

Facility Name & ID Number Fairview Care Center of Joliet

0048983 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,315</u>	<u>2,321</u>	<u>12,542</u>	<u>45,178</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,315</u>	<u>2,321</u>	<u>12,542</u>	<u>45,178</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.97%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 01/01/2007

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 203 and days of care provided 7,420

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	223,093	28,011	15,847	266,951		266,951	(15,098)	251,854		1
2	Food Purchase		211,558		211,558		211,558	(109)	211,449		2
3	Housekeeping	197,624	20,890		218,514		218,514		218,514		3
4	Laundry	55,598	14,399		69,997		69,997		69,997		4
5	Heat and Other Utilities			161,265	161,265		161,265	996	162,261		5
6	Maintenance	101,001		126,704	227,705		227,705	29,770	257,475		6
7	Other (specify):*							3,901	3,901		7
8	TOTAL General Services	577,316	274,858	303,816	1,155,990		1,155,990	19,461	1,175,451		8
	B. Health Care and Programs										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	1,881,003	167,252	33,880	2,082,135		2,082,135	17,787	2,099,922		10
10a	Therapy	6,114	83		6,197		6,197		6,197		10a
11	Activities	111,452	9,256	1,856	122,564		122,564		122,564		11
12	Social Services	78,071		5,262	83,333		83,333	4,556	87,889		12
13	CNA Training										13
14	Program Transportation							2,660	2,660		14
15	Other (specify):*							13,098	13,098		15
16	TOTAL Health Care and Programs	2,076,640	176,591	77,998	2,331,229		2,331,229	38,101	2,369,330		16
	C. General Administration										
17	Administrative	133,253		53,200	186,453		186,453	17,335	203,788		17
18	Directors Fees										18
19	Professional Services			268,428	268,428		268,428	(159,263)	109,166		19
20	Dues, Fees, Subscriptions & Promotions			51,147	51,147		51,147	(13,748)	37,399		20
21	Clerical & General Office Expenses	120,216	2,117	480,390	602,723		602,723	(346,595)	256,128		21
22	Employee Benefits & Payroll Taxes			517,650	517,650		517,650		517,650		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,405	3,405		3,405	1,640	5,045		24
25	Other Admin. Staff Transportation			8,894	8,894		8,894	943	9,837		25
26	Insurance-Prop.Liab.Malpractice			186,743	186,743		186,743	878	187,621		26
27	Other (specify):*							24,244	24,244		27
28	TOTAL General Administration	253,469	2,117	1,569,857	1,825,443		1,825,443	(474,566)	1,350,877		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,907,425	453,566	1,951,671	5,312,662		5,312,662	(417,005)	4,895,657		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Fairview Care Center of Joliet

#0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			105,307	105,307		105,307	(8,201)	97,106			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,329	57,329		57,329	(147)	57,182			32
33	Real Estate Taxes			101,278	101,278		101,278		101,278			33
34	Rent-Facility & Grounds			868,764	868,764		868,764	7,562	876,326			34
35	Rent-Equipment & Vehicles			9,481	9,481		9,481	9,962	19,443			35
36	Other (specify):*											36
37	TOTAL Ownership			1,142,159	1,142,159		1,142,159	9,176	1,151,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		355,822	706,259	1,062,081		1,062,081		1,062,081			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*	88,821			88,821		88,821	(88,821)	(0)			43
44	TOTAL Special Cost Centers	88,821	355,822	817,402	1,262,045		1,262,045	(88,821)	1,173,224			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,996,246	809,388	3,911,232	7,716,866		7,716,866	(496,650)	7,220,216			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,164)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,895)	30		9
10	Interest and Other Investment Income	(221)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,866)	21		18
19	Entertainment	(1,602)	21		19
20	Contributions	(6,958)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(196,676)	21		24
25	Fund Raising, Advertising and Promotional	(3,447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,399)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(327,013)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (557,349)		\$	30

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	2	
		Amount	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)	60,699		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 60,699		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (496,650)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview Care Center of Joliet

ID# 0048983

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veteran Expense	\$ (21,658)	10	1
2	Other Income	(98)	21	2
3	Bank Charges	(330)	21	3
4	Vending Income	(2,400)	21	4
5	COPE Dues	(6,428)	20	5
6	Non-Allowable Expense	(216,000)	21	6
7	Marketing Wage	(21,648)	43	7
8	Non-Allowable Professional	(3,650)	19	8
9	Non-Allowable Legal	(2,687)	19	9
10	Capitalized R&M	(19,705)	06	10
11	Additional R&M	36,729	06	11
12	Non-Allowable Travel	(500)	25	12
13	Theft & Loss	(465)	21	13
14	Non-Allowable Office Expense	(1,000)	21	14
15	Advertising & Promotion Payroll	(67,173)	43	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	(327,013)		49

Fairview Care Center of Joliet

ID# 0048983

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

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				(15,098)								(15,098)	1
2	Food Purchase	(109)											(109)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			996									996	5
6	Maintenance	9,860		6,748	13,162								29,770	6
7	Other (specify):*			1,720	2,181								3,901	7
8	TOTAL General Services	9,751		9,464	246								19,461	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(21,658)			39,445								17,787	10
10a	Therapy													10a
11	Activities													11
12	Social Services				4,556								4,556	12
13	CNA Training													13
14	Program Transportation				2,660								2,660	14
15	Other (specify):*				13,098								13,098	15
16	TOTAL Health Care and Programs	(21,658)			59,759								38,101	16
	C. General Administration													
17	Administrative			8,416	8,919								17,335	17
18	Directors Fees													18
19	Professional Services	(6,337)		(135,614)	(17,312)								(159,263)	19
20	Fees, Subscriptions & Promotions	(16,833)		359	2,726								(13,748)	20
21	Clerical & General Office Expenses	(422,836)		79,570	(3,329)								(346,595)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			702	938								1,640	24
25	Other Admin. Staff Transportation	(500)		1,211	232								943	25
26	Insurance-Prop.Liab.Malpractice			878									878	26
27	Other (specify):*			20,504	3,740								24,244	27
28	TOTAL General Administration	(446,506)		(23,974)	(4,086)								(474,566)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(458,412)		(14,510)	55,918								(417,005)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(9,895)		1,616	77								(8,201)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(221)		74									(147)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			7,562									7,562	34
35	Rent-Equipment & Vehicles			1,573	8,389								9,962	35
36	Other (specify):*													36
37	TOTAL Ownership	(10,116)		10,825	8,466								9,176	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):*	(88,821)											(88,821)	43
44	TOTAL Special Cost Centers	(88,821)											(88,821)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(557,349)		(3,685)	64,384								(496,650)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 996	\$	996	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	6,748		6,748	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	1,720		1,720	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	8,589		8,589	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	9,827		9,827	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	5,605		5,605	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	359		359	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	79,570		79,570	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	702		702	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,211		1,211	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	878		878	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	20,504		20,504	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,616		1,616	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	74		74	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	7,562		7,562	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,220		1,220	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	353		353	31
32	V								32
33	V	19 BOOKKEEPING FEES	111,219	YAM MANAGEMENT, LLC	100.00%			(111,219)	33
34	V	19 ACCOUNTING	30,000	YAM MANAGEMENT, LLC	100.00%			(30,000)	34
35	V	17 MANAGEMENT FEES	10,000	YAM MANAGEMENT, LLC	100.00%			(10,000)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 151,219			\$ 147,534	\$ *	(3,685)	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	6 DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 13,162	\$	13,162	15
16	V	7 EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	2,181		2,181	16
17	V	10 NURSING SALARY		YAM CONSULTING, LLC	100.00%	71,195		71,195	17
18	V	12 SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	8,516		8,516	18
19	V	14 PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	2,660		2,660	19
20	V	15 EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	13,098		13,098	20
21	V	17 ADMIN. - NON RELETED		YAM CONSULTING, LLC	100.00%	10,119		10,119	21
22	V	19 PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	964		964	22
23	V	20 FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	2,726		2,726	23
24	V	21 CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	14,071		14,071	24
25	V	24 SEMINARS		YAM CONSULTING, LLC	100.00%	938		938	25
26	V	25 AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	232		232	26
27	V	27 EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,740		3,740	27
28	V	30 DEPRECIATION		YAM CONSULTING, LLC	100.00%	77		77	28
29	V	35 AUTO RENTAL		YAM CONSULTING, LLC	100.00%	8,389		8,389	29
30	V								30
31	V								31
32	V	12 SOCIAL WORK	3,960					(3,960)	32
33	V	01 DIETARY CONSULTING	15,098					(15,098)	33
34	V	10 RN CONSULTING	31,750					(31,750)	34
35	V	17 DIR. OF OPERATIONS CONSULT	1,200					(1,200)	35
36	V	19 DATA PROCESSING FEES	18,276					(18,276)	36
37	V	21 MARKETING	17,400					(17,400)	37
38	V								38
39	Total		\$ 87,684			\$ 152,067	\$ *	64,384	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Yosef Meystel	Owner	Administrative	54.65%	See Attached	5.70	14.25%	Mgmt Fees	\$ 42,000	17-3	1
2	Jay Meystel	Owner	Administrative	2.00%	See Attached	2.90	7.25%	Salary Alloc.	5,280	17-7	2
3	Joel Meystel	Owner	Administrative	1.00%	See Attached	2.90	14.50%	Salary Alloc.	3,310	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 50,590		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

YAM MANAGEMENT, LLC

Street Address

3501 W. HOWARD STREET

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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	5	UTILITIES	AVAIL. BED DAYS	516,637	12	\$ 6,943	\$ 74,095	\$ 996	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	516,637	12	47,049	41,077	74,095	6,748	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	516,637	12	11,995		74,095	1,720	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	516,637	12	59,890	59,890	74,095	8,589	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	516,637	12	68,520	68,520	74,095	9,827	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	39,084		74,095	5,605	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	2,504		74,095	359	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	554,814	499,630	74,095	79,570	8
9	24	SEMINARS	AVAIL. BED DAYS	516,637	12	4,893		74,095	702	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	8,444		74,095	1,211	10
11	26	INSURANCE	AVAIL. BED DAYS	516,637	12	6,121		74,095	878	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	142,965		74,095	20,504	12
13	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	11,270		74,095	1,616	13
14	32	INTEREST	AVAIL. BED DAYS	516,637	12	513		74,095	74	14
15	34	RENT	AVAIL. BED DAYS	516,637	12	52,725		74,095	7,562	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	8,509		74,095	1,220	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	516,637	12	2,458		74,095	353	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,028,697	\$ 669,116	\$ 147,534		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 YAM CONSULTING, LLC
 Street Address 3501 W. HOWARD STREET
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

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	6	DIETARY	AVAIL. BED DAYS	516,637	12	\$ 91,773	\$ 89,792	74,095	\$ 13,162	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	516,637	12	15,208		74,095	2,181	2
3	10	NURSING SALARY	AVAIL. BED DAYS	516,637	12	496,414	496,414	74,095	71,195	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	516,637	12	59,382	59,382	74,095	8,516	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	516,637	12	18,550		74,095	2,660	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	516,637	12	91,325		74,095	13,098	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	516,637	12	70,560	70,560	74,095	10,119	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	6,724		74,095	964	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	19,007		74,095	2,726	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	98,110	79,705	74,095	14,071	10
11	24	SEMINARS	AVAIL. BED DAYS	516,637	12	6,543		74,095	938	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	1,616		74,095	232	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	26,075		74,095	3,740	13
14	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	539		74,095	77	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	58,491		74,095	8,389	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,060,316	\$ 795,852		\$ 152,067	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	The Private Bank		X	Line of Credit			\$	\$ 771,473	03/06/09	0.0325	\$ 48,989	1							
2	The Private Bank		X	Improvements				193,750	06/01/10	0.0375	8,340	2							
3												3							
4												4							
5	See Supplemental Schedule											5							
Working Capital																			
6	Allocated from YAM Mgmt.		X								74	6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$ 965,223			\$ 57,403	9							
B. Non-Facility Related*																			
10	Interest Income		X								(221)	10							
11												11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ (221)	14							
15	TOTALS (line 9+line14)						\$	\$ 965,223			\$ 57,182	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet # 0048983 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

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

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

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

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Building Company (Pages 12F & 12G)							67	
68	Related Party Allocations (Pages 12H & 12I)		4,212	45	276	231	550	68	
69	Financial Statement Depreciation			105,307		(105,307)		69	
70	TOTAL (lines 4 thru 69)	\$	4,212	\$ 105,352		\$ 276	\$ (105,076)	\$ 550	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 4,212	\$ 105,352		\$ 276	\$ (105,076)	\$ 550	1
2	Long Elevator & Machine Co Inv #10110049 - Replaced Existing S	2007	2,960		20	148	148	382	2
3	Econocare - 1St Floor Dining Room	2007	16,550		20	1,103	1,103	2,666	3
4	Econocare - 1St Floor Dining Room	2007	10,009		20			10,009	4
5	Seco Refrigeration Inv.. 4769-146 - Install New Unit 1St Floor Lob	2007	16,985		20	1,415	1,415	3,185	5
6	Seco Refrigeration	2007	8,796		20	733	733	1,588	6
7	Atlas Construction - 2Nd Floor Oxygen Room	2007	3,590		20	239	239	509	7
8	Bailey'S Carpet	2007	2,945		20	421	421	912	8
9	Seco Refrigeration Inv. 3610-150 - Boiler Section Replacement	2007	7,319		20	610	610	1,322	9
10	On-Line Communications #8319 - Nurse Call System 1St Floor &	2008	7,394		20	493	493	945	10
11	Judicial Receivers Corp. #111841 - Rehab 1St Floor Shower Room	2008	16,985		20	1,699	1,699	3,397	11
12	Judicial Receivers Corp #111842 - Rehab 1St Floor Men'S Visitor	2008	4,067		20	407	407	813	12
13	Judicial Receivers Corp #111843 - Rehab 1St Floor Women'S Visi	2008	3,824		20	382	382	765	13
14	Champion Roofing #15723	2008	77,806		20	7,781	7,781	13,616	14
15	Econocare #3220 - Kitchen Tiles	2008	15,027		20	751	751	1,190	15
16	Dgtell New Data Cables	2008	2,600		20	260	260	390	16
17	Champion Roofing #16326	2008	36,250		20	3,625	3,625	5,438	17
18	Fox Valley Sprinkler System	2008	12,240		20	1,224	1,224	1,734	18
19	Sendra Service - 4' Gate Valve	2008	3,385		20	339	339	451	19
20	Lozano Electric	2008	3,675		20	368	368	490	20
21	Lozano Electric	2008	12,000		20	1,200	1,200	1,800	21
22	Champion Roofing #16017	2008	36,250		20	3,625	3,625	5,438	22
23	Econocare Resident Room Improvements - Flooring, Light Fixtur	2008	40,921		20	4,092	4,092	4,774	23
24	Econocare Lobby Improvements - Flooring, Window Treatments	2008	8,530		20	853	853	995	24
25	Nico Plumbing 4" Lining Kitchen Piping	2008	26,400		20	2,640	2,640	2,860	25
26	Nico Plumbing - Kitchen Improvements	2009	3,652		20	335	335	335	26
27	On-Line Communications - Nurse Call	2009	11,629		20	1,171	1,171	1,171	27
28	Econocare - Double Doors And Wall	2009	7,204		20	375	375	375	28
29	Econocare - Elevator	2009	10,013		20	250	250	250	29
30	Econocare - Tiles & Other Improvements	2009	16,718		20	967	967	967	30
31	Champion - Coping Metal & A/C Ducts	2009	17,300		20	1,009	1,009	1,009	31
32	Nico Plumbing - Insulated Water Valves	2009	3,550		20	207	207	207	32
33	Seco Refrigeration - 3 Roof Top Units	2009	18,800		20	1,097	1,097	1,097	33
34	TOTAL (lines 1 thru 33)		\$ 469,586	\$ 105,352		\$ 40,095	\$ (65,257)	\$ 71,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 469,586	\$ 105,352		\$ 40,095	\$ (65,257)	\$ 71,630	1
2	Econocare - Nurses Stations & Other	2009	24,866		20	1,141	1,141	1,141	2
3	Power Transformer	2009	4,786		20	479	479	479	3
4	Electrical Improvements - Tie Ins & Runs For Lighting	2009	90,000		20	4,500	4,500	4,500	4
5	Water Supply Repair Band	2009	2,714		20	136	136	136	5
6	Dialysis Rm Project - Moshe Calamaro Architect Fees	2009	3,490		20	116	116	116	6
7	Dialysis Rm Project - City Of Joliet Building Permits	2009	3,873		20	129	129	129	7
8	Seco Walk-In Freezer Door	2009	2,936		20	73	73	73	8
9	Econocare Wallcovering, Handrails, Bumpers	2009	59,176		20	1,433	1,433	1,433	9
10	Rjv Woods Remodeling-Carpentry, Electric, Flooring, Demo, Dry	2009	50,020		20	804	804	804	10
11	Peter Pro Floor Hardwood Flooring	2009	4,800		20	80	80	80	11
12	Peter Pro Floor Hardwood Flooring	2009	4,800		20	80	80	80	12
13	Performance Blend Valve	2009	21,225		20	66	66	66	13
14	Hvac Buildout For Dialysis Room	2009	14,250		20	356	356	356	14
15	Pph Co Plumbing Improvements	2009	43,891		20	1,097	1,097	1,097	15
16	Painting Soffit	2009	10,000		20	500	500	500	16
17	Elevator Renovation	2009	3,955		20	198	198	198	17
18	Sprinkler Repair	2009	5,750		20	288	288	288	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)		\$ 820,117	\$ 105,352		\$ 51,570	\$ (53,782)	\$ 83,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 820,117	\$ 105,352		\$ 51,570	\$ (53,782)	\$ 83,105	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)		\$ 820,117	\$ 105,352		\$ 51,570	\$ (53,782)	\$ 83,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

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Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 820,117	\$ 105,352		\$ 51,570	\$ (53,782)	\$ 83,105	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)		\$ 820,117	\$ 105,352		\$ 51,570	\$ (53,782)	\$ 83,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2007	3,069	21	20	177	156	439	9
10	Allocated from YAM Management	2008	211	5	20	21	16	33	10
11	Allocated from YAM Management	2009	932	19	20	78	59	78	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 (12H & 12I lines 1 thru 33)	\$ 4,212	\$ 45		\$ 276	\$ 231	\$ 550	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 198,200	\$ 174	\$ 32,116	\$ 31,942	10	\$ 70,818	71
72	Current Year Purchases	116,949	821	12,556	11,735	10	12,556	72
73	Fully Depreciated Assets	993				10	993	73
74								74
75	TOTALS	\$ 316,142	\$ 995	\$ 44,672	\$ 43,677		\$ 84,367	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocatd from YAM Management	2009	\$ 3,389	\$ 654	\$ 864	\$ 210	5	\$ 1,373	76
77										77
78										78
79										79
80	TOTALS			\$ 3,389	\$ 654	\$ 864	\$ 210		\$ 1,373	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)	\$ 1,139,648	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,001	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,106	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,895)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 168,845	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: _____

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:				\$ <u>868,764</u>			3
4	Additions							4
5	<u>Alloc. From YAM Management</u>				<u>7,562</u>			5
6								6
7	TOTAL				\$ <u>876,326</u>			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: _____*

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: \$ 9,834 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc. From YAM Management</u>		\$ _____	\$ <u>1,220</u>	17
18	<u>Alloc. From YAM Consulting</u>			<u>8,389</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>9,609</u>	21

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 309,994	\$		\$ 309,994	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,727			56,727	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			311,937			311,937	4
5	Physician Care	39 - 03	visits			8,076			8,076	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				326,687		326,687	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					19,525	29,135		48,660	13
14	TOTAL			\$		\$ 706,259	\$ 355,822		\$ 1,062,081	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 237,103	\$	1
2	Cash-Patient Deposits	10,128		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,055,805		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,638		6
7	Other Prepaid Expenses	1,360		7
8	Accounts Receivable (owners or related parties)	119,800		8
9	Other(specify): See Attached Schedule	136,814		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,587,648	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	837,733		15
16	Equipment, at Historical Cost	333,120		16
17	Accumulated Depreciation (book methods)	(179,399)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	573,193		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,564,647	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,152,295	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 795,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,368		28
29	Short-Term Notes Payable	921,473		29
30	Accrued Salaries Payable	146,196		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,757		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	25,265		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,039,370	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	43,750		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 43,750	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,083,120	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,069,175	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,152,295	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 791,310	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 791,310	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	683,865	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	(406,000)	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)	\$ 277,865	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)	\$ 1,069,175	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,337,968	1
2	Discounts and Allowances for all Levels	(166,284)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,171,684	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,833,616	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,833,616	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	348,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,564	19
20	Radiology and X-Ray	9,543	20
21	Other Medical Services	364	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 391,810	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	221	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 221	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,400,731	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,155,990	31
32	Health Care	2,331,229	32
33	General Administration	1,825,443	33
B. Capital Expense			
34	Ownership	1,142,159	34
C. Ancillary Expense			
35	Special Cost Centers	1,150,902	35
36	Provider Participation Fee	111,143	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,716,866	40
41	Income before Income Taxes (line 30 minus line 40)**	683,865	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 683,865	43

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

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

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

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

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,973	2,131	\$ 100,328	\$ 47.08	1
2	Assistant Director of Nursing	1,513	1,668	63,137	37.85	2
3	Registered Nurses	10,081	10,612	325,838	30.70	3
4	Licensed Practical Nurses	21,928	23,361	589,883	25.25	4
5	CNAs & Orderlies	51,573	55,236	611,290	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	520	558	6,114	10.96	8
9	Activity Director	2,005	2,086	32,224	15.45	9
10	Activity Assistants	7,976	8,482	79,228	9.34	10
11	Social Service Workers	3,793	4,048	78,071	19.29	11
12	Dietician					12
13	Food Service Supervisor	1,978	2,086	44,111	21.15	13
14	Head Cook	5,712	6,120	74,799	12.22	14
15	Cook Helpers/Assistants	11,055	11,421	104,183	9.12	15
16	Dishwashers					16
17	Maintenance Workers	5,808	6,257	101,001	16.14	17
18	Housekeepers	17,240	18,703	197,624	10.57	18
19	Laundry	3,885	4,280	55,598	12.99	19
20	Administrator	2,548	2,694	133,253	49.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,815	8,499	120,216	14.14	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	6,757	7,296	190,527	26.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,849	3,051	88,821	29.11	33
34	TOTAL (lines 1 - 33)	167,009	178,589	\$ 2,996,246 *	\$ 16.78	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	288	\$ 15,847	01-03	35
36	Medical Director	Monthly	37,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	514	32,080	10-03	38
39	Pharmacist Consultant	Monthly	1,800	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	36	1,856	11-03	44
45	Social Service Consultant	96	5,262	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	934	\$ 93,845		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			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Care Center of Joliet

0048983

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$15,854.3 IAHC \$2,436
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,441 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 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,143
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.