

		FOR BHF USE				

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

<p>I. IDPH License ID Number: <u>0040493</u></p> <p>Facility Name: <u>Fairmont Care Center</u></p> <p>Address: <u>5061 N. Pulaski Road</u> <u>Chicago</u> <u>60630</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 604-8112</u> Fax # <u>(773) 604-8113</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/11/1995</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u></td> <td>Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____	(Date) _____	(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u>	Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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Facility Name & ID Number Fairmont Care Center

0040493 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	186	TOTALS	186	67,890	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	919	404	10,158	11,481	8
9	SNF/PED					9
10	ICF	38,869	4,724	1,498	45,091	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,788	5,128	11,656	56,572	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.33%

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

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

I. On what date did you start providing long term care at this location?
Date started 5/11/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/11/1995 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 186 and days of care provided 8,570

Medicare Intermediary CGS Administrators LLC

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Fairmont Care Center # 0040493 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	589,141	205,269	24,633	819,043		819,043		819,043		1
2	Food Purchase		413,118		413,118		413,118	(374)	412,744		2
3	Housekeeping	496,167	73,662	1,318	571,147		571,147		571,147		3
4	Laundry	60,627	59,151		119,778		119,778		119,778		4
5	Heat and Other Utilities			310,152	310,152		310,152	(16,522)	293,630		5
6	Maintenance	84,355	293,064	247,440	624,859		624,859	659	625,518		6
7	Other (specify):*										7
8	TOTAL General Services	1,230,290	1,044,264	583,543	2,858,097		2,858,097	(16,237)	2,841,860		8
	B. Health Care and Programs										
9	Medical Director			121,334	121,334		121,334		121,334		9
10	Nursing and Medical Records	4,830,226	572,085	29,532	5,431,843		5,431,843	(115)	5,431,728		10
10a	Therapy	246,387	26,798		273,185		273,185		273,185		10a
11	Activities	172,422	27,471	4,928	204,821		204,821		204,821		11
12	Social Services	123,123		4,794	127,917		127,917		127,917		12
13	CNA Training										13
14	Program Transportation			3,781	3,781		3,781		3,781		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,372,158	626,354	164,369	6,162,881		6,162,881	(115)	6,162,766		16
	C. General Administration										
17	Administrative	185,366		605,000	790,366		790,366	(250,934)	539,432		17
18	Directors Fees										18
19	Professional Services			86,391	86,391		86,391	39,512	125,903		19
20	Dues, Fees, Subscriptions & Promotions			105,380	105,380		105,380	(68,719)	36,661		20
21	Clerical & General Office Expenses	228,642	72,642	702,870	1,004,154		1,004,154	(418,090)	586,064		21
22	Employee Benefits & Payroll Taxes			1,048,763	1,048,763		1,048,763		1,048,763		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,556	4,556		4,556	4,999	9,555		24
25	Other Admin. Staff Transportation			431	431		431		431		25
26	Insurance-Prop.Liab.Malpractice			153,274	153,274		153,274	118	153,392		26
27	Other (specify):*							100,862	100,862		27
28	TOTAL General Administration	414,008	72,642	2,706,665	3,193,315		3,193,315	(592,252)	2,601,063		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,016,456	1,743,260	3,454,577	12,214,293		12,214,293	(608,604)	11,605,689		29

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

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

Facility Name & ID Number

Fairmont Care Center

#0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,781	22,781		22,781	732,357	755,138			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			219,126	219,126		219,126	912,161	1,131,287			32
33	Real Estate Taxes			435,882	435,882		435,882		435,882			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,314,418)	5,582			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,997,789	1,997,789		1,997,789	330,101	2,327,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		639,756	1,371,295	2,011,051		2,011,051		2,011,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			392,928	392,928		392,928		392,928			42
43	Other (specify):*							0	0			43
44	TOTAL Special Cost Centers		639,756	1,764,223	2,403,979		2,403,979	0	2,403,979			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,016,456	2,383,016	7,216,589	16,616,061		16,616,061	(278,503)	16,337,558			45

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

Fairmont Care Center

ID# 0040493

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Sequestration	\$ (90,906)	21	1
2	Bank Charges	(4,885)	21	2
3	Patient Lost Articles	(115)	10	3
4	Building Co - Accounting	(1,957)	19	4
5	Building Co - Licenses & Fees	(75)	20	5
6	Capitalized R&M	(38,493)	06	6
7	Non-Allowable Legal Fees	(13,225)	19	7
8	Annual Report	(100)	20	8
9	Marketing Fees	(177,762)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(327,518)		49

Fairmont Care Center

Report Period Beginning: ID# 0040493
 Ending: 01/01/18
 12/31/18

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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(374)											(374)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,522)											(16,522)	5
6	Maintenance	(38,493)	38,983	169									659	6
7	Other (specify):*													7
8	TOTAL General Services	(55,389)	38,983	169									(16,237)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(115)											(115)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(115)											(115)	16
	C. General Administration													
17	Administrative			(250,934)									(250,934)	17
18	Directors Fees													18
19	Professional Services	(15,182)	1,957	52,737									39,512	19
20	Fees, Subscriptions & Promotions	(71,259)	75	2,465									(68,719)	20
21	Clerical & General Office Expenses	(658,206)		240,116									(418,090)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,999									4,999	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			118									118	26
27	Other (specify):*			100,862									100,862	27
28	TOTAL General Administration	(744,647)	2,032	150,363									(592,252)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(800,151)	41,015	150,532									(608,604)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	130,202	597,552	4,603									732,357	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,878)	862,500	52,539									912,161	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,320,000)	5,582									(1,314,418)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	127,324	140,052	62,725									330,101	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):*	(177,762)		177,762									0	43
44	TOTAL Special Cost Centers	(177,762)		177,762									0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(850,589)	181,067	391,019									(278,503)	45

Facility Name & ID Number

Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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 NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,320,000	Fairmont Property LLC		\$	(1,320,000)	1
2	V	32 Interest		Fairmont Property LLC		862,500	862,500	2
3	V	30 Depreciation		Fairmont Property LLC		597,552	597,552	3
4	V	06 Repairs and Maintenance		Fairmont Property LLC		38,983	38,983	4
5	V	20 Licenses and Fees		Fairmont Property LLC		75	75	5
6	V	19 Accounting		Fairmont Property LLC		1,957	1,957	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,320,000			\$ 1,501,067	\$ * 181,067	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$	Lancaster, LTD		\$ 52,737	\$ 52,737	15
16	V	21 Clerical Expenditures		Lancaster, LTD		240,116	240,116	16
17	V	27 Employee Benefits		Lancaster, LTD		42,517	42,517	17
18	V	24 Seminar and Travel		Lancaster, LTD		4,999	4,999	18
19	V	17 Administrative Consulting		Lancaster, LTD		279,066	279,066	19
20	V	43 Marketing Fees		Lancaster, LTD		177,762	177,762	20
21	V	20 Dues, Fees and Subscriptions		Lancaster, LTD		2,465	2,465	21
22	V	30 Depreciation		Lancaster, LTD		4,603	4,603	22
23	V	6 Repairs and Maintenance		Lancaster, LTD		169	169	23
24	V	27 Payroll Taxes		Lancaster, LTD		50,738	50,738	24
25	V	32 Interest		Lancaster, LTD		52,539	52,539	25
26	V	26 General Insurance		Lancaster, LTD		118	118	26
27	V	34 Rent		Lancaster, LTD		5,582	5,582	27
28	V							28
29	V	17 Christopher Vicere		Lancaster, LTD		75,000	75,000	29
30	V	27 Christopher Vicere-payroll tax		Lancaster, LTD		7,607	7,607	30
31	V	17 Management Fees	605,000	Lancaster, LTD			(605,000)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 605,000			\$ 996,019	\$ * 391,019	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Christopher Vicere	VP-Finance	Administrative	9.52%	See Attached	16	33.33%	Alloc. Salary	\$ 75,000	17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 75,000		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 Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Lancaster, Ltd.
 Street Address 5061 N Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 463-6247

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	3	\$ 225,000	\$ 225,000	16	\$ 75,000	1
2	27	Christopher Vicere-payroll tax	Hours Worked	24	3	11,411		16	7,607	2
3										3
4	19	Professional Services	Census Days	129,211	3	120,452		56,572	52,737	4
5	21	Clerical Expenditures	Census Days	129,211	3	548,427	461,915	56,572	240,116	5
6	27	Employee Benefits	Census Days	129,211	3	97,109		56,572	42,517	6
7	24	Seminar and Travel	Census Days	129,211	3	11,417		56,572	4,999	7
8	17	Administrative Consulting	Census Days	129,211	3	637,389	637,389	56,572	279,066	8
9	43	Marketing Fees	Census Days	129,211	3	406,011	404,782	56,572	177,762	9
10	20	Dues, Fees and Subscriptions	Census Days	129,211	3	5,631		56,572	2,465	10
11	30	Depreciation	Census Days	129,211	3	10,514		56,572	4,603	11
12	6	Repairs and Maintenance	Census Days	129,211	3	385		56,572	169	12
13	27	Payroll Taxes	Census Days	129,211	3	115,886		56,572	50,738	13
14	32	Interest	Census Days	129,211	3	120,000		56,572	52,539	14
15	26	General Insurance	Census Days	129,211	3	270		56,572	118	15
16	34	Rent	Census Days	129,211	3	12,750		56,572	5,582	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,322,652	\$ 1,729,086		\$ 996,019	25

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending: 12/31/18

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

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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

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Name of Related Organization _____

Street Address _____

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Facility Name & ID Number

Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Harston Investment		X	Long Term Loan			\$	\$ 11,500,000			\$	862,500						
2																		
3																		
4																		
5																		
Working Capital																		
6	Shareholder Loan	X						5,650,000										
7	Lancaster	X						1,000,000				219,126						
8	Allocated from Lancaster LTD		X									52,539						
9	TOTAL Facility Related						\$	\$ 18,150,000			\$	1,134,165						
B. Non-Facility Related*																		
10	Interest Income		X									(2,878)						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(2,878)						
15	TOTALS (line 9+line14)						\$	\$ 18,150,000			\$	1,131,287						

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.)

** 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 **Fairmont Care Center**

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	380,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	395,882	2
3. Under or (over) accrual (line 2 minus line 1).		\$	15,882	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	420,000	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.		\$	435,882	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>267,897</u>	8
	2014	<u>273,298</u>	9
	2015	<u>337,054</u>	10
	2016	<u>368,352</u>	11
	2017	<u>395,882</u>	12

2018 Accrual: \$395,882 x 1.06 = \$420,000 (Rounded)

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$		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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0040493
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>13-11-300-009-0000</u>	<u>Long Term Care Facility</u>	\$ <u>395,882.06</u>	\$ <u>395,882.06</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>395,882.06</u>	\$ <u>395,882.06</u>

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0040493
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
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 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1995</u>	\$ <u>685,000</u>	1
2	<u>Additions</u>		<u>2007</u>	<u>46,500</u>	2
3	TOTALS			\$ 731,500	3

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
186	1995	1951	\$ 2,240,980	\$ 597,552	35	\$ 64,028	\$ (533,524)	\$ 1,358,567	4
	2007	2007	(60,256)						5
									6
									7
									8
Improvement Type**									
Various		1995	5,144		20	130	130	3,091	9
Various		1996	2,136		20	55	55	1,223	10
Various		1997	1,504,119		20	1,759	1,759	1,340,049	11
Various		1998	16,813		20	431	431	8,890	12
Various		1999	2,430,399		20	1,114	1,114	2,271,923	13
Various		2001	28,439		20	729	729	12,670	14
Various		2002	31,500		20			31,500	15
Various		2007	275,974		20	16,473	16,473	262,905	16
Various		2008	424,608		20	47,494	47,494	417,903	17
Various		2009	111,307		20	10,838	10,838	104,879	18
Various		2010	219,286		20	26,180	26,180	189,968	19
Various		2011	84,800		20	8,366	8,366	65,938	20
Various		2012	34,866		20	6,091	6,091	31,587	21
Various		2013	12,396		20	1,900	1,900	10,080	22
Various		2014	3,342,223		20	373,055	373,055	1,551,105	23
									24
									25
									26
									27
									28
									29
									30
									31
									32
									33
									34
									35
									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 Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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		637,188			31,859	31,859	72,857	67
68								68
69			22,781			(22,781)		69
70		\$ 11,341,922	\$ 620,333		\$ 590,502	\$ (29,831)	\$ 7,735,135	70

