

Description	Amount
Management Fees - Wappooh	$ 61,664
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 61,664

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting	$ 87,046
Templin Healthcare Accounting Services LLP	Accounting	4,209
Barnett & Levine	Accounting	1,520
CSC	Legal	406
Barrett Twomey Broom Hughes & Hoke, LLP	Legal	164
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 93,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,356
Unemployment Compensation Insurance	6,124
FICA Taxes	85,789
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Expense	14,698
Vaccines	251
Other Employee Benefits	3,724
Physicals	715
TOTAL (agree to Schedule V, line 22, col.8)	$ 125,657

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 75)	1,032
Patient Background Checks	
Miscellaneous Licenses & Fees	1,343
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,365

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	303
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 303

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **None** 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. $ **136,018**
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' PREPARATION 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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **503**

(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? **0**
d. Have vehicle usage logs been maintained? **Yes**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees