

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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.

**I. IDPH License ID Number:** 0027367

**Facility Name:** FAIR ACRES NURSING HOME

**Address:** 514 EAST JACKSON DUQUOIN 62832  
 Number City Zip Code

**County:** PERRY

**Telephone Number:** (618) 542-4731 Fax # (618) 542-4732

**HFS ID Number:** 371119686001

**Date of Initial License for Current Owners:** 10/10/82

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** ROGER W. BAGLEY **Telephone Number:** (618) 549-8331  
JAMESTOWN MGMT CORP

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>ROGER W. BAGLEY</u>	
	(Title) <u>CONTROLLER</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	<u>29</u>	Skilled (SNF)	<u>29</u>	<u>10,585</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>16,425</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>964</u>	<u>1,860</u>	<u>2,824</u>	8
9	SNF/PED					9
10	ICF	<u>9,569</u>	<u>4,592</u>		<u>14,161</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,569</u>	<u>5,556</u>	<u>1,860</u>	<u>16,985</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.88%

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

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

G. Do pages 3 &amp; 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 1966

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 29 and days of care provided 1,860Medicare Intermediary NATIONAL GOVERNMENT SERVICES

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2007 Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	87,896	4,707	5,843	98,446		98,446		98,446		1
2	Food Purchase		68,018		68,018	3,607	71,625	(237)	71,388		2
3	Housekeeping	47,323	6,549		53,872	966	54,838		54,838		3
4	Laundry	37,288	3,696		40,984		40,984		40,984		4
5	Heat and Other Utilities			74,385	74,385	395	74,780		74,780		5
6	Maintenance	28,424	17,194	34,214	79,832		79,832	1,026	80,858		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>200,931</b>	<b>100,164</b>	<b>114,442</b>	<b>415,537</b>	<b>4,968</b>	<b>420,505</b>	<b>789</b>	<b>421,294</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			900	900		900		900		9
10	Nursing and Medical Records	498,831	19,785	232,468	751,084	(3,607)	747,477		747,477		10
10a	Therapy			21	21		21		21		10a
11	Activities	15,333	1,454	1,510	18,297		18,297		18,297		11
12	Social Services	22,540		1,511	24,051		24,051		24,051		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>536,704</b>	<b>21,239</b>	<b>236,410</b>	<b>794,353</b>	<b>(3,607)</b>	<b>790,746</b>		<b>790,746</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	56,080			56,080	40,953	97,033		97,033		17
18	Directors Fees										18
19	Professional Services			135,750	135,750	(73,039)	62,711	(60,491)	2,220		19
20	Dues, Fees, Subscriptions & Promotions			11,203	11,203	141	11,344	(3,373)	7,971		20
21	Clerical & General Office Expenses	19,912	6,922	4,918	31,752	12,378	44,130	(396)	43,734		21
22	Employee Benefits & Payroll Taxes			122,022	122,022	7,940	129,962		129,962		22
23	Inservice Training & Education			475	475		475		475		23
24	Travel and Seminar			1,203	1,203	16	1,219		1,219		24
25	Other Admin. Staff Transportation					1,956	1,956		1,956		25
26	Insurance-Prop.Liab.Malpractice			35,583	35,583	1,503	37,086		37,086		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>75,992</b>	<b>6,922</b>	<b>311,154</b>	<b>394,068</b>	<b>(8,152)</b>	<b>385,916</b>	<b>(64,260)</b>	<b>321,656</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>813,627</b>	<b>128,325</b>	<b>662,006</b>	<b>1,603,958</b>	<b>(6,791)</b>	<b>1,597,167</b>	<b>(63,471)</b>	<b>1,533,696</b>		<b>29</b>

\*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 **FAIR ACRES NURSING HOME**

#0027367

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			14,946	14,946	1,660	16,606	13,281	29,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					986	986	15,667	16,653			33
34	Rent-Facility & Grounds			54,000	54,000	4,145	58,145	(54,000)	4,145			34
35	Rent-Equipment & Vehicles			1,009	1,009		1,009		1,009			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			69,955	69,955	6,791	76,746	(25,052)	51,694			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,762	116,356	177,118		177,118		177,118			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		60,762	156,871	217,633		217,633		217,633			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	813,627	189,087	888,832	1,891,546		1,891,546	(88,523)	1,803,023			45

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

Facility Name & ID Number **FAIR ACRES NURSING HOME**

# **0027367**

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,421	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	(237)	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	(350)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,852)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,985)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(388)	20		28
29	Other-Attach Schedule	1,026			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,411)		\$	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)	(87,112)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (87,112)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (88,523)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

FAIR ACRES NURSING HOME

ID# 0027367

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DETAIL OF LINE 29 SCH VI	\$	1
2			2
3	DEFERRED PAINTING SCH XIX	1,026	6
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	1,026	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(237)	0	0	0	0	0	0	0	0	0	0	(237)	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	1,026	0	0	0	0	0	0	0	0	0	0	1,026	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>789</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>789</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(1,852)	(58,639)	0	0	0	0	0	0	0	0	0	(60,491)	19
20	Fees, Subscriptions & Promotions	(3,373)	0	0	0	0	0	0	0	0	0	0	(3,373)	20
21	Clerical & General Office Expenses	(396)	0	0	0	0	0	0	0	0	0	0	(396)	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	<b>TOTAL General Administration</b>	<b>(5,621)</b>	<b>(58,639)</b>	<b>0</b>	<b>(64,260)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,832)</b>	<b>(58,639)</b>	<b>0</b>	<b>(63,471)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	3,421	9,860	0	0	0	0	0	0	0	0	0	13,281	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	15,667	0	0	0	0	0	0	0	0	0	15,667	33
34	Rent-Facility & Grounds	0	(54,000)	0	0	0	0	0	0	0	0	0	(54,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>3,421</b>	<b>(28,473)</b>	<b>0</b>	<b>(25,052)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,411)</b>	<b>(87,112)</b>	<b>0</b>	<b>(88,523)</b>	<b>45</b>								

Facility Name & ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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
<u>LIST ATTACHED</u>		<u>CANTERBURY MANOR NURSING CENTER</u>	<u>WATERLOO</u>	<u>Twin Willows</u>	<u>DuQuoin</u>	<u>Real Estate Rental</u>
		<u>FAIRVIEW NURSING CENTER</u>	<u>DUQUOIN</u>	<u>Land Trust</u>		
				<u>Jamestown Mgmt Cor</u>	<u>Carbondale</u>	<u>Management</u>

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 <u>Rent</u>	\$ <u>54,000</u>	<u>TWIN WILLOWS LAND TRUST</u>	<u>100.00%</u>	\$	\$ <u>(54,000)</u>	1
2	V	30 <u>Depreciation</u>		<u>TWIN WILLOWS LAND TRUST</u>	<u>100.00%</u>	<u>9,860</u>	<u>9,860</u>	2
3	V	33 <u>Real Estate Taxes</u>		<u>TWIN WILLOWS LAND TRUST</u>	<u>100.00%</u>	<u>15,667</u>	<u>15,667</u>	3
4	V	19 <u>Jamestown Mgmt Fee</u>	<u>131,793</u>	<u>JAMESTOWN MANAGEMENT CORP</u>	<u>0.00%</u>	<u>73,154</u>	<u>(58,639)</u>	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	<b>Total</b>		\$ <u>185,793</u>			\$ <u>98,681</u>	\$ * <u>(87,112)</u>	14

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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 FAIR ACRES NURSING HOME

# 0027367 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 East Main Building 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	12,896	\$ 6,150	\$	2,025	\$ 966	1	
2	5	UTILITIES	HOURS OF SERVICE	12,896	2,515		2,025	395	2	
3	17	ADMINISTRATIVE	HOURS OF SERVICE	9,152	260,824	260,824	1,437	40,953	3	
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	12,896	735		2,025	115	4	
5	20	LICENSES AND DUES	HOURS OF SERVICE	12,896	900		2,025	141	5	
6	21	CLERICAL SALARIES	HOURS OF SERVICE	3,744	66,764	66,764	588	10,485	6	
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	12,896	12,054		2,025	1,893	7	
8	22	PAYROLL TAXES	HOURS OF SERVICE	12,896	50,562		2,025	7,940	8	
9	24	SEMINARS	HOURS OF SERVICE	9,152	99		1,437	16	9	
10	25	AUTO EXPENSE	HOURS OF SERVICE	9,152	12,455		1,437	1,956	10	
11	26	GENERAL INSURANCE	HOURS OF SERVICE	12,896	9,574		2,025	1,503	11	
12	30	DEPRECIATION	HOURS OF SERVICE	12,896	10,572		2,025	1,660	12	
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	12,896	6,281		2,025	986	13	
14	34	RENT	HOURS OF SERVICE	12,896	26,400		2,025	4,145	14	
15									15	
16									16	
17									17	
18		***EXCESS SALARIES OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO COST REPORT								18
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 465,885	\$ 327,588		\$ 73,154	25	

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Twin Willows Land Trust	X		working capital		12/2007	45,000	45,000			6									
7										7										
8										8										
9	<b>TOTAL Facility Related</b>						\$ 45,000	\$ 45,000		\$	9									
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 45,000	\$ 45,000		\$	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.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, 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 2006 report.		\$	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.)		\$ <b>15,667</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>15,667</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>15,667</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<b>14,601</b>	<b>8</b>
	2003	<b>14,387</b>	<b>9</b>
	2004	<b>17,013</b>	<b>10</b>
	2005	<b>15,291</b>	<b>11</b>
	2006	<b>15,667</b>	<b>12</b>
<b>Line 7 does not agree with the amount of SCH V line 33 because line 7 does not include the Jamestown allocation of \$986 from SCH VIII page 8. To reconcile R.E. Tax on page 4 line 33, add line 7 \$15667 and Jamestown allocation of \$986 to total R.E. Tax of \$16653</b>			
		<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME FAIR ACRES NURSING HOME COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0027367

CONTACT PERSON REGARDING THIS REPORT Roger W. Bagley

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

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1-61-0270-010</u>	<u>SEC 17 TWP 06 RNG 01 S SW SW</u>	<u>\$ 15,667.00</u>	<u>\$ 15,667.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ 15,667.00</b>	<b>\$ 15,667.00</b>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 FAIR ACRES NURSING HOME

# 0027367 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,703 B. General Construction Type: Exterior MASONRY Frame MASONRY & STEEL 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).

NOT 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	<u>BUILDING</u>	<u>125,722</u>		<u>\$ 18,792</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>125,722</u>		<u>\$ 18,792</u>	<u>3</u>

Facility Name &amp; ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1966	1966	\$ 179,381	\$	40	\$	\$	\$ 179,381	4
5			1966	1966	175,379		20			175,379	5
6			1987	1987	263,386		40	6,585	6,585	134,992	6
7											7
8											8
		<b>Improvement Type**</b>									
9		FULLY DEPRECIATED		1974	15,221					15,221	9
10		FULLY DEPRECIATED		1980	5,082					5,082	10
11		BUILDING IMPROVEMENT		1971	2,768					2,768	11
12		BUILDING IMPROVEMENT		1972	1,823					1,823	12
13		BUILDING IMPROVEMENT		1973	9,170					9,170	13
14		BUILDING IMPROVEMENT		1981	1,158					1,158	14
15		ROOF		1982	3,890					3,890	15
16		LAND IMPROVEMENT		1982	10,400					10,400	16
17		FIRE ALARM & SEAL PARKING LOT		1983	4,351					4,351	17
18		A/C ROOFTOP, WATERLINE, STORAGE BUILDING		1984	13,711					13,711	18
19		SEWER REPAIR		1987	1,330					1,330	19
20		PARKING LOT & PLUMBING		1988	14,182	77		339	262	12,321	20
21		A/C COMPRESSOR & ROOF		1989	23,834			764	764	14,289	21
22		ROOF REPAIR		1990	18,354			612	612	10,710	22
23		WATER HEATER & A/C UNITS		1990	4,675	38			(38)	4,675	23
24		CABINETS & NURSES STATION		1992	6,893	223		223		6,893	24
25		PARKING LOT SEALED & STRIPED		1994	4,138			276	276	3,726	25
26		HEAT EXCHANGE OF ROOF TOP UNITS INSTALLED		1995	2,638					2,638	26
27		WALL A/C UNITS INSTALLED		1996	1,976			132	132	1,518	27
28		REPAIRS TO GASOLINE		1997	3,786	189		189		1,985	28
29		REPLACED CARPETING		1997	795					795	29
30		INSTALLED 2 PT AC AIR & HEAT UNITS		1997	2,376			158	158	1,660	30
31		WATER HEATER & INSTALLATION		1998	780			78	78	741	31
32		ENTRANCE SIGN		1999	1,002					1,002	32
33		GAZEBO WITH RAMP & RAILING		1999	3,377	169		169		1,436	33
34		LANDSCAPING		1999	978					978	34
35		Repairs to damaged asphalt, seal/stripe parking lot		1999	2,101	210		210		1,785	35
36		INSTALL TILE FLOORING		2000	22,927	2,293		2,293		17,197	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 FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	INSTALL SHOWER FAUCET REPLACEMENTS	2000	\$ 1,731	\$ 173	10	\$ 173	\$	\$ 1,298	37
38	INSTALL CARPET ON WALLS	2000	4,898		10			4,898	38
39	WATER GARDEN	2000	922	92	5	92		690	39
40	Remove & replace damaged asphalt & fill cracks in parking lot	2001	10,546	703	15	703		4,570	40
41	REPLACE BATHROOM FLOOR TILES ON A & B HALLS	2001	2,994	299	10	299		1,944	41
42	REPLACE FLOORT TILES IN 3 BATHROOMS	2002	7,989	799	10	799		4,394	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346	1,335	10	1,335		7,342	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	268	10	268		1,206	44
45	INSTALL CABLE WIRING FOR TV CABLE	2003	1,220	244	5	244		1,098	45
46	INSTALL MIXING VALVE	2004	2,220	222	10	222		777	46
47	SEAL & PATCH PARKING LOT	2005	2,027	203	8	253	50	633	47
48	Replace hotwater storage tank & circulating pump	2005	7,100	355	20	355		888	48
49	INSTALL TILE & COVE BASE IN LOBBY	2005	1,186	119	10	119		297	49
50	REPAIR NORTH WING ROOF	2005	4,096	410	10	410		1,025	50
51	REPLACE 100 GAL HOTWATER HEATER	2005	4,900	490	10	490		1,225	51
52	Resurfaced counter and desk tops at nurses station and	2006	2,578	172	15	172		258	52
53	replaced bumper edge								53
54	POURED SIDEWALK FOR EMER EXIT ON B WING	2007	2,000	67	15	67		67	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 874,295	\$ 9,150		\$ 18,029	\$ 8,879	\$ 675,615	70

\*\*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	\$ 98,448	\$ 3,754	\$ 9,266	\$ 5,512	VAR	\$ 70,674	71
72	Current Year Purchases	13,352	2,042	932	(1,110)	VAR	932	72
73	Fully Depreciated Assets	152,500				VAR	152,500	73
74								74
75	TOTALS	\$ 264,300	\$ 5,796	\$ 10,198	\$ 4,402		\$ 224,106	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			\$	\$ 1,660	\$ 1,660	\$		\$ 23,537	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,660	\$ 1,660	\$		\$ 23,537	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)	\$ 1,157,387	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,606	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,887	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,281	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 923,258	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 1,009      Description: STORAGE 171; DISHMACHINE 838

(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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	\$	770	\$ 44,529	\$ 172	770	\$ 44,701	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		121	10,166		121	10,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		998	55,572	100	998	55,672	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 prescrpts				39,181		39,181	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 feed, oxygen Other (specify): <b>IV, labs, xray</b>	39/2 & 39/3				6,089	21,309		27,398	13
14	<b>TOTAL</b>			\$	1,889	\$ 116,356	\$ 60,762	1,889	\$ 177,118	14

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

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 15,603	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	514,047		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	14,404		5
6	Prepaid Insurance	3,692		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Fed Tax Deposit</u>	600		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 548,346	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	156,058		15
16	Equipment, at Historical Cost	224,224		16
17	Accumulated Depreciation (book methods)	(305,745)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 74,537	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 622,883	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 56,114	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,001		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,812		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>401k Liability</u>	8,472		36
37	<u>Note payable from Twin Willows</u>	45,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 149,399	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 149,399	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 473,484	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 622,883	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 496,704	1
2	Restatements (describe):		2
3	<b>2006 INCOME TAX PAID</b>	(559)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 496,145	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(22,661)	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)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (22,661)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 473,484	24 *

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

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,511,371	1
2	Discounts and Allowances for all Levels	109,929	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,621,300</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	225,700	6
7	Oxygen	15,597	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 241,297</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,714	19
20	Radiology and X-Ray	1,010	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 3,724</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,564	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,564</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,868,885</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	415,537	31
32	Health Care	794,353	32
33	General Administration	394,068	33
<b>B. Capital Expense</b>			
34	Ownership	69,955	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	177,118	35
36	Provider Participation Fee	40,515	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,891,546</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(22,661)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (22,661)</b>	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. State taxes are deducted on Federal tax 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 **FAIR ACRES NURSING HOME**

# **0027367**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**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	1,832	2,056	\$ 50,026	\$ 24.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,664	1,766	39,302	22.25	3
4	Licensed Practical Nurses	9,366	10,161	152,372	15.00	4
5	CNAs & Orderlies	23,488	25,782	236,297	9.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,370	1,408	15,333	10.89	9
10	Activity Assistants					10
11	Social Service Workers	1,541	1,711	22,540	13.17	11
12	Dietician					12
13	Food Service Supervisor	1,802	2,031	19,037	9.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,924	8,445	68,859	8.15	15
16	Dishwashers					16
17	Maintenance Workers	1,805	1,946	28,424	14.61	17
18	Housekeepers	5,005	5,298	47,323	8.93	18
19	Laundry	3,789	4,014	37,288	9.29	19
20	Administrator	1,904	2,080	56,080	26.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,311	1,517	19,912	13.13	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) <u>ward clerk</u>	1,751	1,869	20,834	11.15	33
34	TOTAL (lines 1 - 33)	64,552	70,084	\$ 813,627 *	\$ 11.61	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	107	\$ 5,843	L1/C3	35
36	Medical Director		900	L9/C3	36
37	Medical Records Consultant		300	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	L10/C3	39
40	Physical Therapy Consultant	1	21	L10A/C3	40
41	Occupational Therapy Consultant			L10A/C3	41
42	Respiratory Therapy Consultant			L10A/C3	42
43	Speech Therapy Consultant			L10A/C3	43
44	Activity Consultant	22	1,511	L11/C3	44
45	Social Service Consultant	22	1,510	L12C/3	45
46	Other(specify) <u>UR REVIEW</u>		900	L10/C3	46
47	<u>Purchasing &amp; billing Cons</u>		1,370	L19/C3	47
48	<u>Wound Consultant</u>		100	L10/C3	48
49	TOTAL (lines 35 - 48)	152	\$ 13,055		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	L10/3	50
51	Licensed Practical Nurses	3,754	105,382	L10/3	51
52	Certified Nurse Assistants/Aides	7,049	125,186	L10/3	52
53	TOTAL (lines 50 - 52)	10,803	\$ 230,568		53



Facility Name & ID Number FAIR ACRES NURSING HOME

Report Period Beginning: 01/01/2007 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	PAINTING	2003	\$ 8,624	3	\$ 2,875	\$ 2,875	\$ 1,437	\$	\$	\$	\$	\$	\$
2	PAINTING	2004	6,156	3	1,026	2,052	2,052	1,026					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 14,780		\$ 3,901	\$ 4,927	\$ 3,489	\$ 1,026	\$	\$	\$	\$	\$

Facility Name &amp; ID Number FAIR ACRES NURSING HOME

**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? 5
- (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 during this cost report period. \$ 40,515  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ 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? N/A 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

FAIR ACRES NURSING HOME INC #0027367  
RECLASSIFICATION ON DPA COST REPORT  
PAGES 3 & 4 COLUMN 5

12/31/2007

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	3607	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		3607
VARIOUS	VARIOUS LINE ITEMS	73154	
19	PROFESSIONAL SERVICES SEE SCH VIII FOR BREAKDOWN		73154

FAIR ACRES NURSING HOME INC #0027367  
RECLASSIFICATION ON DPA COST REPORT  
PAGES 3 & 4 COLUMN 5

12/31/2007

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	2564	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2564
VARIOUS	VARIOUS LINE ITEMS		
19	PROFESSIONAL SERVICES SEE SCH VIII FOR BREAKDOWN		