

		FOR BHF USE					

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 Centre</u></p> <p>Address: <u>5061 N Pulaski Road</u> <u>Chicago</u> <u>60630</u> <small>Number City Zip Code</small></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>11th May, 1995</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christopher Vicere</u> Telephone Number: <u>(773) 604-4416</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>1-Jan-2014</u> to <u>31-Dec-2014</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ <small>(Date)</small> <u>30th March, 2015</u> (Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Vice President - Finance</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ <small>(Date)</small> _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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) _____ <small>(Date)</small> <u>30th March, 2015</u> (Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Vice President - Finance</u>	Paid Preparer	(Signed) _____ <small>(Date)</small> _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ <small>(Date)</small> <u>30th March, 2015</u> (Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Vice President - Finance</u>							
Paid Preparer	(Signed) _____ <small>(Date)</small> _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Fairmont Care Centre

0040493 Report Period Beginning: 1-Jan-2014 Ending: 31-Dec-2014

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 10/3/14

	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	104	Skilled (SNF)	114	38,860	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	72	Intermediate/DD	72	26,280	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	186	65,140	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	2,842	44	6,670	9,556	8
9	SNF/PED					9
10	ICF	38,946	2,869	31	41,846	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,788	2,913	6,701	51,402	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.91%

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 11th May 1995

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11th May 1995 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 114 and days of care provided 6,252

Medicare Intermediary CGS Administrators, LLC.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 31st Dec 2014 Fiscal Year: 31st Dec 2014

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

Facility Name & ID Number

Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014

Ending:

31-Dec-2014

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	505,167	76,945	22,477	604,589		604,589	604,589			1
2	Food Purchase		441,071		441,071	(31,447)	409,624	(202)	409,422		2
3	Housekeeping	344,009	69,300		413,309		413,309	413,309			3
4	Laundry	54,486	22,693		77,179		77,179	77,179			4
5	Heat and Other Utilities			325,976	325,976		325,976	325,976			5
6	Maintenance	77,474	122,804	200,323	400,601		400,601	8,561	409,162		6
7	Other (specify):*										7
8	TOTAL General Services	981,136	732,813	548,776	2,262,725	(31,447)	2,231,278	8,359	2,239,637		8
	B. Health Care and Programs										
9	Medical Director			72,532	72,532		72,532	72,532			9
10	Nursing and Medical Records	4,104,140	326,924	18,054	4,449,118		4,449,118	4,449,118			10
10a	Therapy		44,837		44,837		44,837	44,837			10a
11	Activities	100,338	37,709	2,984	141,031		141,031	141,031			11
12	Social Services	101,653		1,426	103,079		103,079	103,079			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,306,131	409,470	94,996	4,810,597		4,810,597	4,810,597			16
	C. General Administration										
17	Administrative	82,400		742,720	825,120		825,120	(335,470)	489,650		17
18	Directors Fees										18
19	Professional Services			108,486	108,486		108,486	9,139	117,625		19
20	Dues, Fees, Subscriptions & Promotions			113,339	113,339		113,339	(70,614)	42,725		20
21	Clerical & General Office Expenses	168,540	56,073	308,335	532,948		532,948	(26,258)	506,690		21
22	Employee Benefits & Payroll Taxes			1,095,666	1,095,666	31,447	1,127,113	13,961	1,141,074		22
23	Inservice Training & Education			4,715	4,715		4,715	3,807	8,522		23
24	Travel and Seminar			2,897	2,897		2,897	16,904	19,801		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			410,631	410,631		410,631	620	411,251		26
27	Other (specify):* *Payroll Taxes (Sch VII)							55,325	55,325		27
28	TOTAL General Administration	250,940	56,073	2,786,789	3,093,802	31,447	3,125,249	(332,586)	2,792,663		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,538,207	1,198,356	3,430,561	10,167,124		10,167,124	(324,227)	9,842,897		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 Centre

#0040493

Report Period Beginning:

1-Jan-2014

Ending:

31-Dec-2014

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			188,200	188,200		188,200	211,411	399,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,102	2,102		2,102	666,260	668,362			32
33	Real Estate Taxes			250,897	250,897		250,897		250,897			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,320,000)				34
35	Rent-Equipment & Vehicles			21,540	21,540		21,540		21,540			35
36	Other (specify):*											36
37	TOTAL Ownership			1,782,739	1,782,739		1,782,739	(442,329)	1,340,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		331,349	705,930	1,037,279		1,037,279		1,037,279			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,710	97,710		97,710		97,710			42
43	Other (specify):* *Assessment Tax @\$6.07**			274,061	274,061		274,061		274,061			43
44	TOTAL Special Cost Centers		331,349	1,077,701	1,409,050		1,409,050		1,409,050			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,538,207	1,529,705	6,291,001	13,358,913		13,358,913	(766,556)	12,592,357			45

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

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,358,644)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	2		13
14	Non-Care Related Interest	(62,259)	32		14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,735)	24		19
20	Contributions	(250)	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	(225,379)	21		24
25	Fund Raising, Advertising and Promotional	(222,561)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,326)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule Page 5A	8,190	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,868,166)		\$	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)	1,101,610	6,6A&6B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,101,610		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (766,556)		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

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-2014

Ending: 31-Dec-2014

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Deferred Maintenance Cost (allocated for 2014)	\$ 8,190	6	1
2	As per Page 22			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				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		8,190	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014

Ending:

31-Dec-2014

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(202)	0	0	0	0	0	0	0	0	0	0	(202)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	8,190	371	0	0	0	0	0	0	0	0	0	8,561	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	7,988	371	0	0	0	0	0	0	0	0	0	8,359	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	273,914	(609,384)	0	0	0	0	0	0	0	0	(335,470)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,489	0	1,650	0	0	0	0	0	0	0	9,139	19
20	Fees, Subscriptions & Promotions	(222,811)	151,947	0	250	0	0	0	0	0	0	0	(70,614)	20
21	Clerical & General Office Expenses	(226,705)	199,121	0	1,326	0	0	0	0	0	0	0	(26,258)	21
22	Employee Benefits & Payroll Taxes	0	13,961	0	0	0	0	0	0	0	0	0	13,961	22
23	Inservice Training & Education	0	3,807	0	0	0	0	0	0	0	0	0	3,807	23
24	Travel and Seminar	(5,735)	22,639	0	0	0	0	0	0	0	0	0	16,904	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	620	0	0	0	0	0	0	0	0	0	620	26
27	Other (specify):*	0	48,265	7,060	0	0	0	0	0	0	0	0	55,325	27
28	TOTAL General Administration	(455,251)	721,763	(602,324)	3,226	0	(332,586)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(447,263)	722,134	(602,324)	3,226	0	(324,227)	29						

STATE OF ILLINOIS

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014 Ending:

Summary B

31-Dec-2014

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	(1,358,644)	4,946	0	1,565,109	0	0	0	0	0	0	0	211,411	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(62,259)	3,538	(3,029)	728,010	0	0	0	0	0	0	0	666,260	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(1,320,000)	0	0	0	0	0	0	0	(1,320,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,420,903)	8,484	(3,029)	973,119	0	(442,329)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,868,166)	730,618	(605,353)	976,345	0	0	0	0	0	0	0	(766,556)	45

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	19 Professional Services	\$	Lancaster, Ltd.		7,489	\$	7,489	1
2	V	21 Clerical Expenses		Lancaster, Ltd.		199,121		199,121	2
3	V	22 Employee Benefits		Lancaster, Ltd.		13,961		13,961	3
4	V	24 Seminars and Travel		Lancaster, Ltd.		22,639		22,639	4
5	V	17 Administrative Consulting		Lancaster, Ltd.		273,914		273,914	5
6	V	20 Marketing Fees		Lancaster, Ltd.		144,422		144,422	6
7	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.		7,525		7,525	7
8	V	30 Depreciation		Lancaster, Ltd.		4,946		4,946	8
9	V	6 Repairs and Maintenance		Lancaster, Ltd.		371		371	9
10	V	27 Payroll Taxes		Lancaster, Ltd.		48,265		48,265	10
11	V	32 Interest		Lancaster, Ltd.		3,538		3,538	11
12	V	23 Education and Inservice		Lancaster, Ltd.		3,807		3,807	12
13	V	26 Insurance		Lancaster, Ltd.		620		620	13
14	Total		\$			730,618	\$	* 730,618	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	17 Management Fee Income	\$ 742,720	Lancaster, Ltd.		\$	\$ (742,720)
16	V	17 Officers' Salaries		Lancaster, Ltd.		133,336	133,336
17	V	27 Payroll Taxes-Officers		Lancaster, Ltd.		7,060	7,060
18	V						
19	V						
20	V						
21	V	32 **Direct Interest**	3,029	Lancaster, Ltd.			(3,029)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 745,749			\$ 140,396	\$ * (605,353)

* 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	34 Rental	\$ 1,320,000	Fairmont Property LLC		\$ 728,010	\$ (1,320,000)
16	V	32 Interest		Fairmont Property LLC		728,010	728,010
17	V	30 Depreciation		Fairmont Property LLC		1,565,109	1,565,109
18	V	21 State Replacement Tax		Fairmont Property LLC		1,326	1,326
19	V	19 Professional Fees		Fairmont Property LLC		1,650	1,650
20	V	20 Licenses & Fees		Fairmont Property LLC		250	250
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,320,000			\$ 2,296,345	\$ * 976,345

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2014 Ending: 31-Dec-2014

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	9.50	see attached	16	33.33	Lancaster	\$ 66,668	17-7	1
2	Cheryl Morris	VP-Operations	Administrative	9.50	see attached	16	33.33	Lancaster	66,668	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 133,336		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 Centre

0040493 Report Period Beginning: 1-Jan-2014

Ending: -Dec-2014

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

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)478-1192

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

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	\$ 200,004	\$ 200,004	16	\$ 66,668	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	3	10,591		16	3,530	2
3	17	Cheryl Morris	Hours Worked	48	3	200,004	200,004	16	66,668	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	3	10,591		16	3,530	4
5										5
6										6
7	19	Professional Services	Census Days	127,934	3	18,639		51,402	7,489	7
8	21	Clerical Expenses	Census Days	127,934	3	495,590	454,928	51,402	199,121	8
9	22	Employee Benefits	Census Days	127,934	3	34,747		51,402	13,961	9
10	24	Seminars and Travel	Census Days	127,934	3	56,347		51,402	22,639	10
11	17	Administrative Consulting	Census Days	127,934	3	681,741	671,083	51,402	273,914	11
12	20	Marketing Fees	Census Days	127,934	3	359,450	340,978	51,402	144,422	12
13	20	Dues, Fees and Subscriptions	Census Days	127,934	3	18,729		51,402	7,525	13
14	30	Depreciation	Census Days	127,934	3	12,310		51,402	4,946	14
15	6	Repairs and Maintenance	Census Days	127,934	3	923		51,402	371	15
16	27	Payroll Taxes	Census Days	127,934	3	120,127		51,402	48,265	16
17	32	Interest	Census Days	127,934	3	8,805		51,402	3,538	17
18	23	Education and Inservice	Census Days	127,934	3	9,474		51,402	3,807	18
19	26	Insurance	Census Days	127,934	3	1,542		51,402	620	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,239,614	\$ 1,866,997		\$ 871,014	25

Facility Name & ID Number

Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014

Ending:

31-Dec-2014

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		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 Investments		X	Long Term Loan			\$	\$			\$ 727,083						
2																	
3																	
4																	
5																	
Working Capital																	
6	JP Morgan Chase Bank		X	Working Capital							3,538						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 730,621						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 730,621						

Set off Interest Income (62,259)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None

Line # N/A

668,362

Page 4 Line 32 col. 8

* 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.)