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,341,922	\$ 620,333		\$ 590,502	\$ (29,831)	\$ 7,735,135	1
2	A/C Units	2015	3,695		20	185	185	677	2
3	Shower Spa	2015	9,507		20	475	475	1,822	3
4	Replaced Zone Valves	2015	6,170		20	309	309	1,208	4
5	Rebuild Hot Water Pump	2015	3,868		20	193	193	757	5
6	Rtu Zone System & Dampers	2015	15,000		20	750	750	2,938	6
7	Replaced Hot Water Boilers	2015	9,853		20	493	493	1,888	7
8	Kitchen Doors & Frames	2015	3,018		20	151	151	566	8
9	A/C Repairs	2015	7,334		20	367	367	1,314	9
10	Sewer Repairs	2015	2,991		20	150	150	511	10
11	Replaced A/C Systems	2015	3,300		20	165	165	578	11
12	Replaced A/C Systems	2015	6,600		20	330	330	1,128	12
13	Replaced A/C Systems	2015	2,900		20	145	145	495	13
14	Replaced A/C Systems	2015	2,683		20	134	134	458	14
15	Chiller Repairs	2015	4,768		20	238	238	854	15
16	Chiller Repairs	2015	2,606		20	130	130	434	16
17	13 Room Alert Door Controllers	2016	44,105		20	2,205	2,205	5,329	17
18	Repaired Heating System - Piping & Materials	2016	4,541		20	227	227	662	18
19	Repair Kitchen Exhaust Fan/Removed Light Fixtures & Ceiling T	2016	4,457		20	223	223	631	19
20	Repaired Piping & Transformer In Air Handler	2016	2,844		20	142	142	367	20
21	Installed 2 5 Ton Split Systems For 1St & 2Nd Floors	2016	21,777		20	1,089	1,089	2,813	21
22	Repaired Pump Chiller	2016	2,801		20	140	140	338	22
23	Resident Rms - Reapir Control Boards/Pump/Circuit Board/Pipin	2016	7,332		20	367	367	855	23
24	Repaired Walk-In Freezer	2016	2,650		20	133	133	287	24
25	Repaired Rooftop Heating Unit	2017	2,631		20	132	132	263	25
26	Repaired Walk-In Freezer In Kitchen	2017	2,909		20	145	145	291	26
27	Repaired Water Heatr Pump - 3Rd Floor	2017	2,999		20	150	150	275	27
28	Replaced Compressor	2017	2,832		20	142	142	201	28
29	Repaired Shower Valves/Installed Panels On Walls-Rm 703	2017	3,877		20	194	194	242	29
30	Repaired Pumps In Laundry Room	2017	2,527		20	126	126	147	30
31	Repaired Hot Water Heater	2017	4,042		20	202	202	236	31
32	Installed Fire Alarms	2017	6,042		20	302	302	378	32
33	Repaired Wiring For Smoke Detectors-Rm 126	2017	2,506		20	125	125	198	33
34	TOTAL (lines 1 thru 33)		\$ 11,547,087	\$ 620,333		\$ 600,761	\$ (19,572)	\$ 7,764,276	34

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 11,547,087	\$ 620,333		\$ 600,761	\$ (19,572)	\$ 7,764,276		1
2	Roof Replacement	2018 54,675		20	1,139	1,139	1,139		2
3	Office Hvac	2018 29,766		20	992	992	992		3
4	20 Ton Roof Chiller	2018 46,998		20	1,371	1,371	1,371		4
5	Furnace Installation	2018 3,850		20	193	193	193		5
6	Conduit, Wiring, Breake Installation - Infrared Heater	2018 5,437		20	272	272	272		6
7	Network Upgrade - Analog Gateways, Phone System Upgrade, Da	2018 19,331		20	967	967	967		7
8	Walk In Freezer Condenser Repair	2018 3,085		20	154	154	154		8
9	Kitchen Leak Repair - 2" Pipe And Fittings	2018 3,519		20	176	176	176		9
10	Rooftop Unit Hvac - Motor Repair	2018 3,270		20	164	164	164		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)	\$ 11,717,019	\$ 620,333		\$ 606,188	\$ (14,145)	\$ 7,769,703		34

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,717,019	\$ 620,333		\$ 606,188	\$ (14,145)	\$ 7,769,703	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,717,019	\$ 620,333		\$ 606,188	\$ (14,145)	\$ 7,769,703	34

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,717,019	\$ 620,333		\$ 606,188	\$ (14,145)	\$ 7,769,703	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,717,019	\$ 620,333		\$ 606,188	\$ (14,145)	\$ 7,769,703	34

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	16 Motorized Zone Dampers in 16 Rooms	2015	15,000		20	750	750	3,000	9
10	22 Exhaust Fans in Roof with Curb Adapters	2015	71,000		20	3,550	3,550	14,200	10
11	Nurse Call Panels	2015	4,400		20	220	220	880	11
12	Installed Handrails in Corridors	2016	7,123		20	356	356	1,068	12
13	Installed copper drains/countertop/faucet/repared walls/paint	2016	7,500		20	375	375	1,125	13
14	Installed Flooring for Resident Rooms	2016	4,548		20	227	227	682	14
15	Installed Handrails in Hallways	2016	11,900		20	595	595	1,785	15
16	Installed door entries and magnetic locks	2016	6,300		20	315	315	945	16
17	Hallway - ceiling/tile/trim/crown moulding/vinyl flooring	2017	266,487		20	13,324	13,324	26,649	17
18	Repaired 2 nurse stations and new vinly flooring	2017	75,600		20	3,780	3,780	7,560	18
19	Repaired elevators	2017	113,780		20	5,689	5,689	11,378	19
20	Flooring in employee area/nurse station pumper/fireplace	2017	3,000		20	150	150	300	20
21	Repaired elevators - carpentry/drywall/conduit/wiring	2017	9,500		20	475	475	950	21
22	Installed electrical work for elevator fire alarms/generator room	2017	5,650		20	283	283	565	22
23	Nurse Call System	2018	35,400		20	1,770	1,770	1,770	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)		\$ 637,188	\$		\$ 31,859	\$ 31,859	\$ 72,857	34

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

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 637,188	\$		\$ 31,859	\$ 31,859	\$ 72,857	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 637,188	\$		\$ 31,859	\$	\$ 72,857	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,294,805	\$ 4,603	\$ 136,638	\$ 132,035	10	\$ 804,531	71
72	Current Year Purchases	123,120		12,312	12,312	10	12,312	72
73	Fully Depreciated Assets	1,753,838				10	1,753,838	73
74								74
75	TOTALS	\$ 3,171,763	\$ 4,603	\$ 148,950	\$ 144,347		\$ 2,570,681	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)	\$ 15,620,282	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 624,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 755,138	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 130,202	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,340,384	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	<u>Allocated from Lancaster LTD</u>				<u>5,582</u>			5
6								6
7	TOTAL				\$ <u>5,582</u>			7

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12.	<u> </u> /2019	\$ <u> </u>
13.	<u> </u> /2020	\$ <u> </u>
14.	<u> </u> /2021	\$ <u> </u>

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5	5				
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 447,793	\$		\$ 447,793	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			190,790			190,790	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			686,978			686,978	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				557,728		557,728	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					45,734	82,028		127,762	13
14	TOTAL			\$		\$ 1,371,295	\$ 639,756		\$ 2,011,051	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.

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,100	\$ 1,100	1
2	Cash-Patient Deposits	81,164	81,164	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,615,518	5,615,518	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,840	77,840	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	64,487	64,487	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,840,109	\$ 5,840,109	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		805,500	13
14	Buildings, at Historical Cost		2,180,724	14
15	Leasehold Improvements, at Historical Cost	1,079,722	9,410,596	15
16	Equipment, at Historical Cost	1,873,506	2,365,204	16
17	Accumulated Depreciation (book methods)	(2,645,570)	(8,809,210)	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)	\$ 307,658	\$ 5,952,814	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,147,767	\$ 11,792,923	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 654,390	\$ 654,390	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,164	81,164	28
29	Short-Term Notes Payable	6,650,000	6,650,000	29
30	Accrued Salaries Payable	949,385	949,385	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,681	29,681	31
32	Accrued Real Estate Taxes(Sch.IX-B)	420,000	420,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	4,384,924	3,989,224	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,169,544	\$ 12,773,844	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>		10,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,510,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,169,544	\$ 24,283,844	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,021,777)	\$ (12,490,921)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,147,767	\$ 11,792,923	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,391,116)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,391,114)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(630,663)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (630,663)	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)	\$ (7,021,777)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning: 01/01/18

