

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0024992</u></p> <p>Facility Name: <u>FAIRVIEW NURSING CENTER</u></p> <p>Address: <u>602 EAST JACKSON</u> <u>DUQUOIN</u> <u>62832</u> Number City Zip Code</p> <p>County: <u>PERRY</u></p> <p>Telephone Number: <u>(618) 542-3441</u> Fax # <u>(618) 542-6351</u></p> <p>IDPA ID Number: <u>370923910001</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROGER W. BAGLEY</u> Telephone Number: <u>(618) 549-8331</u> JAMESTOWN MANAGEMENT CORP</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>ROGER W. BAGLEY</u></td> </tr> <tr> <td></td> <td>(Title) <u>CONTROLLER</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>ROGER W. BAGLEY</u>		(Title) <u>CONTROLLER</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
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Paid Preparer	(Signed) _____ (Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) () _____ Fax # () _____																																						

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	7,320	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	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				
		Public Aid Recipient	Private Pay	Other		Total
		8	SNF			1,514
9	SNF/PED					9
10	ICF	15,934	5,126		21,060	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,934	6,640	562	23,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.18%

D. How many bed-hold days during this year were paid by Public Aid? 3 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/10/70

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 562

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/04 Fiscal Year: _____

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	95,007	5,240	6,222	106,469		106,469		106,469		1
2	Food Purchase		69,290		69,290	3,103	72,393	(213)	72,180		2
3	Housekeeping	64,226	6,387		70,613	(38)	70,575		70,575		3
4	Laundry	46,607	4,962		51,569		51,569		51,569		4
5	Heat and Other Utilities			49,274	49,274	346	49,620		49,620		5
6	Maintenance	20,529	11,383	21,848	53,760		53,760		53,760		6
7	Other (specify):*										7
8	TOTAL General Services	226,369	97,262	77,344	400,975	3,411	404,386	(213)	404,173		8
	B. Health Care and Programs										
9	Medical Director			900	900		900		900		9
10	Nursing and Medical Records	580,719	15,531	81,917	678,167	(2,299)	675,868		675,868		10
10a	Therapy	2,051		168	2,219		2,219		2,219		10a
11	Activities	32,738	3,658	1,340	37,736	(2,153)	35,583		35,583		11
12	Social Services	22,014		1,340	23,354		23,354		23,354		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	637,522	19,189	85,665	742,376	(4,452)	737,924		737,924		16
	C. General Administration										
17	Administrative	53,906		7,147	61,053	46,544	107,597		107,597		17
18	Directors Fees										18
19	Professional Services			141,204	141,204	(76,558)	64,646	(59,184)	5,462		19
20	Dues, Fees, Subscriptions & Promotions			8,407	8,407	132	8,539	(1,919)	6,620		20
21	Clerical & General Office Expenses	23,457	5,741	7,640	36,838	12,091	48,929	(421)	48,508		21
22	Employee Benefits & Payroll Taxes			218,649	218,649	9,921	228,570		228,570		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,663	2,663	148	2,811		2,811		24
25	Other Admin. Staff Transportation					1,315	1,315		1,315		25
26	Insurance-Prop.Liab.Malpractice			42,392	42,392	1,430	43,822		43,822		26
27	Other (specify):*										27
28	TOTAL General Administration	77,363	5,741	428,102	511,206	(4,977)	506,229	(61,524)	444,705		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	941,254	122,192	591,111	1,654,557	(6,018)	1,648,539	(61,737)	1,586,802		29

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

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

Facility Name & ID Number

FAIRVIEW NURSING CENTER

#0024992

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			27,344	27,344	1,619	28,963	27,966	56,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			625	625		625	15,800	16,425			32
33	Real Estate Taxes			14,373	14,373	519	14,892		14,892			33
34	Rent-Facility & Grounds			44,828	44,828	3,880	48,708	(44,828)	3,880			34
35	Rent-Equipment & Vehicles			883	883		883		883			35
36	Other (specify):*											36
37	TOTAL Ownership			88,053	88,053	6,018	94,071	(1,062)	93,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,795	45,145	70,940		70,940		70,940			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,724	41,724		41,724		41,724			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		25,795	86,869	112,664		112,664		112,664			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	941,254	147,987	766,033	1,855,274		1,855,274	(62,799)	1,792,475			45

