

Facility Name & ID Number Fairview Nursing Center

0024992 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	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			1,696	1,696	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	9,474	5,487		14,961	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,474	5,487	1,696	16,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.05%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 1,557

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	137,573	7,281	5,260	150,114		150,114		150,114		1
2	Food Purchase		88,333		88,333		88,333	(688)	87,645		2
3	Housekeeping	80,664	12,148		92,812		92,812		92,812		3
4	Laundry	51,664	7,895		59,559		59,559		59,559		4
5	Heat and Other Utilities			56,487	56,487		56,487	(715)	55,772		5
6	Maintenance	58,890	21,702	40,820	121,412		121,412		121,412		6
7	Other (specify):* Waste Removal			2,082	2,082		2,082		2,082		7
8	TOTAL General Services	328,791	137,359	104,649	570,799		570,799	(1,403)	569,396		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	693,461	28,461	255,654	977,576		977,576		977,576		10
10a	Therapy										10a
11	Activities	50,175	1,344	1,550	53,069		53,069	(2,305)	50,764		11
12	Social Services	26,834		1,550	28,384		28,384		28,384		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	770,470	29,805	261,154	1,061,429		1,061,429	(2,305)	1,059,124		16
	C. General Administration										
17	Administrative	80,544		30,000	110,544		110,544		110,544		17
18	Directors Fees										18
19	Professional Services			85,758	85,758		85,758		85,758		19
20	Dues, Fees, Subscriptions & Promotions			32,464	32,464		32,464	(25,330)	7,134		20
21	Clerical & General Office Expenses	34,787	6,004	105,662	146,453		146,453	(6,241)	140,212		21
22	Employee Benefits & Payroll Taxes			133,246	133,246		133,246		133,246		22
23	Inservice Training & Education			395	395		395		395		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,354	2,354		2,354		2,354		25
26	Insurance-Prop.Liab.Malpractice			51,544	51,544		51,544		51,544		26
27	Other (specify):*										27
28	TOTAL General Administration	115,331	6,004	441,423	562,758		562,758	(31,571)	531,187		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,214,592	173,168	807,226	2,194,986		2,194,986	(35,279)	2,159,707		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			30,405	30,405		30,405	10,617	41,022		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			20,000	20,000		20,000		20,000		33
34	Rent-Facility & Grounds			12,840	12,840		12,840	(12,840)			34
35	Rent-Equipment & Vehicles			3,842	3,842		3,842		3,842		35
36	Other (specify):*										36
37	TOTAL Ownership			67,087	67,087		67,087	(2,223)	64,864		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		68,646	194,566	263,212		263,212		263,212		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			137,511	137,511		137,511		137,511		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		68,646	332,077	400,723		400,723		400,723		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,214,592	241,814	1,206,390	2,662,796		2,662,796	(37,502)	2,625,294		45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(688)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,617	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	(6,241)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,822)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,528)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,662)		\$	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)	(12,840)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,840)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (37,502)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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BHF USE ONLY							
48		49		50		51	

Fairview Nursing Center

ID# 0024992

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Activity Income Against Expense	\$ (2,305)	11	1
2	Offset Energy Incentive Against Utilities Expense	(715)	5	2
3	IDPH License Paid in Prior Year	1,492	20	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
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22				22
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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	(1,528)		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		None		See PG 6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 12,840	Fairview Residential Center Land Trust	39.70%	\$	\$	(12,840) 1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 12,840			\$	\$ *	(12,840) 14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018

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12/31/2018

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center # 0024992 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.	\$	20,000	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.)	\$	19,352	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(648)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	20,648	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	20,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	19,020	8
	2014	19,237	9
	2015	19,160	10
	2016	19,505	11
	2017	19,352	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Center COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1-61-0270-100</u>	<u>Long Term Care Property</u>	\$ <u>19,351.82</u>	\$ <u>19,351.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>19,351.82</u></u>	\$ <u><u>19,351.82</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 76,320, 1968, \$ 3,996, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 76,320, (blank), \$ 3,996, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

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Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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
	Improvement Type**										
9		Fire Alarm		1981	1,190		10			1,190	9
10		Sewer Line		1982	1,056		10			1,056	10
11		Plumbing Improvements		1984	1,193		10			1,193	11
12		Roof & Landscaping		1984	1,488		10			1,488	12
13		Activity Room		1986	15,306		20			15,306	13
14		Activity Room		1987	5,223		20			5,223	14
15		Roof & Landscaping		1987	9,775		10			9,775	15
16		Parking Lot		1987	18,960		15			18,960	16
17		Security System		1988	2,583		15			2,583	17
18		Renovations		1989	2,723		15			2,723	18
19		Hot Water Heater		1990	4,128		15			4,128	19
20		6 Wall A/C Units		1990	7,205		8			7,205	20
21		Landscaping		1990	495		10			495	21
22		Showers/Cubicle Tracks		1990	8,459	119	15		(119)	8,459	22
23		Roof		1990	13,831	439	25		(439)	13,831	23
24		Telephone		1991	3,274		20			3,274	24
25		Water Heater		1991	1,945		15			1,945	25
26		Emergency Lights		1992	960		15			960	26
27		Seal & Stripe Parking Lot		1994	1,421		5			1,421	27
28		Emergency Lights		1995	994		15			994	28
29		Hot Water Heater		1995	7,433		15			7,433	29
30		Subpanels & Circuits Installed to A/C		1996	2,394		10			2,394	30
31		Pt A/C Unit		1996	1,163		10			1,163	31
32		A/C Untis		1996	1,071		10			1,071	32
33		Installed Service Cable		1997	7,666		15			7,666	33
34		A/C Untis		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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		(124)	3,917	44
45	Building Addition	1998	239,137		15			239,137	45
46	Parking Lot	1998	13,916		15			13,916	46
47	Flooring- Adjustment to 1998 Building Addition	1999	737		5			737	47
48	Door alarm system	1999	6,691		10			6,691	48
49	Wallpaper & Painting	1999	8,314		5			8,314	49
50	Install Bookcase in Admin Office	1999	333		10			333	50
51	Landscaping	1999	5,931		10			5,931	51
52	Seal Coated and Striped Parking Lot	1999	1,646		8			1,646	52
53	Install Telephones in Breakroom & Dining	1999	777		5			777	53
54	Move Phone Lines	1999	328		5			328	54
55	Entrance Sign	1999	1,000		5			1,000	55
56	Paint Window Grids	1999	175		5			175	56
57	Installation of Flooring	1999	8,949		10			8,949	57
58	Fountain & Light	1999	1,774		5			1,774	58
59	Balance of Trim, Mirrors, Permanent Decorative Features	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 plumbings & electrical services, install								63
64	cabinetry & countertops, and installed new flooring. Labor &								64
65	materials to gut an existing bathroom & rehab room to create								65
66	2 new bathrooms & storage area for housekeeping & dietary								66
67	(to be complete in 2000). Labor & Materials to install new								67
68	cabinets , relocated plumbing & electrical, repair drywall &								68
69	paint the breakroom								69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 682		\$	\$ (682)	\$ 834,312	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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		\$ 834,312	\$ 682		\$	\$ (682)	\$ 834,312	1
2	Labor & Materials to complete 1999 bathroom project	2000	20,296		10			20,296	2
3	Installed ceramic tile, sinks, toilet stool, showers, and								3
4	lighting fixtures								4
5	Labor & Materials to remove existing wall in order to convert	2000	11,212		10			11,212	5
6	storage room into a resident room, removed existing closets								6
7	& installed shower area, relocated doors, electrical &								7
8	plumbing services, repaired & painted drywall and relocated								8
9	call lights								9
10	Excavate & replace driveway asphalt & fill in cracks with tar	2001	3,075		15			3,075	10
11	Reinforce & raise sinking floor on B Wing	2001	7,380		15			7,380	11
12	Gut beauty shop area & construct a new handicapped	2001	16,165		15			16,165	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet, sink,								13
14	door, sprinkler heads, cubicle tracks, & curtains & cove base								14
15	Sewer repair to 3 bed ward bathroom. Removed concrete &	2001	2,800		15			2,800	15
16	replaced deteriorated sewer line, install new line, & new								16
17	clean out & pour new floor.								17
18	Relocate beauty shop to Pt area. Installed lines, clean out &	2001	1,223		15			1,223	18
19	shut off valves, drill & knock out outside brick wall, install								19
20	fan, finish drywall, paint, install tile on drywall, install								20
21	sink & shelves								21
22	Convert existing bathroom to handicapped bathroom, remove	2001	7,124		15			7,124	22
23	tile, install box for call lights, tear out & reconstruct								23
24	showers, file wall & showers, install handrails in tub &								24
25	shower, hang tracks & curtains, put new lever, hand door								25
26	lever								26
27	Add fan to isolation room for Medicare Compliance	2001	386		15			386	27
28	Install 2 sprinkler heads in store room & water heater closet	2001	338		15			338	28
29	Upgrade emergency lighting & moved annunciator panel &	2001	15,138		10			15,138	29
30	smoke detector								30
31	Upgraded nurses call station	2001	645		10			645	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 920,094	\$ 682		\$	\$ (682)	\$ 920,094	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 920,094	\$ 682		\$	\$ (682)	\$ 920,094	1
2	Install Grease trap & wet well	2002	13,224		10			13,224	2
3	Replace rusted out main line in B Hallway & reinstalled	2002	3,494		10			3,494	3
4	drain to connect to mainline in B Hall Bath								4
5	Removed old flooring & replaced with ceramic tile in A Hall	2002	1,706		10			1,706	5
6	Bathroom								6
7	Repair roof over front Dining Room & Activity Room	2002	8,230		10			8,230	7
8	Landscaping off Courtyard	2004	1,109		10			1,109	8
9	Remove, repair & install tile flooring in Dining Room	2005	7,222		10			7,222	9
10	Replace tile in Hall, TV Room, & Small Hallway	2008	3,310		10	165	165	3,310	10
11	Replace roof over Kitchen & Dining Room & Repairs to	2009	7,615		10	762	762	7,238	11
12	A & B Halls								12
13	5' x 6' Entrance Sign	2009	1,599		5			1,599	13
14	Repair flat roof area on back of building	2010	5,980	399	15	399		3,390	14
15	Demo & Install ductwork on back of building	2010	3,792	253	15	253		2,149	15
16	Installed fire rated carpet on walls	2011	6,126		5			6,126	16
17	Seal & Stripe parking lot	2011	1,380		5			1,380	17
18	Install 400 Amp Breaker box & new disconnect	2011	4,395		20	220	220	1,649	18
19	Replace 139 Sprinkler heads	2012	17,509	584	15	1,167	583	7,587	19
20	Replace roof on East & West wings	2013	20,139	671	20	1,343	672	7,385	20
21	Install Fire Sprinkler system on C wing	2013	11,700	390	25	468	78	2,574	21
22									22
23	Replaced B Wing Roof	2014	19,305	644	15	1,287	643	5,792	23
24	Replaced Sprinkler system throughout the building	2014	79,900	2,523	25	3,196	673	7,192	24
25	except Medicare C wing								25
26	Replace Admin section roof	2014	9,490	316	15	633	317	2,847	26
27	Cost Reduction- Sprinkler System (See Line 24)	2015	(2,100)		25	(84)	(84)	(336)	27
28	Storage Shed	2015	8,271	318	10	827	509	2,895	28
29	Install Vinyl wallcovering & Crash Rails - C Wing	2015	7,052	440	10	705	265	1,839	29
30	Replace flooring/wall tiles in C wing Large Bathroom	2015	4,672	292	10	467	175	1,636	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,165,214	\$ 7,512		\$ 11,808	\$ 4,296	\$ 1,021,331	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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 12C, Carried Forward		\$ 1,165,214	\$ 7,512		\$ 11,808	\$ 4,296	\$ 1,021,331	1
2	Install Security System	2016	7,815	684	7	1,117	433	3,349	2
3	Install rooftop A/C Heater - C Wing roof	2016	5,200	455	7	743	288	2,229	3
4	Install new water line/ tankless water heater- Laundry	2016	4,203	368	7	600	232	1,801	4
5	Therapy Room Imp-Replace flooring, cabinets, countertops,								5
6	blinds, track lighting, patched & painted walls	2016	5,972	398	15	398		1,194	6
7	Beauty shop/bathroom Imp-Replace flooring, new water lines,								7
8	sinks, toilet, electrical upgradesm exhaust fan	2016	7,233	482	15	482		1,447	8
9	Water Heater & Installation	2017	4,676	935	5	935		1,403	9
10	Wall Repairs, Paint Ceiling, and Handrails	2017	7,502	500	15	500		875	10
11	3 Door Cooler	2017	3,154	315	10	315		473	11
12	Paint, flooring, & installation for dining room	2017	21,586	2,159	10	2,159		2,878	12
13	Flooring & installation for A-Wing Bathrooms	2017	3,137	209	15	209		279	13
14	Wander Guard Alarm	2017	3,022	432	7	432		540	14
15	Wash Basin, shower system, vanity for A- Wing	2017	3,995	266	15	266		333	15
16	Sliding doors & cabinets for dining & activity	2017	3,874	258	15	258		387	16
17	New doors for A-Wing Offices	2017	2,278	152	15	152		228	17
18	Tankless Water Heater	2018	5,140	471	10	471		471	18
19	40 Gal Water Heater	2018	1,806	151	10	151		151	19
20	Windows entire facility	2018	22,000	1,100	15	1,100		1,100	20
21	Wall Rep & Painting of A & B wings	2018	3,740	499	5	499		499	21
22	Wallcovering, Crash Rail & Corner Guards for entire facility	2018	11,017	1,285	5	1,285		1,285	22
23	Flooring for entire facility	2018	50,728	2,959	10	2,959		2,959	23
24	Wooden Pt Room Doors for entire facility	2018	15,214	507	15	507		507	24
25	New Heating & Cooling units all pt rooms	2018	117,749	4,579	15	4,579		4,579	25
26	400Amp tfr switch & wire to main service	2018	3,547	118	15	118		118	26
27	3/4 inch Conduit for C Hall	2018	6,165	128	20	128		128	27
28	Repair & Painting of A & C Wing Rooms	2018	5,984	399	5	399		399	28
29	Door installation & Parts	2018	9,911	165	15	165		165	29
30	New Sink & Under Sink Water Heater	2018	3,222	36	15	36		36	30
31	Blinds throughout the facility	2018	8,466	141	10	141		141	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,513,550	\$ 27,663		\$ 32,912	\$ 5,249	\$ 1,051,285	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 63,240	\$ 1,646	\$ 7,014	\$ 5,368	5-15 Yrs	\$ 38,271	71
72	Current Year Purchases	11,760	1,096	1,096		5-12 Yrs	1,096	72
73	Fully Depreciated Assets	328,268					328,268	73
74								74
75	TOTALS	\$ 403,268	\$ 2,742	\$ 8,110	\$ 5,368		\$ 367,635	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)	\$ 1,920,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,405	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,022	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,617	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,418,920	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2019</u>	\$ _____
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,842

Description: Storage

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				57,775		57,775	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39,2					10,871		10,871	12
13	Other (specify): <u>Therapy, Lab, X-Ray</u>	39,3				194,566			194,566	13
14	TOTAL			\$		\$ 194,566	\$ 68,646		\$ 263,212	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(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	\$ 42,371	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	430,903		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,209		7
8	Accounts Receivable (owners or related parties)	9,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 494,483	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	11,688		14
15	Leasehold Improvements, at Historical Cost	689,936		15
16	Equipment, at Historical Cost	535,640		16
17	Accumulated Depreciation (book methods)	(847,203)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 390,061	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 884,544	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 266,774	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,521		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,327		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,648		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	30,387		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 388,657	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 388,657	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 495,887	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 884,544	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,227,808	1
2	Restatements (describe):		2
3			3
4	Prior Year Bad Debt Adjustment	(400,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 827,808	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(240,421)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(91,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (331,921)	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)	\$ 495,887	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 2,044,579	1
2	Discounts and Allowances for all Levels	(15,380)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,029,199	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,792	6
7	Oxygen	688	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 312,480	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	688	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	60,864	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,450	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,206	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,208	23
D. Non-Operating Revenue			
24	Contributions	2,305	24
25	Interest and Other Investment Income***	4,802	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,107	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	3,666	28
28a	Energy Incentive	715	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,381	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,422,375	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	570,799	31
32	Health Care	1,061,429	32
33	General Administration	562,758	33
B. Capital Expense			
34	Ownership	67,087	34
C. Ancillary Expense			
35	Special Cost Centers	263,212	35
36	Provider Participation Fee	137,511	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,662,796	40
41	Income before Income Taxes (line 30 minus line 40)**	(240,421)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (240,421)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 977,974	44
45	Private Pay - Net Inpatient Revenue	815,597	45
46	Medicare - Net Inpatient Revenue	245,732	46
47	Other-(specify) <u>Insurance</u>	24,466	47
48	Other-(specify) <u>Discounts and Allowances</u>	(34,570)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,029,199	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Fairview Nursing Center

0024992

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,019	\$ 62,438	\$ 27.60	1
2	Assistant Director of Nursing				2
3	Registered Nurses	4,177	109,524	23.94	3
4	Licensed Practical Nurses	7,198	150,196	19.48	4
5	CNAs & Orderlies	29,468	371,303	11.79	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	3,372	50,175	13.74	10
11	Social Service Workers	1,775	26,834	13.08	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	12,410	137,573	10.45	15
16	Dishwashers				16
17	Maintenance Workers	3,641	58,890	15.83	17
18	Housekeepers	7,782	80,664	9.87	18
19	Laundry	3,865	51,664	12.54	19
20	Administrator	2,012	80,544	35.81	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,881	34,787	17.87	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	79,600	\$ 1,214,592 *	\$ 14.27	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	102	\$ 5,260	1,3	35
36	Medical Director	Monthly	2,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,550	11,3	44
45	Social Service Consultant	24	1,550	12,3	45
46	Other(specify)				46
47	Utilization Review		1,683	10,3	47
48					48
49	TOTAL (lines 35 - 48)	150	\$ 12,443		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	18	\$ 943	10,3	50
51	Licensed Practical Nurses	3,900	167,765	10,3	51
52	Certified Nurse Assistants/Aides	3,120	85,263	10,3	52
53	TOTAL (lines 50 - 52)	7,038	\$ 253,971		53

SEE ACCOUNTANTS' PREPARATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line 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. \$ 137,511
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 688
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT