

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992 Report Period Beginning: 01/01/08 Ending: 12/31/08

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				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			1,146	1,146	8
9	SNF/PED					9
10	ICF	13,726	5,561		19,287	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,726	5,561	1,146	20,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.46%

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

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

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

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 1,146

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: _____

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

Facility Name & ID Number **FAIRVIEW NURSING CENTER** # **0024992** Report Period Beginning: **01/01/08** Ending: **12/31/08**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,329	4,680	5,480	111,489		111,489		111,489		1
2	Food Purchase		72,934		72,934	3,933	76,867	(196)	76,671		2
3	Housekeeping	57,641	9,143		66,784	81	66,865		66,865		3
4	Laundry	39,199	7,102		46,301		46,301		46,301		4
5	Heat and Other Utilities			65,517	65,517	467	65,984		65,984		5
6	Maintenance	20,988	16,651	28,685	66,324		66,324	583	66,907		6
7	Other (specify):*										7
8	TOTAL General Services	219,157	110,510	99,682	429,349	4,481	433,830	387	434,217		8
	B. Health Care and Programs										
9	Medical Director			975	975		975		975		9
10	Nursing and Medical Records	585,585	19,785	94,301	699,671	(590)	699,081		699,081		10
10a	Therapy										10a
11	Activities	35,545	5,069	1,555	42,169	(2,845)	39,324		39,324		11
12	Social Services	16,993		1,555	18,548		18,548		18,548		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	638,123	24,854	98,386	761,363	(3,435)	757,928		757,928		16
	C. General Administration										
17	Administrative	42,219		12,866	55,085	38,631	93,716		93,716		17
18	Directors Fees										18
19	Professional Services			148,333	148,333	(76,356)	71,977	(71,062)	915		19
20	Dues, Fees, Subscriptions & Promotions			8,422	8,422	126	8,548	(3,900)	4,648		20
21	Clerical & General Office Expenses	26,055	6,856	6,558	39,469	16,466	55,935	(425)	55,510		21
22	Employee Benefits & Payroll Taxes			150,003	150,003	8,800	158,803		158,803		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,990	2,990	410	3,400		3,400		24
25	Other Admin. Staff Transportation					1,913	1,913		1,913		25
26	Insurance-Prop.Liab.Malpractice			34,912	34,912	1,619	36,531		36,531		26
27	Other (specify):*										27
28	TOTAL General Administration	68,274	6,856	364,084	439,214	(8,391)	430,823	(75,387)	355,436		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	925,554	142,220	562,152	1,629,926	(7,345)	1,622,581	(75,000)	1,547,581		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:

01/01/08

Ending:

12/31/08

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	
	D. Ownership											
30	Depreciation			27,902	27,902	1,987	29,889	19,390	49,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			12,904	12,904	1,028	13,932		13,932			33
34	Rent-Facility & Grounds			59,901	59,901	4,330	64,231	(59,901)	4,330			34
35	Rent-Equipment & Vehicles			947	947		947		947			35
36	Other (specify):*											36
37	TOTAL Ownership			101,654	101,654	7,345	108,999	(40,511)	68,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,397	81,463	127,860		127,860		127,860			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		46,397	123,187	169,584		169,584		169,584			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	925,554	188,617	786,993	1,901,164		1,901,164	(115,511)	1,785,653			45

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

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

0024992

Report Period Beginning: **01/01/08**

Ending: **12/31/08**

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	9,479	30		9
10	Interest and Other Investment Income	(10,473)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(196)	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				18
19	Entertainment				19
20	Contributions	(425)	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	(3,188)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(612)	20		28
29	Other-Attach Schedule	483			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,932)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(110,579)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,579)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (115,511)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

FAIRVIEW NURSING CENTER

ID# 0024992

Report Period Beginning: 01/01/08

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DETAIL FOR LINE 39 SCH VI	\$	1
2	ELIMINATE CHAMBER OF COMMERCE DUES	(100)	20
3			3
4	DEFERRED PAINTING PER SCH XIX	583	6
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	483	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(196)	0	0	0	0	0	0	0	0	0	0	(196)	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	583	0	0	0	0	0	0	0	0	0	0	583	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	387	0	0	0	0	0	0	0	0	0	0	387	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	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	(71,062)	0	0	0	0	0	0	0	0	0	(71,062)	19
20	Fees, Subscriptions & Promotions	(3,900)	0	0	0	0	0	0	0	0	0	0	(3,900)	20
21	Clerical & General Office Expenses	(425)	0	0	0	0	0	0	0	0	0	0	(425)	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	(4,325)	(71,062)	0	(75,387)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,938)	(71,062)	0	(75,000)	29								