Ending: 12/31/18

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,808,861	1
2	Discounts and Allowances for all Levels	(4,765,559)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,043,302	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,288,569	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,288,569	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	541,092	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,320	19
20	Radiology and X-Ray	19,846	20
21	Other Medical Services	35,991	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 612,249	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,878	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,878	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	38,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,985,398	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,858,097	31
32	Health Care	6,162,881	32
33	General Administration	3,193,315	33
B. Capital Expense			
34	Ownership	1,997,789	34
C. Ancillary Expense			
35	Special Cost Centers	2,011,051	35
36	Provider Participation Fee	392,928	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,616,061	40
41	Income before Income Taxes (line 30 minus line 40)**	(630,663)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (630,663)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,543,847	44
45	Private Pay - Net Inpatient Revenue	1,410,291	45
46	Medicare - Net Inpatient Revenue	1,731,785	46
47	Other-(specify) <u>Insurance/Pend</u>	1,357,379	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,043,302	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,043	2,222	\$ 122,085	\$ 54.94	1
2	Assistant Director of Nursing	1,950	2,175	88,580	40.73	2
3	Registered Nurses	51,815	58,677	1,892,761	32.26	3
4	Licensed Practical Nurses	36,735	40,327	1,129,218	28.00	4
5	CNAs & Orderlies	97,892	107,772	1,548,992	14.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,071	15,458	246,387	15.94	8
9	Activity Director	1,974	2,346	37,181	15.85	9
10	Activity Assistants	9,211	10,183	135,241	13.28	10
11	Social Service Workers	5,639	6,058	123,123	20.32	11
12	Dietician					12
13	Food Service Supervisor	1,961	2,126	50,663	23.83	13
14	Head Cook	34,297	38,707	538,478	13.91	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,121	4,221	84,355	19.98	17
18	Housekeepers	34,253	37,840	496,167	13.11	18
19	Laundry	3,875	4,427	60,627	13.69	19
20	Administrator	2,041	2,886	185,366	64.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,366	12,211	228,642	18.72	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	1,989	2,126	48,590	22.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	314,233	349,762	\$ 7,016,456 *	\$ 20.06	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	863	\$ 24,633	01-03	35
36	Medical Director	3,066	116,534	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	50	10-03	38
39	Pharmacist Consultant	745	17,865	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	Monthly	4,928	11-03	44
45	Social Service Consultant	205	4,794	12-03	45
46	Other(specify) <u>Medical Librarian</u>	Monthly	4,800	09-03	46
47	<u>Telemedicine Physician</u>	Per Visit	2,250	10-03	47
48					48
49	TOTAL (lines 35 - 48)	4,879	\$ 175,854		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	375	9,367	10-03	52
53	TOTAL (lines 50 - 52)	375	\$ 9,367		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount	
Safet Keljalic	Administrator	0	\$ 149,505	Workers' Compensation Insurance	\$ 75,160	IDPH License Fee	\$ 3,980		
Joanne Ventrella	Administrator	0	29,930	Unemployment Compensation Insurance	38,213	Advertising: Employee Recruitment	17,019		
Cecilia Ancona	Administrator	0	5,932	FICA Taxes	529,695	Health Care Worker Background Check (Indicate # of checks performed <u>61</u>)	2,320		
				Employee Health Insurance	287,161	Patient Background Checks	411	4,110	
				Employee Meals		Dues and Subscriptions	924		
				Illinois Municipal Retirement Fund (IMRF)*		License and Permits	5,843		
				Employee Physical	8,874	Allocated from Lancaster LTD	2,465		
				401K Contribution	31,504				
				Union Pension Plan	45,839				
				Other Employee Benefits	32,318				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 185,367						
B. Administrative - Other									
Description			Amount						
Management Fees - Lancaster LTD			\$ 605,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 605,000						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal		\$ 14,049			\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Tax Consult		1,110						
Achieve Accreditation LLC	Accreditation Services		2,310						
Marcum LLP	Accounting		5,848				In-State Travel		
Richard Peelo and Associates	Accounting		2,250						
Matrixcare	Data Processing		37,882						
Health Data Systems	Data Processing		10,984				Seminar Expense	4,556	
E-Health Solutions	Data Processing		11,957				Allocated from Lancaster LTD	4,999	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 86,390	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairmont Care Center

0040493

Report Period Beginning:

01/01/18

Ending:

12/31/18

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? 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. \$ #REF! Line 10-02
- (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. \$ 392,928
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No 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) 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.