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 2013 report.		\$	289,000		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.)		\$	267,897		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(21,103)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	272,000		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.		\$	250,897		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>221,340</u>	8	FOR BHF USE ONLY	
	2010	<u>229,827</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$
	2011	<u>227,727</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2012	<u>263,357</u>	11	15	LESS REFUND FROM LINE 6 \$
	2013	<u>267,897</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
** Accrual is based on 2013 Taxes, adjusted for inflation**					

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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Care Facility		1995	\$ 685,000	1
2	Addition to Land - Reclaimed on Demolition		2007	46,500	2
3	TOTALS			\$ 731,500	3

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014 Ending: 31-Dec-2014

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	186	1995		\$ 2,240,980	\$ 512,637	27.6	\$ 55,916	\$ (456,721)	\$ 1,102,455	4
5		2007		(60,256)						5
6										6
7										7
8										8
Improvement Type**										
9	Canopy and Awning	1995		3,300	85	20	83	(2)	1,661	9
10	Intercom System	1995		1,844	47	20	47		910	10
11	Roof Exhausters	1996		2,136	1,183	20	55	(1,128)	1,003	11
12	Permanent Signage	1997		16,625	370	15	370		16,625	12
13	Fire Alarm	1997		68,600	1,759	20	1,759		30,269	13
14	Parking Lot Excavation	1997		45,000	1,005	15	1,005		45,000	14
15	Parking Lot Asphalt	1997		68,000	1,520	15	1,520		68,000	15
16	Concrete Curbs	1997		18,000	401	15	401		18,000	16
17	Phase I Expansion-Landscaping	1997		41,000	915	15	915		41,000	17
18	Site Sewer	1997		28,500	637	15	637		28,500	18
19	Phase I Expansion-Building	1997		1,218,394	178,628	20		(178,628)	1,085,619	19
20	Ceramic Tiled Hallway	1998		10,603	6,355	15	272	(6,083)	4,521	20
21	Electrical Enhancements	1998		6,210	3,723	15	159	(3,564)	2,645	21
22	Phase II-Landscape	1999		15,000	442	15	442		15,000	22
23	Site Sewer	1999		40,376	1,192	15	1,192		40,376	23
24	Fire Protection	1999		43,440	1,114	20	1,114		17,034	24
25	Excavation	1999		49,650	1,465	15	1,465		49,650	25
26	Phase II Expansion	1999		2,281,933	353,005	20		(353,005)	2,145,407	26
27	Electrical-Courtyard	2001		6,520	4,354	15	167	(4,187)	2,331	27
28	Building Roofing	2001		21,919	15,058	20	562	(14,496)	7,423	28
29	Garage Roofing	2001		7,500	5,152	20	192	(4,960)	2,539	29
30	Heating System	2001		17,965	461	15	461		6,086	30
31	Addition to Heating System	2002		8,561		20			8,560	31
32	Improvement to Heating System	2002		11,688		20			11,689	32
33	Parking Lot Expansion	2002		31,500	1,303	20		(1,303)	31,500	33
34	Garden Pond	2003		5,000	664	20	333	(331)	3,830	34
35	Installation of Boiler & Heating Pipes	2003		54,886	8,003	20	4,574	(3,429)	51,456	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014 Ending:

31-Dec-2014

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	
37	Fire rated Wooden Door	2006	\$ 1,440	\$ 1,174	15	\$ 144	\$ (1,030)	\$ 1,188	37
38	3rd floor Renovation Framework & ceiling	2007	11,500	9,473	20	1,150	(8,323)	9,104	38
39	3rd floor Renovation Electrical Installations	2007	3,000	2,471	20	300	(2,171)	2,375	39
40	3rd floor Renovation Carpeting	2007	2,500		20			2,500	40
41	Improvements to Dining Room	2007	97,863		20			97,863	41
42	Cabinets, Installation & Decorations for Dining Room	2007	97,862	10,419	20	9,786	(633)	74,211	42
43	Asphalt Coated Parking Lot	2007	61,905	3,652	20	4,127	475	32,328	43
44	Electrical Installations	2007	11,100		20	1,110	1,110	8,325	44
45	Town Square Construction - Interior & Exterior	2008	472,376	42,544	20	46,004	3,460	300,552	45
46	Corner Parking Lot Construction	2008	22,350	659	20	1,490	831	9,685	46
47	Electronic Telephone exchange	2008	21,165		10			21,165	47
48	Main Entrance Brickwork	2009	2,180	68	15	145	77	845	48
49	Building Roofing	2009	41,000	35,962	10	4,100	(31,862)	23,917	49
50	Condensing Unit	2009	16,882	433	10	1,688	1,255	9,988	50
51	Reconstruction of Resident Baths	2009	19,625	503	10	1,963	1,460	11,450	51
52	Stone/Brick Entrance Sign	2009	4,500	140	15	300	160	1,725	52
53	Concrete walkaway at Reception Exit	2009	4,300	134	15	287	153	1,530	53
54	Replace windows for 16 Resident Rooms	2009	25,000	22,356	10	2,500	(19,856)	12,917	54
55	Security Alarm System for Reception Area	2010	11,960	307	10	1,196	889	5,980	55
56	Digital Paging System	2010	4,940	279	5	988	709	4,364	56
57	High Wattage Berkay Heater	2010	7,325	188	10	733	545	3,542	57
58	Windows changed for whole facility	2010	94,900	6,630	10	9,490	2,860	39,542	58
59	Renovate 8 Resident Rooms-Tiles,Flooring,Ceiling,Lighting	2010	122,641	8,568	10	12,264	3,696	51,100	59
60	2 Carrier Roof Top Air conditioning Units for 8 Rooms	2010	24,970	1,723	10	2,497	774	10,196	60
61	Roofing Replacement south end Roof	2011	44,232		10	4,423	4,423	16,955	61
62	Overhead Electric Service Feeder for Kitchen	2011	6,830		5	1,366	1,366	4,895	62
63	Underground Hot Water Pipe & Return Pipe for Radiators	2011	33,738	865	10	3,374	2,509	10,965	63
64	Security Camera Network System, in & around Facility	2012	19,754	1,896	5	3,951	2,055	10,207	64
65	Airconditioning roof top unit (3 Ton Capacity)	2012	3,036	78	10	304	226	760	65
66	Patient Hoyer Lift, installed in ceiling	2012	6,280	603	5	1,256	653	2,931	66
67	Hot Water Pump & Piping for Laundry Room	2012	5,796	149	10	580	431	1,257	67
68	Additional Hot Water Pump & Piping for Laundry Room	2013	5,796	149	10	580	431	1,160	68
69	Ceiling affixed Patient Hoyer lift	2013	6,600	1,056	5	1,320	264	2,530	69
70	TOTAL (lines 4 thru 69)		\$ 7,620,220	\$ 1,253,957		\$ 193,057	\$ (1,060,900)	\$ 5,627,141	70

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

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2014 Ending:

31-Dec-2014

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		\$ 7,620,220	\$ 1,253,957		\$ 193,057	\$ (1,060,900)	\$ 5,627,141	1
2	Pre-Const exps,Rezoning, Permits,Architect & IDPH Fees	2014	206,038	2,186	10	6,009	3,823	6,009	2
3	Construction of Building for Sub Acute Unit & PT Gym	2014	1,832,000	19,438	10	53,433	33,995	53,433	3
4	Demolish Garage,Construct Trench Foundation & Door	2014	110,850	1,176	10	3,233	2,057	3,233	4
5	Parking Lot-Foundation,Storm Water basin,Asphalt,Lights	2014	107,500	56,438	15	2,389	(54,049)	2,389	5
6	4 outdoor & 10 Window A/C's & Relocate electrical conduits	2014	43,650	463	10	1,273	810	1,273	6
7	Fit 20 Baths w/GFCI Timers,Public Restroom, 2 new Baths	2014	43,200	458	10	1,260	802	1,260	7
8	Fire Alarm Panel & Link Smoke Detectors to Alarm Panel	2014	16,250	172	10	474	302	474	8
9	16 Mounted Nurses Visual Call Station linked to Fire Alarm	2014	44,000	467	10	1,283	816	1,283	9
10	Entry Sign w/Foundation & Wiring, Lanscaping for Entrance	2014	34,000	17,850	15	756	(17,094)	756	10
11	Install Tiles/Drywall/Fixture & Paint/Stain Hallway+2 Rooms	2014	34,700	368	10	1,012	644	1,012	11
12	Interior Doors for Nurses Stn. & new floor in Hall outside	2014	53,300	566	10	1,555	989	1,555	12
13	Roofing for Sub-Acute unit & PT Gym	2014	175,000	1,857	10	5,104	3,247	5,104	13
14	Boiler Installation & Hot water Pipe for Main Building	2014	219,780	2,332	10	6,410	4,078	6,410	14
15	Monorail System for Hoyer Lifts installed in Sub-Acute Unit	2014	68,009	13,602	5	4,534	(9,068)	4,534	15
16	Quartz Ledge for PT Gym, Window sealing for 20 Rooms	2014	7,044	75	10	205	130	205	16
17	Carpet,Rails,Acrovyn for Corridor & Fireplace area-Town Sq.	2014	27,473	16,484	5	1,832	(14,652)	1,832	17
18	Carpet,Vinyl,Cove,Wallpaper,Artworks for Living Room	2014	25,047	15,028	5	1,670	(13,358)	1,670	18
19	Vinyl,Wall unit,Quartz, Ceiling for Nurse stn. & Dr. Office	2014	16,219	9,731	5	1,081	(8,650)	1,081	19
20	Library Unit & Window Treatment for Garden Room	2014	6,971	4,183	5	465	(3,718)	465	20
21	Floor & Wall Tiles for Shower/SPA Tub Room	2014	5,986	64	10	175	111	175	21
22	Carpet,Cove,Wallpaper,Hand rails,Chandeliers for Corridor	2014	50,653	30,392	5	3,377	(27,015)	3,377	22
23	Carpet,Vinyl,Cove,Work Unit w/Shelves & Cabinet - PT Gym	2014	43,064	25,838	5	2,871	(22,967)	2,871	23
24	Floor & Wall Tiles, Vanity Lights & Mirror for PT Bathroom	2014	720	8	10	21	13	21	24
25	Vinyl,Wardrobe, Fixtures,Window T'ment - 20 Resident Rms.	2014	205,877	123,526	5	13,725	(109,801)	13,725	25
26	Wall/Floor Tiles,Vanity w/Sink,Cabinet,Mirror - Room Baths	2014	72,586	770	10	2,117	1,347	2,117	26
27	Floor Tiles,Base Cabinet, w/Quartz Top - Linen Utility Room	2014	6,664	71	10	194	123	194	27
28	Installation/Complete Wiring of Digital PBX with 61 Phones	2014	51,149	26,853	5	852	(26,001)	852	28
29	Installation & Wiring 13 CCTV Cameras in Sub Acute Unit	2014	6,922	3,634	5	231	(3,403)	231	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,134,872	\$ 1,627,987		\$ 310,598	\$ (1,317,389)	\$ 5,744,682	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	\$ 618,015	\$ 14,912	\$ 63,844	\$ 48,932		\$ 247,421	71
72	Current Year Purchases	178,955	107,518	13,220	(94,298)		13,220	72
73	Fully Depreciated Assets	1,652,799	2,891	7,002	4,111		1,652,799	73
74	**Lancaster Allocation**		4,946	4,946			45,131	74
75	TOTALS	\$ 2,449,769	\$ 130,267	\$ 89,012	\$ (41,255)		\$ 1,958,571	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)	\$ 14,316,141	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,758,254	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 399,610	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,358,644)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,703,253	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: *** Fairmont Property, LLC (a related entity)***

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>**Leased from Related Party**</u>		\$			3
4	Additions						4
5							5
6							6
7	TOTAL			\$			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

None

N/A

9. Option to Buy: YES NO Terms: N/A*

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: \$ 21,540 Description: Rehabilitation Equipment for the whole year @\$1,795 for each month

(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.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5 Supplies (Actual or Allocated)	6 Total Units (Column 2 + 4)	7 Total Cost (Col. 3 + 5 + 6)	8
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39-3	hrs	\$			\$ 236,576	\$		\$ 236,576	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs				100,188			100,188	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	39-3	hrs				366,396			366,396	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation **Inhalation Therapy**	39-3	hrs				2,770			2,770	8	
9	Pharmacy		# of prescripts					293,525		293,525	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): **Medical Supplies**	39-2						19,323		19,323	12	
13	Other (specify): **Speciality Beds**	39-2						18,501		18,501	13	
14	TOTAL			\$			\$ 705,930	\$ 331,349		\$ 1,037,279	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 Centre# 0040493Report Period Beginning: 1-Jan-2014

Ending:

31-Dec-2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2014 (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	\$ 56,839	\$ 56,839	1
2	Cash-Patient Deposits	81,701	81,701	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,095,941	4,095,941	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,868	61,868	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)	2,308	2,308	8
9	Other(specify): **Refundable Deposits**	10,000	10,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,310,647	\$ 4,310,647	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		731,500	13
14	Buildings, at Historical Cost		2,180,724	14
15	Leasehold Improvements, at Historical Cost	892,155	8,629,514	15
16	Equipment, at Historical Cost	1,818,367	2,186,944	16
17	Accumulated Depreciation (book methods)	(2,468,446)	(6,562,140)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**		107,759	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 242,076	\$ 7,274,301	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,552,723	\$ 11,584,948	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 540,138	\$ 634,538	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,701	81,701	28
29	Short-Term Notes Payable	1,742,018	1,008,589	29
30	Accrued Salaries Payable	837,839	837,839	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,542	16,542	31
32	Accrued Real Estate Taxes(Sch.IX-B)	272,000	272,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,490,238	\$ 2,851,209	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,850,000	14,850,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,850,000	\$ 14,850,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,340,238	\$ 17,701,209	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,787,515)	\$ (6,116,261)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,552,723	\$ 11,584,948	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,545,790)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,545,790)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,458,383)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	10,000	10
11	Contributions and Grants	1,206,658	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)	\$ (241,725)	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)	\$ (2,787,515)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,898,191)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,898,191)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,434,728)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	10,000	10
11	Contributions and Grants	1,206,658	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)	\$ (1,218,070)	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)	\$ (6,116,261)	24 *

* This must agree with page 17, line 47, Col. 2.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,543,168	1
2	Discounts and Allowances for all Levels	(2,937,474)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,605,694	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,756,053	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,756,053	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	261,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,169	19
20	Radiology and X-Ray	12,168	20
21	Other Medical Services	21,250	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 301,227	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	62,259	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,259	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	175,297	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 175,297	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,900,530	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,262,725	31
32	Health Care	4,810,597	32
33	General Administration	3,093,802	33
B. Capital Expense			
34	Ownership	1,782,739	34
C. Ancillary Expense			
35	Special Cost Centers	1,037,279	35
36	Provider Participation Fee	97,710	36
D. Other Expenses (specify):			
37			37
38	**State Assessment Tax @\$6.07**	274,061	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,358,913	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,458,383)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,458,383)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpayer

*** See the instructions. If this total amount has not been offset against interest

expense on Schedule V, line 32, please include a detailed explanation. **Set off on Pg 9 & 5**

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

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2014

Ending: 31-Dec-2014

31-Dec-2014

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	1,621	2,086	\$ 96,892	\$ 46.45	1
2	Assistant Director of Nursing	2,013	2,086	80,041	38.37	2
3	Registered Nurses	52,509	57,195	1,617,961	28.29	3
4	Licensed Practical Nurses	26,680	28,957	672,893	23.24	4
5	CNAs & Orderlies	117,770	129,083	1,572,899	12.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,989	2,086	29,489	14.14	9
10	Activity Assistants	5,080	5,518	70,849	12.84	10
11	Social Service Workers	5,798	6,245	101,653	16.28	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,086	40,507	19.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,813	37,735	464,660	12.31	15
16	Dishwashers					16
17	Maintenance Workers	4,031	4,360	77,474	17.77	17
18	Housekeepers	26,595	28,791	344,009	11.95	18
19	Laundry	4,042	4,357	54,486	12.51	19
20	Administrator	1,974	2,121	82,400	38.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,360	9,212	168,540	18.30	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	2,517	2,851	63,454	22.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	297,829	324,769	\$ 5,538,207 *	\$ 17.05	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	788	\$ 22,477	1-3	35
36	Medical Director	1,908	72,532	9-3	36
37	Medical Records Consultant	163	4,608	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	456	10,957	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	128	2,984	11-3	44
45	Social Service Consultant	62	1,426	12-3	45
46	Other(specify)				46
47	**Dementia Consultant	83	2,489	10-3	47
48					48
49	TOTAL (lines 35 - 48)	3,588	\$ 117,473		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