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

FAIRVIEW NURSING CENTER

ID# 0024992

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DETAIL FOR LINE 29 SCH VI	\$		1
2	PICK UP ONE YEAR OF 2 YEAR IDPH	200	20	2
3	LICENSE PAID IN 2003			3
4				4
5	ELIMINATE CHAMBER OF COMMERCE DUES	(100)	20	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
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	100		49

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	OHF 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	17,338	30		9
10	Interest and Other Investment Income	(2,057)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(213)	2		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	(46)	21		18
19	Entertainment				19
20	Contributions	(375)	21		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	(1,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(534)	20		28
29	Other-Attach Schedule	100			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 12,728		\$	30

OHF 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)	(75,527)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,527)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (62,799)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(213)	0	0	0	0	0	0	0	0	0	0	(213)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(213)	0	0	0	0	0	0	0	0	0	0	(213)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(59,184)	0	0	0	0	0	0	0	0	0	(59,184)	19
20	Fees, Subscriptions & Promotions	(1,919)	0	0	0	0	0	0	0	0	0	0	(1,919)	20
21	Clerical & General Office Expenses	(421)	0	0	0	0	0	0	0	0	0	0	(421)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,340)	(59,184)	0	(61,524)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,553)	(59,184)	0	(61,737)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	17,338	10,628	0	0	0	0	0	0	0	0	0	27,966 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,057)	17,857	0	0	0	0	0	0	0	0	0	15,800 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(44,828)	0	0	0	0	0	0	0	0	0	(44,828) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	15,281	(16,343)	0	(1,062) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	12,728	(75,527)	0	(62,799) 45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	Carbondale	Management
		SENIOR MANOR NURSING HOME	SPARTA	Fairview Residential	Duquoin	Owns building
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Land Trust		

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	19	MANAGEMENT FEES	\$ 135,978	JAMESTOWN MANAGEMENT CORPORATION	100.00%	\$ 76,794	\$ (59,184)	1
2	V	30	DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	10,628	10,628	2
3	V	34	RENT	44,828	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%		(44,828)	3
4	V	32	INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	17,857	17,857	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		\$ 180,806			\$ 105,279	\$ *	(75,527)	14

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

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT***								\$		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

Facility Name & ID Number **FAIRVIEW NURSING CENTER**

0024992 Report Period Beginning: **01/01/04**

Ending: **12/31/04**

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 Corp
 Street Address 1001 E 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	HOURS OF SERVICE 16,655		\$ 6,090	\$	2,448	\$ 895	1
2	5	UTILITIES	HOURS OF SERVICE 16,655		2,357		2,448	346	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE 11,093		316,560	316,560	1,631	46,544	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE 16,655		1,609		2,448	236	4
5	20	LICENSE AND DUES	HOURS OF SERVICE 16,655		900		2,448	132	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE 5,562		67,833	67,833	817	9,964	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE 16,655		11,228		2,448	1,650	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE 16,655		55,218		2,448	8,116	8
9	24	SEMINARS	HOURS OF SERVICE 11,093		1,008		1,631	148	9
10	25	AUTO EXPENSE	HOURS OF SERVICE 11,093		8,946		1,631	1,315	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE 16,655		9,731		2,448	1,430	11
12	30	DEPRECIATION	HOURS OF SERVICE 16,655		11,018		2,448	1,619	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE 16,655		3,529		2,448	519	13
14	34	RENT	HOURS OF SERVICE 16,655		26,400		2,448	3,880	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 522,427	\$ 384,393		\$ 76,794	25

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANTERRA BANK		X	FINANCE CONSTRUCTION	\$2,666.00	03-01-99	\$ 310,000	\$ 258,680	02-01-16	0.0600	\$ 17,857	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANTERRA BANK		X	REVOLVING LINE OF						0.0550	625	6
7				CREDIT FOR OPERATING								7
8				FUNDS								8
9	TOTAL Facility Related				\$2,666.00		\$ 310,000	\$ 258,680			\$ 18,482	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 310,000	\$ 258,680			\$ 18,482	15

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

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

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

Facility Name & ID Number **FAIRVIEW NURSING CENTER**

0024992 Report Period Beginning: **01/01/04** Ending: **12/31/04**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2003 report.		\$ 15,000	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.)		\$ 14,373	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (627)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 15,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 14,373	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	12,982	8
	2000	14,318	9
	2001	14,244	10
	2002	14,587	11
	2003	14,373	12
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<p>***Line 7 does not include the Jamestown allocation from page 8 SCH VIII \$518. Real estate taxes on page 4 line 33 should reconcile to line 7 \$14373 + Jamestown \$519 = \$14892</p>			

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING CENTER COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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. 1-61-0270-100	sec 17 twp 06 rng 01 s sw sw ne e 215	\$ 14,373.00	\$ 14,373.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,373.00</u>	\$ <u>14,373.00</u>

B. Real Estate Tax Cost Allocation:

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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING	76,230	1968	\$ 3,996	1
2					2
3	TOTALS	76,230		\$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1968	1968	\$ 94,863	\$	40	\$ 2,372	\$ 2,372	\$ 87,091	4
5		1968	1968	61,381		20			61,381	5
6		1970	1970	3,953		20			3,953	6
7	18	1970	1970	26,047		38	685	685	23,804	7
8	16	1976	1976	177,922		30	5,931	5,931	170,517	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	765	765	14,344	13
14	ACTIVITY ROOM		1987	5,223		20	261	261	4,763	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	275	275	3,988	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	564	445	8,178	22
23	ROOF		1990	13,831	439	25	553	114	8,019	23
24	TELEPHONE		1991	3,274		20	164	164	2,214	24
25	WATER HEATER		1991	1,945		15	130	130	1,755	25
26	EMERGENCY LIGHTS		1992	960		15	64	64	800	26
27	SEAL & STRIPE PARKING LOT		1994	1,421		5			1,421	27
28	EMERGENCY LIGHTS		1995	994		15	99	99	941	28
29	HOT WATER HEATER		1995	7,433		15	496	496	4,712	29
30	SUBPANELS & CIRCUITS INSTALLED TO A/C		1996	2,394	239	10	240	1	2,040	30
31	PT A/C UNIT		1996	1,163	116	10	116		986	31
32	A/C UNIT		1996	1,071	107	10	107		914	32
33	INSTALLED SERVICE CABLE		1997	7,666	511	15	511		3,833	33
34	A/C UNITS		1998	698	62	10	70	8	455	34
35	HOT WATER HEATER		1998	2,985	267	15	199	(68)	1,294	35
36	OVERBED LIGHTING		1998	8,932	798	15	595		3,868	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	CARPET	1998	\$ 588	\$ 53	5	\$	\$ (53)	\$ 588	37	
38	1998	1998	3,599	321	15	240	(81)	1,560	38	
39	CABINETS & COUNTERTOPS	1998	708	63	5		(63)	708	39	
40	WALLPAPER & INSTATION	1998	9,457	845	5		(845)	9,457	40	
41	PAINTING	1998	11,779	1,052	5		(1,052)	11,779	41	
42	Trim, pictures, mirrors, permanent decorative fixtures	1998	2,007	179	5		(179)	2,007	42	
43	FLOOR COVE BASE	1998	901	80	5		(80)	901	43	
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	1,436	44	
45	BUILDING ADDITION	1998	239,137		15	15,942	15,942	87,681	45	
46	PARKING LOT	1998	13,916		15	928	928	6,032	46	
47	FLOORING - ADJUSTMENT TO 1998 BUILDING ADDITION	1999	737		5	75	75	737	47	
48	DOOR ALARM SYSTEM	1999	6,691		10	669	669	3,680	48	
49	WALLPAPER & PAINTING	1999	8,314	831	5	831		8,314	49	
50	INSTALL BOOKCASE IN ADMIN OFFICE	1999	333	9	10	36	27	333	50	
51	LANDSCAPING	1999	5,931	593	10	593		3,262	51	
52	SEAL COATED & STRIPED PARKING LOT	1999	1,646	206	8	206		1,133	52	
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777	105	5	79	(26)	777	53	
54	MOVE PHONE LINES	1999	328	37	5	27	(10)	328	54	
55	ENTRANCE SIGN	1999	1,000	50	5	100	50	1,000	55	
56	PAINT WINDOW GRIDS	1999	175	12	5	17	5	175	56	
57	INSTALLATION OF FLOORING	1999	8,949	895	10	895		4,922	57	
58	FOUNTAIN & LIGHT	1999	1,774	236	5	177	(59)	1,774	58	
59	balance of trim, mirrors, permanent decorative fixtures to refurbish the building	1999	3,952	69	5	397	328	3,952	59	
60									60	
61	AWNINGS		420	37	5	42	5	420	61	
62	Labor & materials to remove existing wall & rebuild new wall, relocate plumbing & electrical services, install cabinetry & countertops, and installed new tile flooring. Labor & materials to gut an existing bathroom and rehab room to create 2 new bathrooms and storage areas for housekeeping and dietary (to be completed in 2000). Labor & materials to install new cabinets, relocate plumbing & electrical, repair drywall & paint the breakroom.	1999	8,559	856	10	856		4,708	62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 9,311		\$ 36,568	\$ 27,460	\$ 615,603	70	

**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:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 834,312	\$ 9,311		\$ 36,568	\$ 27,257	\$ 615,603	1
2	Labor & materials to complete 1999 bathroom project	2000	20,296	2,030	10	2,030		9,135	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	1,121	10	1,121		5,045	5
6	storage room into a resident room. Removed existing								6
7	closets, installed shower area, relocated doors, electrical,								7
8	and plumbing services, repaired and painted drywall &								8
9	relocated call lights.								9
10	Excavate & replace driveway asphalt & fill in cracks with tar	2001	3,075	205	15	205		718	10
11	Reinforce & raise sinking floor on B wing.	2001	7,380	492	15	492		1,722	11
12	Gut beauty shop area and construct a new handicapped	2001	16,165	1,078	15	1,078		3,773	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet								13
14	sink, door, sprinkler heads, cubicle tracks & curtains,								14
15	and cove base.								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete	2001	2,800	187	15	187		654	16
17	replaced deteriorated sewer line, install new line, and new								17
18	clean out and pour new floor.								18
19	Relocate beauty shop to PT area. Installed lines, clean out	2001	1,223	82	15	82		287	19
20	& shut off valves, drill & knock out outside brick wall								20
21	install fan, finish drywall, paint, install tile on drywall,								21
22	install sink & shelves.								22
23	Convert existing bathroom to handicapped bathroom	2001	7,124	475	15	475		1,662	23
24	Remove tile, install box for call lights, tear out & reconstruct								24
25	showers, tile walls & showers, install handrails in tub &								25
26	showers, hank tracks & curtains, put new lever handle door								26
27	lever.								27
28	Add fan to isolation room for Medicare compliance	2001	386	26	15	26		91	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	23	15	23		80	29
30	Upgrade emergency lighting & moved annunciator panel	2001	15,138	1,514	10	1,514		5,299	30
31	& smoke detectors.								31
32	Upgrade nurses call station.	2001	645	65	10	65		227	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 920,094	\$ 16,609		\$ 43,866	\$ 27,257	\$ 644,296	34

**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:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	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	\$ 16,609		\$ 43,866	\$ 27,257	\$ 644,296	1
2	Install grease trap and wet well	2002	13,224	1,322	10	1,322		3,305	2
3	Replaced rusted out main line drain in B hallway and	2002	3,494	349	10	171	(178)	427	3
4	reinstalled drain to connect to mainline in B hall bath								4
5	Removed old flooring and replaced with ceramic tile in	2002	1,706	171	10	349	178	873	5
6	A hall bathroom								6
7	Repair roof over front dining room and activity room	2002	8,230	823	10	823		2,058	7
8	LANDSCAPING OF COURTYARD	2004	1,109	55	10	55		55	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 947,857	\$ 19,329		\$ 46,586	\$ 27,257	\$ 651,014	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 98,871	\$ 2,850	\$ 8,466	\$ 5,616		\$ 66,412	71
72	Current Year Purchases	5,165	5,165	258	(4,907)		258	72
73	Fully Depreciated Assets	172,298					172,298	73
74								74
75	TOTALS	\$ 276,334	\$ 8,015	\$ 8,724	\$ 709		\$ 238,968	75

D. Vehicle Depreciation (See instructions).*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			\$	\$ 1,619	\$ 1,619	\$		\$ 16,182	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,619	\$ 1,619	\$		\$ 16,182	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)	\$ 1,228,187	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,963	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,929	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,966	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 906,164	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	PARKING LOT 1968	\$ 3,720	\$	\$ 3,720	86
87	ROOF 1968	7,440		7,440	87
88	FIRE ALARM 1969	130		130	88
89	EQUIPMENT VAR	24,719		24,719	89
90	Assets no longer in use (obsolete)				90
91	TOTALS	\$ 36,009	\$	\$ 36,009	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

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> </u> /2005	\$ <u> </u>
13.	<u> </u> /2006	\$ <u> </u>
14.	<u> </u> /2007	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 883 Description: DISH MACHINE 769; STORAGE 114

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES 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>WE ONLY HIRE TRAINED AIDES.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost							
1	Licensed Occupational Therapist	39/3;39/2	hrs	\$	231	\$ 16,919	\$ 200	231	\$	17,119	1			
2	Licensed Speech and Language Development Therapist	39/3	hrs		87	6,914		87		6,914	2			
3	Licensed Recreational Therapist		hrs								3			
4	Licensed Physical Therapist	39/3	hrs		30	19,307		30		19,307	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				18,273			18,273	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10			
11	Academic Education		hrs								11			
12	Exceptional Care Program										12			
13	med sup, tube feeding, oxygen, Other (specify): lab, xray	39/2 39/3				2,005	7,322			9,327	13			
14	TOTAL			\$	348	\$ 45,145	\$ 25,795	348	\$	70,940	14			

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

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 59,668	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	223,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	318,807		5
6	Prepaid Insurance	(8,983)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INVESTMENT	6,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 598,605	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	154,747		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	390,799		16
17	Accumulated Depreciation (book methods)	(430,827)		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)	\$ 114,719	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 713,324	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 32,505	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,750		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,505		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401k LIABILITY	9,418		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 97,178	\$	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)	\$ 97,178	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 616,146	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 713,324	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 542,417	1
2	Restatements (describe):		2
3	2003 IL REPLACEMENT TAX	(1,628)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 540,789	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	89,652	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) EXCESS SALARIES ELIMINATED	(14,295)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 75,357	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)	\$ 616,146	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

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

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

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,846,937	1
2	Discounts and Allowances for all Levels	7,306	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,854,243	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,080	6
7	Oxygen	4,608	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 87,688	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	938	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 938	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,057	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,057	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,944,926	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	400,975	31
32	Health Care	742,376	32
33	General Administration	511,206	33
B. Capital Expense			
34	Ownership	88,053	34
C. Ancillary Expense			
35	Special Cost Centers	70,940	35
36	Provider Participation Fee	41,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,855,274	40
41	Income before Income Taxes (line 30 minus line 40)**	89,652	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 89,652	43

* 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. IL replacement tax deduction on federal return

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

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

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

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Ending:

12/31/04

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	1,952	2,080	\$ 42,823	\$ 20.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	898	936	17,580	18.78	3
4	Licensed Practical Nurses	13,099	14,044	194,662	13.86	4
5	Nurse Aides & Orderlies	34,350	36,246	325,654	8.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	196	212	2,051	9.67	8
9	Activity Director	2,839	3,046	32,738	10.75	9
10	Activity Assistants					10
11	Social Service Workers	1,706	1,950	22,014	11.29	11
12	Dietician					12
13	Food Service Supervisor	2,097	2,210	23,873	10.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,459	9,189	71,134	7.74	15
16	Dishwashers					16
17	Maintenance Workers	1,502	1,653	20,529	12.42	17
18	Housekeepers	6,368	6,901	64,226	9.31	18
19	Laundry	4,001	4,354	46,607	10.70	19
20	Administrator	1,872	2,080	53,906	25.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,977	2,080	23,457	11.28	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)	81,316	86,981	\$ 941,254 *	\$ 10.82	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	119	\$ 6,222	1/3	35
36	Medical Director		300	9/3	36
37	Medical Records Consultant		900	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	10/3	39
40	Physical Therapy Consultant	2	134	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	34	10/3	43
44	Activity Consultant	42	1,340	11/3	44
45	Social Service Consultant	42	1,340	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		12	19/3	47
48	UTILIZATION REVIEW		900	10/3	48
49	TOTAL (lines 35 - 48)	206	\$ 11,602		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10/3	50
51	Licensed Practical Nurses	1,315	37,285	10/3	51
52	Nurse Aides	2,371	43,012	10/3	52
53	TOTAL (lines 50 - 52)	3,686	\$ 80,297		53

Facility Name & ID Number FAIRVIEW NURSING CENTER

002492

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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. _____
- (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? _____
- (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? _____
- (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? 10yrs
- (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 _____
- (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. _____
- (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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,724
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 of Public Aid, 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 benefit on Schedule V. \$ 1,805 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees