



Facility Name & ID Number Fairview Nursing Center

# 0024992 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,402	1,340	2,558	7,300	8
9	SNF/PED					9
10	ICF	7,578	4,436		12,014	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,980	5,776	2,558	19,314	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.63%

D. How many bed-hold days during this year were paid by the Department?

N/A (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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 11/10/1970

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified 20 and days of care provided 2,147

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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
	<b>A. General Services</b>										
1	Dietary	111,520	6,106	5,287	122,913		122,913		122,913	1	
2	Food Purchase		89,693		89,693		89,693	(2,768)	86,925	2	
3	Housekeeping	65,307	10,267		75,574		75,574	2,104	77,678	3	
4	Laundry	40,129	7,123		47,252		47,252		47,252	4	
5	Heat and Other Utilities			56,833	56,833		56,833	928	57,761	5	
6	Maintenance	34,338	31,342	41,641	107,321		107,321		107,321	6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	251,294	144,531	103,761	499,586		499,586	264	499,850	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200	9	
10	Nursing and Medical Records	823,185	31,981	10,653	865,819		865,819		865,819	10	
10a	Therapy									10a	
11	Activities	44,409	2,854	1,516	48,779		48,779		48,779	11	
12	Social Services	24,094		1,516	25,610		25,610		25,610	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	891,688	34,835	14,885	941,408		941,408		941,408	16	
	<b>C. General Administration</b>										
17	Administrative	82,707	8,123	198,854	289,684		289,684	(167,677)	122,007	17	
18	Directors Fees									18	
19	Professional Services			1,063	1,063		1,063	6,036	7,099	19	
20	Dues, Fees, Subscriptions & Promotions			8,381	8,381		8,381	(3,340)	5,041	20	
21	Clerical & General Office Expenses	30,557		5,386	35,943		35,943	65,475	101,418	21	
22	Employee Benefits & Payroll Taxes			162,129	162,129		162,129	2,768	164,897	22	
23	Inservice Training & Education			254	254		254		254	23	
24	Travel and Seminar			2,567	2,567		2,567	336	2,903	24	
25	Other Admin. Staff Transportation			1,394	1,394		1,394	1,926	3,320	25	
26	Insurance-Prop.Liab.Malpractice			48,536	48,536		48,536	2,650	51,186	26	
27	Other (specify):* <b>Mgmt Alloc of Benefi</b>							11,520	11,520	27	
28	<b>TOTAL General Administration</b>	113,264	8,123	428,564	549,951		549,951	(80,306)	469,645	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,256,246	187,489	547,210	1,990,945		1,990,945	(80,042)	1,910,903	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 &amp; ID Number

Fairview Nursing Center

#0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

## 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	
	<b>D. Ownership</b>											
30	Depreciation			72,666	72,666		72,666	(44,045)	28,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			19,020	19,020		19,020	2,281	21,301			33
34	Rent-Facility & Grounds			12,840	12,840		12,840	(3,380)	9,460			34
35	Rent-Equipment & Vehicles			6,367	6,367		6,367		6,367			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			110,893	110,893		110,893	(45,144)	65,749			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,124	182,519	272,643		272,643		272,643			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			139,318	139,318		139,318		139,318			42
43	Other (specify):* <b>Non-Allowable Co</b>			23,078	23,078		23,078	(23,078)				43
44	<b>TOTAL Special Cost Centers</b>		90,124	344,915	435,039		435,039	(23,078)	411,961			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,256,246	277,613	1,003,018	2,536,877		2,536,877	(148,264)	2,388,613			45

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

Facility Name & ID Number Fairview Nursing Center

# 0024992

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

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	(59,626)	32		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	(275)	43		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	(633)	43		18
19	Entertainment				19
20	Contributions	(1,110)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,605)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(23,065)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (86,314)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(61,950)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (61,950)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (148,264)</b>		<b>37</b>

\*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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

Fairview Nursing Center

ID# 0024992

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs	\$ (12,704)	43	1
2	X-Rays	(2,525)	43	2
3	Miscellaneous Income	(40)	21	3
4	Public Relations	(3,570)	20	4
5	Resident Funeral Flowers	(760)	43	5
6	Dog Expenses Food & Grooming	(600)	43	6
7	Replaced Resident Items (lost/damaged)	(1,685)	43	7
8	Expenses Of Metropolis Prop	(1,181)	43	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	<b>Total</b>		(23,065)	49

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Fairview Residential Center Land Trust	39.70%	\$ 8,983	\$ 8,983	1
2	V	34 Rent	12,840	Fairview Residential Center Land Trust	39.70%		(12,840)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 12,840			\$ 8,983	\$ * (3,857)	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	3 Housekeeping	\$	Jamestown Management Company	100.00%	\$ 2,104	\$ 2,104
16	V	5 Utilities		Jamestown Management Company	100.00%	928	928
17	V	17 Admin Salaries		Jamestown Management Company	100.00%	31,177	31,177
18	V	17 Management Fees	198,854	Jamestown Management Company	100.00%		(198,854)
19	V	19 Legal & Accounting		Jamestown Management Company	100.00%	6,036	6,036
20	V	20 Licenses & Dues		Jamestown Management Company	100.00%	230	230
21	V	21 Clerical & Office Expense		Jamestown Management Company	100.00%	6,840	6,840
22	V	21 Clerical Salaries		Jamestown Management Company	100.00%	58,675	58,675
23	V	27 Employee Benefits		Jamestown Management Company	100.00%	11,520	11,520
24	V	24 Seminars		Jamestown Management Company	100.00%	336	336
25	V	25 Auto Expense		Jamestown Management Company	100.00%	1,926	1,926
26	V	26 General Insurance		Jamestown Management Company	100.00%	2,650	2,650
27	V	30 Depreciation		Jamestown Management Company	100.00%	6,598	6,598
28	V	33 Real Estate Taxes		Jamestown Management Company	100.00%	2,281	2,281
29	V	34 Rent		Jamestown Management Company	100.00%	9,460	9,460
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 198,854			\$ 140,761	\$ * (58,093)

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

Facility Name & ID Number

Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Lucinda Bain	46.97	Fair Acres Nursing Home	DuQuion	Jamestown Mgmt	Carbondale	Management	1
2	Coletta McClary	46.97			Fairview Residential	DuQuoin	Real Estate	2
3	Kristin McClary Powers	1.01			Land Trust			3
4	James David McClary	1.01						4
5	Sara Glitzer	1.01						5
6	Marcia McClary Kell	1.01						6
7	David Brent Bain	1.01						7
8	Susan Beth Helsley	1.01						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	Kristin McClary Powers	Managing Partner	Administrative	1.01	See Sch 7A	11	29.00	Salary	\$ 12,400	17(7)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,400		13

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

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

Facility Name & ID Number Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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 Jamestown Management Corporation  
 Street Address 1001 East Main Bldg 4a  
 City / State / Zip Code Carbondale, IL 62901  
 Phone Number ( 618-549-8331  
 Fax Number ( 618-549-0133

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	3	Housekeeping	Units of Service	10,866	\$ 7,341	\$	3,115	\$ 2,104	1
2	5	Utilities	Units of Service	10,866	3,236		3,115	928	2
3	19	Legal & Accounting	Units of Service	10,866	21,056		3,115	6,036	3
4	20	Licenses & Dues	Units of Service	10,866	804		3,115	230	4
5	21	Clerical & Office Expense	Units of Service	10,866	23,859		3,115	6,840	5
6	27	Employee Benefits	Units of Service	10,866	40,186		3,115	11,520	6
7	24	Seminars	Units of Service	4,712	1,172		1,351	336	7
8	25	Auto Expense	Units of Service	4,712	6,718		1,351	1,926	8
9	26	General Insurance	Units of Service	10,866	9,243		3,115	2,650	9
10	30	Depreciation	Units of Service	10,866	23,014		3,115	6,598	10
11	33	Real Estate Taxes	Units of Service	10,866	7,957		3,115	2,281	11
12	34	Rent	Units of Service	10,866	33,000		3,115	9,460	12
13									13
14	17	Administrative	Units of Service	2,832	108,737	108,737	812	31,177	14
15	21	Clerical Salaries	Units of Service	8,034	204,688	204,688	2,303	58,675	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 491,011	\$ 313,425		\$ 140,761	25

Facility Name & ID Number

Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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

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.)

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2013 report.			\$	<b>19,500</b>	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.)	2013		\$	<b>19,020</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(480)</b>	3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>19,500</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5														
		Allocated from Management Co.		2,281															
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>21,301</b>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>16,796</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>18,006</u>	9																
	2011	<u>18,707</u>	10																
	2012	<u>19,067</u>	11																
	2013	<u>19,020</u>	12																
<b>This entity accrues the same real estate tax each year.</b>																			

**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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Center COUNTY Perry  
 FACILITY IDPH LICENSE NUMBER 0024992  
 CONTACT PERSON REGARDING THIS REPORT Brenda Cullum  
 TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1-61-0270-100</u>	<u>Long Term Care Property</u>	\$ <u>19,019.82</u>	\$ <u>19,019.82</u>
2. <u>15-22-128-023</u>	<u>Jamestown Management Co. Alloc.</u>	\$ <u>6,313.86</u>	\$ <u>2,281.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>25,333.68</u></u>	\$ <u><u>21,300.82</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

Facility Name & ID Number Fairview Nursing Center

# 0024992 Report Period Beginning:

1/1/2014 Ending:

12/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (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).

N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>76,320</u>	<u>1968</u>	<u>\$ 3,996</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>76,320</b>		<b>\$ 3,996</b>	<b>3</b>

Facility Name &amp; ID Number Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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	42			1968	\$ 94,863	\$	40	\$	\$	\$ 94,863	4
5				1968	61,381		20			61,381	5
6				1970	3,953		20			3,953	6
7	18			1970	26,047		38			26,047	7
8	16			1976	177,922		30			177,922	8
	<b>Improvement Type**</b>										
9		Fire Alarm		1981	1,190		10			1,190	9
10		Sewer Line		1982	1,056		10			1,056	10
11		Plumbing Improvements		1984	1,193		10			1,193	11
12		Roof & Landscaping		1984	1,488		10			1,488	12
13		Activity Room		1986	15,306		20			15,306	13
14		Activity Room		1987	5,223		20			5,223	14
15		Roof & Landscaping		1987	9,775		10			9,775	15
16		Parking Lot		1987	18,960		15			18,960	16
17		Security System		1988	2,583		15			2,583	17
18		Renovations		1989	2,723		15			2,723	18
19		Hot Water Heater		1990	4,128		15			4,128	19
20		6 Wall A/c Units		1990	7,205		8			7,205	20
21		Landscaping		1990	495		10			495	21
22		Showers/cubicle Tracks		1990	8,459	119	15		(119)	8,459	22
23		Roof & Landscaping		1990	13,831	439	25	553	114	13,549	23
24		Telephone		1991	3,274		20			3,274	24
25		Water Heater		1991	1,945		15			1,945	25
26		Emergency Lights		1992	960		15			960	26
27		Seal & Stripe Parking Lot		1994	1,421		5			1,421	27
28		Emergency Lights		1995	994		15			994	28
29		Hot Water Heater		1995	7,433		15			7,433	29
30		Subpanels & Circuits Installed To A/c		1996	2,394		10			2,394	30
31		Pt A/c Unit		1996	1,163		10			1,163	31
32		A/c Units		1996	1,071		10			1,071	32
33		Installed Service Cable		1997	7,666		15			7,666	33
34		A/c Units		1998	698		10			698	34
35		Hot Water Heater		1998	2,985		15			2,985	35
36		Overbed Lighting		1998	8,932		15			8,932	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

## 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	Carpet	1998	588		5			\$ 588	37
38	Install Baseboard Heating	1998	3,599		15			\$ 3,599	38
39	Cabinets & Countertops	1998	708		5			\$ 708	39
40	Wallpaper & Installation	1998	9,457		5			\$ 9,457	40
41	Painting	1998	11,779		5			\$ 11,779	41
42	Trim, Pictures, Mirrors, Permanent Decorative Fixtures	1998	2,007		5			\$ 2,007	42
43	Floor Cove Base	1998	901		5			\$ 901	43
44	Morton Storage Building	1998	3,917	124	15	132	8	\$ 3,917	44
45	Building Addition	1998	239,137		15	7,978	7,978	\$ 239,137	45
46	Parking Lot	1998	13,916		15			\$ 13,916	46
47	Flooring- Adjustment To 1998 Building Addition	1999	737		5			\$ 737	47
48	Door Alarm System	1999	6,691		10			\$ 6,691	48
49	Wallpaper & Painting	1999	8,314		5			\$ 8,314	49
50	Install Bookcase In Admin Office	1999	333		10			\$ 333	50
51	Landscaping	1999	5,931		10			\$ 5,931	51
52	Seal Coated And Striped Parking Lot	1999	1,646		8			\$ 1,646	52
53	Install Telephones In Breakroom & Dining	1999	777		5			\$ 777	53
54	Move Phone Lines	1999	328		5			\$ 328	54
55	Entrance Sign	1999	1,000		5			\$ 1,000	55
56	Paint Windoe Grids	1999	175		5			\$ 175	56
57	Installation Of Flooring	1999	8,949		10			\$ 8,949	57
58	Fountain & Light	1999	1,774		5			\$ 1,774	58
59	Balance Of Trim, Mirrors, Permanent Decorative Fixtures	1999	3,952		5			\$ 3,952	59
60	To Refurbish The Building								60
61	Awnings	1999	420		5			\$ 420	61
62	Labor & Materials To Remove Existing Wall & Rebuild New	1999	8,559		10			\$ 8,559	62
63	Wall Relocate Plumbing & Electrical Services, Install								63
64	Cabinetry, & Countertops And Installed New Flooring. Labor								64
65	&Materials To Gut An Existing Bathroom & Rehab Room To								65
66	Create 2 New Bathrooms &Storage Area For Housekeeping								66
67	& Datary ( To Ve Complete In 2000). Labor & Materials								67
68	To Install New Cabinets, Relocated Plumbing & Electrical,								68
69	Repair Drywall & Paint The Breakroom.								69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 682		\$ 8,663	\$ 7,981	\$ 834,030	70

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

Facility Name &amp; ID Number Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 834,312	\$ 682		\$ 8,663	\$ 7,981	\$ 834,030	1
2	Labor & Materials To Complete 1999 Bathroom Project	2000	20,296		10			20,296	2
3	Installed Ceramic Tile, Sinks, Toilet Stool, Showers, And								3
4	Lighting Fixtures								4
5	Labor & Materials To Remove Existing Wall In Order To Convert	2000	11,212		10			11,212	5
6	Storage Room Into A Resident Room. Removed Existing								6
7	Closets, Installed Shower Area, Relocated Doors, Electrical,								7
8	& Plumbing Services, Repaired & Painted Drywall &								8
9	Relocated Call Lights								9
10	Excavate & Replace Driveway Asphalt & Fill In Cracks With Tar	2001	3,075	205	15	205		2,768	10
11	Reinforce & Raise Sinking Floor On B Wing	2001	7,380	492	15	492		6,642	11
12	Gut Beauty Shop Area & Construct A New Handicapped	2001	16,165	1,078	15	1,078		14,553	12
13	Bathroom. New Wiring, Plumbing, Flooring, Shower, Toilet,								13
14	Sink, Door, Sprinkler Heads, Cubicle Tracks, & Curtains &								14
15	Cove Base.								15
16	Sewer Repair To 3 Bed Ward Bathroom. Removed Concrete &	2001	2,800	187	15	187		2,524	16
17	Replaced Deteriorated Sewer Line, Install New Line, & New								17
18	Clean Out & Pour New Floor								18
19	Relocate Beauty Shop Top Pt Area. Installed Lines, Clean Out &	2001	1,223	82	15	82		1,107	19
20	Shut Off Valves, Drill & Knock Out Outside Brick Wall, Install								20
21	Fan, Finish Drywall, Paint, Install Tile On Drywall, Install								21
22	Sink & Shelves								22
23	Convert Existing Bathroom To Handicapped Bathroom	2001	7,124	475	15	475		6,412	23
24	Remove Tile, Install Box For Call Lights, Tear Out &								24
25	Reconstruct Showers, Tile Wall & Showers, Install Handrails								25
26	In Tub & Showers, Hang Tracks & Curtains, Put New Lever								26
27	Hand Door Lever								27
28	Add Fan To Isolation Room For Medicare Compliance	2001	386	26	15	26		351	28
29	Install 2 Sprinkler Heads In Store Room & Water Heater Closet	2001	338	23	15	23		310	29
30	Upgrade Emergency Lighting & Moved Annunciator Panel	2001	15,138		10			15,138	30
31	& Smoke Detector								31
32	Upgraded Nurses Call Station	2001	645		10			645	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 920,094	\$ 3,250		\$ 11,231	\$ 7,981	\$ 915,988	34

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

Facility Name &amp; ID Number Fairview Nursing Center

# 0024992

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 920,094	\$ 3,250		\$ 11,231	\$ 7,981	\$ 915,988	1
2	Install Grease Trap & Wet Well	2002	13,224		10			13,224	2
3	Replaced Rusted Out Main Line In B Hallway &	2002	3,494		10			3,494	3
4	Reinstalled Drain To Connect To Mainline In B Hall Bath								4
5	Removed Old Flooring & Replaced With Ceramic Tile In	2002	1,706		10			1,706	5
6	A Hall Bathroom								6
7	Repair Roof Over Front Dining Room & Activity Room	2002	8,230		10			8,230	7
8	Landscaping Of Courtyard	2004	1,109	55	10	55		1,109	8
9	Remove, Repair, & Install Tile Flooring In Dining Room	2005	7,222	722	10	722		6,859	9
10	Replace Tile In Hall, TV Room & Small Hallway	2008	3,310		10	331	331	2,152	10
11	Replace Roof Over Kitchen & Dining Room & Repairs To	2009	7,615	1,087	10	762	(325)	4,191	11
12	A & B Halls								12
13	5'x6' Entrance Sign	2009	1,599		5	159	159	1,599	13
14	Repair Flat Roof Area On Back Of Building	2010	5,980	399	15	399		1,795	14
15	Demo & Install Ductwork On Back Of Building	2010	3,792	253	15	253		1,138	15
16	Installed Fire Rated Carpet On Walls	2011	6,126		5	1,225	1,225	4,287	16
17	Seal & Stripe Parking Lot	2011	1,380		5	276	276	966	17
18	Install 400 Amp Breaker Box & New Disconnect	2011	4,395		20	220	220	770	18
19	Replace 139 Sprinkler Heads	2012	17,509	584	15	1,167	583	2,918	19
20	Replace Roof On East And West Wings	2013	20,139	672		1,343	671	2,014	20
21	Install Fire Sprinkler System On C Wing	2013	11,700	390		468	78	702	21
22									22
23	Replaced B Wing Roof	2014	19,305	9,733	15	644	(9,089)	644	23
24	Replaced Sprinkler System throughout the Building	2014	79,900	40,282	25	160	(40,122)	160	24
25	except Medicare C Wing								25
26	Replaced Admin Section Roof	2014	9,490	4,784	15	316	(4,468)	316	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,147,319	\$ 62,211		\$ 19,731	\$ (42,480)	\$ 974,262	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	\$ 75,091	\$	\$ 8,098	\$ 8,098	5-10	\$ 42,937	71
72	Current Year Purchases	14,551	10,455	792	(9,663)	5-15	792	72
73	Fully Depreciated Assets	288,064					288,064	73
74								74
75	TOTALS	\$ 377,706	\$ 10,455	\$ 8,890	\$ (1,565)		\$ 331,793	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,529,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,666	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,621	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (44,045)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,306,055	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Management Company</u>				<u>9,460</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>9,460</b>			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

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: \$ 6,367

Description: See Sch 14A

(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>N/A</u>	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**Facility Name:** Fairview Nursing Center  
**IDPH License ID Number:** 0024992  
**Fiscal Year End:** 12/31/2014

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
BIPAP Machine	2,286
C-PAP Machine	2,359
Vending Machine	150
Storage Shed	727
Dishwasher	845
<b>Total - Line 16</b>	<b><u>6,367</u></b>

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 1/1/2014 Ending: 12/31/2014  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

- (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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L39(3)	hrs	\$	1,357	\$ 70,948	\$	1,357	\$ 70,948	1	
2	Licensed Speech and Language Development Therapist	L39(3)	hrs		316	21,657		316	21,657	2	
3	Licensed Recreational Therapist	L39(3)	hrs		1,627	89,671		1,627	89,671	3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	L39(2)	# of prescripts				82,736		82,736	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>See Sch 16A</u>	L39(2)					7,388		7,388	12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	3,300	\$ 182,276	\$ 90,124	3,300	\$ 272,400	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: Fairview Nursing Center  
IDPH License ID Number: 0024992  
Fiscal Year End: 12/31/2014

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<b>Description</b>	<b>Supplies</b>
Oxygen	6,395
IV Therapy	167
Cardiology	238
Swallow Test	588
<b>Total - Line 12</b>	<b><u>7,388</u></b>

Facility Name &amp; ID Number Fairview Nursing Center

# 0024992

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 21,188	\$ 21,188	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (61,562) )	1,334,551	1,334,551	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	153,903	153,903	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,875	1,875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Capital</u>	13,300	13,300	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,524,817	\$ 1,524,817	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,000	6,000	12
13	Land	846,382	3,996	13
14	Buildings, at Historical Cost		364,166	14
15	Leasehold Improvements, at Historical Cost		783,153	15
16	Equipment, at Historical Cost		377,706	16
17	Accumulated Depreciation (book methods)	(747,474)	(1,306,055)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 104,908	\$ 228,966	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,629,725	\$ 1,753,783	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 76,471	\$ 76,471	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,579	42,579	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,534	6,534	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,500	19,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Sch 17A</u>	39,923	39,923	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 185,007	\$ 185,007	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 185,007	\$ 185,007	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,444,718	\$ 1,568,776	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,629,725	\$ 1,753,783	48

\*(See instructions.)

Facility Name: Fairview Nursing Center  
IDPH License ID Number: 0024992  
Fiscal Year End: 12/31/2014

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
MANAGEMENT FEES PAY	12,128	12,128
INSURANCE	28	28
OTHER ACCRUED EXPENSE	355	355
401K LIABILITY	9,535	9,535
ACCR LIC BED TAX	17,342	17,342
ACCRUED RENT	535	535
<b>Total - Line 36</b>	<b>39,923</b>	<b>39,923</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,321,119	1
2	Restatements (describe):		2
3	2013 IL Replacement Tax	(1,277)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,319,842	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	145,010	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe) Excess Salaries Eliminated	(20,133)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 124,876	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,444,718	24 *

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

Facility Name & ID Number Fairview Nursing Center# 0024992Report Period Beginning: 1/1/2014Ending: 12/31/2014

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,114,689	1
2	Discounts and Allowances for all Levels	74,182	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,188,871</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	395,420	6
7	Oxygen	597	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 396,017</b>	8
<b>C. Other Operating Revenue</b>			
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	73,778	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,852	19
20	Radiology and X-Ray	1,762	20
21	Other Medical Services	5,027	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 94,419</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,996	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,996</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Sch 19A</u>	584	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 584</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,681,887</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	499,586	31
32	Health Care	941,408	32
33	General Administration	549,951	33
<b>B. Capital Expense</b>			
34	Ownership	110,893	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	295,721	35
36	Provider Participation Fee	139,318	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,536,877</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>145,010</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 145,010</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,143,770	44
45	Private Pay - Net Inpatient Revenue	781,805	45
46	Medicare - Net Inpatient Revenue	439,976	46
47	Other-(specify) <u>Prior Year Adjustments</u>	(176,680)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,188,871</b>	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.

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

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

^ - This entity is a cash basis taxpayer

Facility Name: Fairview Nursing Center  
IDPH License ID Number: 0024992  
Fiscal Year End: 12/31/2014

**Schedule 19A**

**XVII. Income Statement**

**Line 28 Other Revenue (specify):**

<u>Description</u>	<u>Amount</u>
OTHER INCOME	271
ACT & CONT INCOME	850
VENDING INCOME	(537)
<b>Total - Line 28</b>	<b><u>584</u></b>

Facility Name & ID Number Fairview Nursing Center

# 0024992

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

**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	1,851	2,080	\$ 52,668	\$ 25.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,015	9,023	192,912	21.38	3
4	Licensed Practical Nurses	7,520	8,044	126,205	15.69	4
5	CNAs & Orderlies	40,342	43,413	451,400	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,006	3,535	44,409	12.56	10
11	Social Service Workers	1,838	1,988	24,094	12.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,233	2,345	33,161	14.14	14
15	Cook Helpers/Assistants	8,107	8,714	78,359	8.99	15
16	Dishwashers					16
17	Maintenance Workers	2,200	2,303	34,338	14.91	17
18	Housekeepers	6,554	6,943	65,307	9.41	18
19	Laundry	2,815	3,049	40,129	13.16	19
20	Administrator	1,926	2,080	82,707	39.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,968	2,090	30,557	14.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,375	95,607	\$ 1,256,246 *	\$ 13.14	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	93	\$ 5,287	1(3)	35
36	Medical Director	Monthly	1,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,623	10(3)	39
40	Physical Therapy Consultant	5	227	39(3)	40
41	Occupational Therapy Consultant	1	16	39(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,516	11(3)	44
45	Social Service Consultant	30	1,516	12(3)	45
46	Other(specify) <u>Utilization Review</u>	Monthly	1,200	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	159	\$ 12,585		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	231	7,830	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	231	\$ 7,830		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	
Lonnie Lindner	Administrator	0	\$ 82,707	Workers' Compensation Insurance	\$ 28,943	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	21,030	Advertising: Employee Recruitment	3,570	
				FICA Taxes	96,103	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed 24 )	239	
				Employee Meals	2,768	Patient Background Checks	102 1,465	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	656	
				Vaccines	391	Miscellaneous Dues & Subscriptions	459	
				Other Employee Benefits	4,184	Allocated from Management Co.	230	
				401(k) Expense	11,478	Less: Public Relations Expense	(3,570)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,707	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 164,897		\$ 5,041		
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 (Eliminated in Col. 7)			\$ 198,854	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 198,854				Seminar Expense	2,567
							Allocated from Management Co.	336
C. Professional Services								
Vendor/Payee	Type	Amount						
Barnett & Levine	Accounting	\$ 1,063						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,063	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,903

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Fairview Nursing Center  
**IDPH License ID Number:** 0024992  
**Fiscal Year End:** 12/31/2014

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Total on Page 21 for Schedule V, line 19, column 3		1,063
<b>Total (agree to Schedule V, line 19, column 3)</b>		<u>1,063</u>
Allocated from Management Company	Accounting	6,036
<b>Total (agree to Schedule V, line 19, column 8)</b>		<u>7,099</u>

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3											N/A	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? 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. \$ N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 139,318  
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. \$ 2,768 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.