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		
Joanne Ventrella	Administrator	N/A	\$ 82,400	Workers' Compensation Insurance	\$ 79,404	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	36,435	Advertising: Employee Recruitment	4,180		
				FICA Taxes	409,359	Health Care Worker Background Check			
				Employee Health Insurance	490,852	(Indicate # of checks performed 33)	330		
				Employee Meals	31,447	Patient Background Checks	72 1,302		
				Illinois Municipal Retirement Fund (IMRF)*		**Licenses & Fees**	22,176		
				Miscellaneous Employee Benefits	21,131	**Promotional Advertising**	79,040		
				Uniform Allowance		**Dues & Subscriptions**	4,321		
				Retirement Plan Contribution	57,971	**Fairmont Property Allocation**	250		
				Dental Insurance	514	**Lancaster Allocation**	151,947		
				Employment Fees		Less: Public Relations Expense	(143,771)		
				Lancaster Allocation	13,961	Non-allowable advertising	(79,040)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 82,400				\$ 1,141,074			\$ 42,725		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Lancaster, Ltd.			\$ 742,720				Out-of-State Travel	\$ 0	
							Lancaster Allocation	64	
							In-State Travel	2,263	
							Lancaster Allocation	20,496	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	634	
\$ 742,720							**Lancaster Allocation**	2,079	
C. Professional Services							Entertainment Expense	(5,735)	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
Health Data Systems, Inc.	Data Processing		\$ 7,323				TOTAL	\$ 19,801	
E-Health Solutions Inc	Data Processing		46,196						
Richard Peelo & Associates	Accounting		2,250						
Frost Ruttenberg & Rothblatt	Accounting		2,400						
Personnel Planners, Inc.	Payroll Tax Consultant		1,512						
Korey Richardson, LLC	Legal		18,931						
Myers, Carden & Sax LLC	Legal		19,184						
Polsinelli PC.	Legal		10,690						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL					
\$ 108,486				\$					

* Attach copy of IMRF notifications

**See instructions.

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	
													Amount of Expense Amortized Per Year
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1	Painting and Decorating	Feb-04	\$ 2,742	3	\$ 457								
2	Painting and Decorating	Sep-04	1,973	3	330								
3	Painting and Decorating	May-05	3,784	3	1,261	631							
4	Painting and Decorating	Aug-05	3,735	3	1,245	623							
5	Painting and Decorating	Oct-06	4,767	3	1,589	1,589	795						
6	Painting and Decorating	Mar 07	350	3	116	118	116						
7	Painting and Decorating	Aug-07	1,200	3	200	400	400	200					
8	Painting and Decorating	Aug-08	3,850	3		642	1,283	1,283	642				
9	Painting and Decorating	Dec-08	1,829	3			610	609	610				
10	Painting and Decorating	May-09	1,550	3			259	516	516	259			
11	Painting and Decorating	Oct-09	1,359	3			226	453	453	227			
12	Painting and Decorating	Jun-10	2,704	3			451	901	901	451			
13	Painting and Decorating	Jul-11	1,493	3				498	497	498			
14	Painting and Decorating	Oct-11	4,590	3				765	1,530	1,530	765		
15	Painting and Decorating	Feb-12	6,027	3					2,009	2,009	2,009		
16	Painting and Decorating	Nov-12	9,420	3					1,570	3,140	3,140	1,570	
17	Painting and Decorating	June-13	6,830	3						2,277	2,276	2,277	
18													
19													
20	TOTALS		\$ 58,203		\$ 5,198	\$ 4,003	\$ 3,689	\$ 3,512	\$ 4,385	\$ 6,993	\$ 9,905	\$ 8,190	\$ 3,847