STATE OF ILLINOIS

Summary B

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

0024992

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	9,479	9,911	0	0	0	0	0	0	0	0	0	19,390	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,473)	10,473	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(59,901)	0	0	0	0	0	0	0	0	0	(59,901)	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	(994)	(39,517)	0	(40,511)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,932)	(110,579)	0	(115,511)	45								

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/08

Ending:

12/31/08

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>FAIR ACRES NURSING HOME</u>	<u>DUQUOIN</u>	<u>Jamestown Mgmt</u>	<u>Carbondale</u>	<u>Management</u>
		<u>CANTERBURY MANOR NURSING HOME</u>	<u>WATERLOO</u>	<u>Fairview Residential Land Trust</u>	<u>DuQuoin</u>	<u>Owms Building</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	19 <u>MANAGEMENT FEES</u>	\$ <u>147,540</u>	<u>JAMESTOWN MANAGEMENT CORPORATION</u>	<u>100.00%</u>	\$ <u>76,478</u>	\$ <u>(71,062)</u>	1
2	V	30 <u>DEPRECIATION</u>		<u>FAIRVIEW RESIDENTIAL CENTER LAND TRUST</u>	<u>39.70%</u>	<u>9,911</u>	<u>9,911</u>	2
3	V	34 <u>RENT</u>	<u>59,901</u>	<u>FAIRVIEW RESIDENTIAL CENTER LAND TRUST</u>	<u>39.70%</u>		<u>(59,901)</u>	3
4	V	32 <u>INTEREST EXPENSE</u>		<u>FAIRVIEW RESIDENTIAL CENTER LAND TRUST</u>	<u>39.70%</u>	<u>10,473</u>	<u>10,473</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	Total		\$ <u>207,441</u>			\$ <u>96,862</u>	\$ * <u>(110,579)</u>	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: 01/01/08 Ending: 12/31/08

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:

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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

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

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

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	12,872	\$ 6,244	\$	2,111	\$ 1,024	1
2	5	UTILITIES	HOURS OF SERVICE	12,872	2,850		2,111	467	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,400	235,489	235,489	1,378	38,631	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	12,872	745		2,111	122	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	12,872	770		2,111	126	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	4,472	85,775	85,775	733	14,059	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	12,872	11,963		2,111	1,962	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	12,872	53,660		2,111	8,800	8
9	24	SEMINARS	HOURS OF SERVICE	8,400	2,501		1,378	410	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,400	11,663		1,378	1,913	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	12,872	9,874		2,111	1,619	11
12	30	DEPRECIATION	HOURS OF SERVICE	12,872	12,116		2,111	1,987	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	12,872	6,269		2,111	1,028	13
14	34	RENT	HOURS OF SERVICE	12,872	26,400		2,111	4,330	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 466,319	\$ 321,264		\$ 76,478	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			
A. Directly Facility Related																				
Long-Term																				
1	FAIRVIEW NURSING CENTE	X		FINANCE CONSTRUCTION	\$3,922.00	3/1/07	\$ 220,000	\$ 154,550	9/01/2012	0.0600	\$ 10,473	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,922.00		\$ 220,000	\$ 154,550			\$ 10,473	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 220,000	\$ 154,550			\$ 10,473	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1-61-0270-100</u>	<u>SEC 17 TWP 06 RNG01 S SW SW N</u>	<u>\$ 14,904.00</u>	<u>\$ 14,904.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 14,904.00	\$ 14,904.00

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,640 B. General Construction Type: Exterior BRICK Frame WOOD & CONCRETE Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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>76,230</u>	<u>1968</u>	<u>\$ 3,996</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	76,230		\$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	42		1968	1968	\$ 94,863	\$	40	\$ 656	\$ 656	\$ 94,863	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	188	188	26,047	7
8	16		1976	1976	177,922		30			177,922	8
		Improvement Type**									
9		FIRE ALARM		1981	1,190		10			1,190	9
10		SEWER LINE		1982	1,056		10			1,056	10
11		PLUMBING IMPROVEMENTS		1984	1,193		10			1,193	11
12		ROOF & LANDSCAPING		1984	1,488		10			1,488	12
13		ACTIVITY ROOM		1986	15,306		20			15,306	13
14		ACTIVITY ROOM		1987	5,223		20			5,223	14
15		ROOF & LANDSCAPING		1987	9,775		10			9,775	15
16		PARKING LOT		1987	18,960		15			18,960	16
17		SECURITY SYSTEM		1988	2,583		15			2,583	17
18		RENOVATIONS		1989	2,723		15			2,723	18
19		HOT WATER HEATER		1990	4,128		15			4,128	19
20		6 WALL A/C UNITS		1990	7,205		8			7,205	20
21		LANDSCAPING		1990	495		10			495	21
22		SHOWERS/CUBICLE TRACKS		1990	8,459	119	15		(119)	8,459	22
23		ROOF & LANDSCAPING		1990	13,831	439	25	553	114	10,231	23
24		TELEPHONE		1991	3,274		20	164	164	2,870	24
25		WATER HEATER		1991	1,945		15			1,945	25
26		EMERGENCY LIGHTS		1992	960		15			960	26
27		SEAL & STRIPE PARKING LOT		1994	1,421		5			1,421	27
28		EMERGENCY LIGHTS		1995	994		15			994	28
29		HOT WATER HEATER		1995	7,433		15	496	496	6,696	29
30		SUBPANELS & CIRCUITS INSTALLED TO A/C		1996	2,394		10			2,394	30
31		PT A/C UNIT		1996	1,163		10			1,163	31
32		A/C UNIT		1996	1,071		10			1,075	32
33		INSTALLED SERVICE CABLE		1997	7,666	511	15	511		5,877	33
34		A/C UNITS		1998	698		10	33	33	698	34
35		HOT WATER HEATER		1998	2,985		15	199	199	2,090	35
36		OVERBED LIGHTING		1998	8,932		15	595	595	6,248	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:

01/01/08

Ending:

12/31/08

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	\$	5	\$	\$	\$ 588	37
38	INSTALL BASEBOARD HEATING	1998	3,599		15	240	240	2,520	38
39	CABINETS & COUNTERTOPS	1998	708		5			708	39
40	WALLPAPER & INSTALLATION	1998	9,457		5			9,457	40
41	PAINTING	1998	11,779		5			11,779	41
42	Trim, pictures, mirrors, permanent decorative fixtures	1998	2,007		5			2,007	42
43	FLOOR COVE BASE	1998	901		5			901	43
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	2,480	44
45	BUILDING ADDTION	1998	239,137		15	15,942	15,942	151,449	45
46	PARKING LOT	1998	13,916		15	928	928	9,744	46
47	FLOORING - ADJUSTMENT TO 1998 BUILDING ADDITION	1999	737		5			737	47
48	DOOR ALARM SYSTM	1999	6,691		10	669	669	6,356	48
49	WALLPAPER & PAINTING	1999	8,314		5			8,314	49
50	INTALL BOOKCASE IN ADMIN OFFICE	1999	333		10			333	50
51	LANDSCAPING	1999	5,931	593	10	593		5,634	51
52	SEAL COATED & STRIPED PARKING LOT	1999	1,646		8			1,646	52
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777		5			777	53
54	MOVE PHONE LINES	1999	328		5			328	54
55	ENTRANCE SIGN	1999	1,000		5			1,000	55
56	PAINT WINDOW GRIDS	1999	175		5			175	56
57	INSTALLATION OF FLOORING	1999	8,949	895	10	895		8,502	57
58	FOUNTAIN & LIGHT	1999	1,774		5			1,774	58
59	balance of trim, mirrors, permanent decorative fixtures to refurbish the building	1999	3,952		5			3,952	59
60									60
61	AWNINGS	1999	420		5			420	61
62	Labor & materials to remove existing wall & rebuild new wall	1999	8,559	856	10	856		8,132	62
63	relocate plumbing & electrical services, install cabinetry,								63
64	& countertops, and installed new tile flooring. Labor &								64
65	materials to gut an existing bathroom and rehab room to								65
66	create 2 new bathrooms and storage area for housekeeping								66
67	and dietary (to be competed in 2000). Labor & materials to								67
68	install new cabinets, relocated plumbing & electrical, repair								68
69	drywall & paint the breakroom.								69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 3,537		\$ 23,779	\$ 20,242	\$ 728,325	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:

01/01/08

Ending:

12/31/08

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	\$ 3,537		\$ 23,779	\$ 20,242	\$ 728,325	1
2	Labor & materials to complete 1999 bathroom project	2000	20,296	2,030	10	2,030		17,255	2
3	Installed ceramic tile, sinkss, 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		9,529	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		1,538	10
11	Reinforce & raise sinking floor on B wing	2001	7,380	492	15	492		3,690	11
12	Gut beauty shop area and construct a new handicapped	2001	16,165	1,078	15	1,078		8,085	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet,								13
14	sink, door, sprinkler heads, cubicle tracks & curtains, and								14
15	cove base.								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete &	2001	2,800	187	15	187		1,402	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		615	19
20	& shut off valves, drill & knock out outside brick wall,								20
21	install fan, finish drywall, paint, intall tile on drywall,								21
22	install sink & shelves.								22
23	Convert existing bathroom to handicapped bathroom.	2001	7,124	475	15	475		3,562	23
24	Remove tile, install box for call lights, tear out & reconstruct								24
25	showers, tile wall & showers, install handrails in tub &								25
26	showers, hang 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		195	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	23	15	23		172	29
30	Upgrade emergency lighting & moved annunciator panel	2001	15,138	1,514	10	1,514		11,355	30
31	& smoke detectors								31
32	Upgraded nurses call station	2001	645	65	10	65		487	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 920,094	\$ 10,835		\$ 31,077	\$ 20,242	\$ 786,210	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:

01/01/08

Ending:

12/31/08

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 12B, Carried Forward		\$ 920,094	\$ 10,835		\$ 31,077	\$ 20,242	\$ 786,210	1
2	Install grease trap and wet well	2002	13,224	1,322	10	1,322		8,593	2
3	Replaced rusted out main line drain in B hallway &	2002	3,494	349	10	349		1,823	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	171		1,557	5
6	A hall bathroom								6
7	Repair roof over front dining room and activity room	2002	8,230	823	10	823		5,350	7
8	LANDSCAPING OF COURTYARD	2004	1,109	111	10	111		499	8
9	Remove, repair, and install tile flooring in dining room	2005	7,222	722	10	722		2,527	9
10	Replace tile in hall, TV room and small hallway	2008	3,310	3,310	10	166	(3,144)	166	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)		\$ 958,389	\$ 17,643		\$ 34,741	\$ 17,098	\$ 806,725	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: 01/01/08 Ending: 12/31/08

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	\$ 96,463	\$ 1,960	\$ 11,972	\$ 10,012		\$ 65,528	71
72	Current Year Purchases	8,299	8,299	579	(7,720)		579	72
73	Fully Depreciated Assets	214,729					214,729	73
74								74
75	TOTALS	\$ 319,491	\$ 10,259	\$ 12,551	\$ 2,292		\$ 280,836	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			\$	\$ 1,987	\$ 1,987	\$		\$ 24,439	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,987	\$ 1,987	\$		\$ 24,439	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)	\$ 1,281,876	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,889	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,279	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,390	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,112,000	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 11968	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.

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 947 Description: storage 188; dishmachine 759

(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.

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><u>WE ONLY HIRE TRAINED AIDES.</u></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)	
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39/3; 39/2	hrs	\$	513	\$ 29,584	\$	50	513	\$	29,634	1				
2	Licensed Speech and Language Development Therapist	39/3	hrs		112	9,716		38	112		9,754	2				
3	Licensed Recreational Therapist		hrs									3				
4	Licensed Physical Therapist	39/3	hrs		670	40,461		163	670		40,624	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					32,825			32,825	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10				
11	Academic Education		hrs									11				
12	Other (specify):											12				
13	med sup, tube feed, oxygen Other (specify): lab, xray, other	39/2 39/3				1,702		13,321			15,023	13				
14	TOTAL			\$	1,295	\$ 81,463	\$	46,397	1,295	\$	127,860	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 FAIRVIEW NURSING CENTER# 0024992Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 41,972	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	478,303		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	381,338		5
6	Prepaid Insurance	4,740		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INVESTMENT</u>	6,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 912,353	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	165,280		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	433,958		16
17	Accumulated Depreciation (book methods)	(539,663)		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): <u>MORTGAGE RECEIVABLE</u>	154,550		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 214,125	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,126,478	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 62,799	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,935		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,308		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,452		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>401K LIABILITY</u>	10,037		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 148,531	\$	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)	\$ 148,531	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 977,947	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,126,478	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 838,155	1
2	Restatements (describe):		2
3	2007 IL REPLACEMENT TAX	(962)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 837,193	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	224,858	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	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) EXCESS SALARIES ELIMINATED	(25,732)	15
16	Other (describe) TREASURY STOCK	(8,372)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 140,754	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)	\$ 977,947	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 1,878,972	1
2	Discounts and Allowances for all Levels	53,355	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,932,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	163,350	6
7	Oxygen	10,913	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 174,263	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,714	19
20	Radiology and X-Ray	138	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,852	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,580	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,580	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)	\$ 2,126,022	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	429,349	31
32	Health Care	761,363	32
33	General Administration	439,214	33
B. Capital Expense			
34	Ownership	101,654	34
C. Ancillary Expense			
35	Special Cost Centers	127,860	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)*	\$ 1,901,164	40
41	Income before Income Taxes (line 30 minus line 40)**	224,858	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 224,858	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 is deducted 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

Report Period Beginning: **01/01/08**

Ending:

12/31/08

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	1,954	2,080	\$ 45,592	\$ 21.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	784	799	15,724	19.68	3
4	Licensed Practical Nurses	10,860	11,802	175,447	14.87	4
5	CNAs & Orderlies	33,776	36,163	348,822	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,838	3,054	35,545	11.64	9
10	Activity Assistants					10
11	Social Service Workers	1,520	1,640	16,993	10.36	11
12	Dietician					12
13	Food Service Supervisor	2,084	2,276	27,190	11.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,327	8,828	74,139	8.40	15
16	Dishwashers					16
17	Maintenance Workers	1,869	1,963	20,988	10.69	17
18	Housekeepers	4,801	5,539	57,641	10.41	18
19	Laundry	2,871	3,144	39,199	12.47	19
20	Administrator	1,870	2,005	42,219	21.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,909	2,080	26,055	12.53	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)	75,463	81,373	\$ 925,554 *	\$ 11.37	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	89	\$ 5,480	1/3	35
36	Medical Director		975	9/3	36
37	Medical Records Consultant		200	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10/3	39
40	Physical Therapy Consultant			10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,555	11/3	44
45	Social Service Consultant	24	1,555	12/3	45
46	Other(specify)				46
47	<u>PURCHASING CONSULTANT</u>		48	19/3	47
48	<u>UTILIZATION REVIEW</u>		975	10/3	48
49	TOTAL (lines 35 - 48)	137	\$ 11,388		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	3,065	91,797	10/3	51
52	Certified Nurse Assistants/Aides	39	729	10/3	52
53	TOTAL (lines 50 - 52)	3,104	\$ 92,526		53

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

Report Period Beginning: **01/01/08** Ending: **12/31/08**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINTING	2005	\$ 3,498		\$ 583	\$ 1,166	\$ 1,166	\$ 583	\$	\$	\$	\$	\$
2													
3													
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18													
19													
20	TOTALS		\$ 3,498		\$ 583	\$ 1,166	\$ 1,166	\$ 583	\$	\$	\$	\$	\$

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? 6
- (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. \$ 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, 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? 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? 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.

FAIRVIEW NURSING CENTER INC

RECLASSIFICATIONS ON DPA COST REPORT

12/31/2008

PAGES 3 & 4 COLUMN 5

#0024992

LINE	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	1088	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		1088
21	CLERICAL & GENERAL OFFICE EXPENSE	445	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		445
2	FOOD PURCHASES	2845	
11	ACTIVITIES RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPT		2845
10	NURSING & MEDICAL RECORDS	943	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		943
VARIOUS	VARIOUS LINE ITEMS	76478	
19	PROFESSIONAL SERVICES SEE SCHEDULE VIII FOR BREAKDOWN		76478