

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	2,025	2,697	1,798	6,520	8
9	SNF/PED					9
10	ICF	9,187	3,966		13,153	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,212	6,663	1,798	19,673	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.84%

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 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 1,798

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: 12/31/2009 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: **01/01/2009** Ending: **12/31/2009**

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	94,789	6,789	6,106	107,684		107,684		107,684		1
2	Food Purchase		78,934		78,934	2,868	81,802	(280)	81,522		2
3	Housekeeping	42,900	5,893		48,793	1,082	49,875		49,875		3
4	Laundry	42,923	3,299		46,222		46,222		46,222		4
5	Heat and Other Utilities			72,846	72,846	559	73,405		73,405		5
6	Maintenance	29,894	25,655	31,706	87,255		87,255		87,255		6
7	Other (specify):*										7
8	TOTAL General Services	210,506	120,570	110,658	441,734	4,509	446,243	(280)	445,963		8
	B. Health Care and Programs										
9	Medical Director			900	900		900		900		9
10	Nursing and Medical Records	694,940	21,907	125,059	841,906	(2,868)	839,038		839,038		10
10a	Therapy										10a
11	Activities	23,537	1,833	1,574	26,944		26,944		26,944		11
12	Social Services	28,078		1,574	29,652		29,652		29,652		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	746,555	23,740	129,107	899,402	(2,868)	896,534		896,534		16
	C. General Administration										
17	Administrative	59,358			59,358	43,369	102,727		102,727		17
18	Directors Fees										18
19	Professional Services			165,343	165,343	(85,209)	80,134	(76,473)	3,661		19
20	Dues, Fees, Subscriptions & Promotions			11,098	11,098	167	11,265	(7,793)	3,472		20
21	Clerical & General Office Expenses	20,934	8,150	6,426	35,510	19,054	54,564	(789)	53,775		21
22	Employee Benefits & Payroll Taxes			144,007	144,007	9,308	153,315		153,315		22
23	Inservice Training & Education			225	225		225		225		23
24	Travel and Seminar			4,777	4,777	566	5,343		5,343		24
25	Other Admin. Staff Transportation					1,972	1,972		1,972		25
26	Insurance-Prop.Liab.Malpractice			39,195	39,195	1,622	40,817		40,817		26
27	Other (specify):*										27
28	TOTAL General Administration	80,292	8,150	371,071	459,513	(9,151)	450,362	(85,055)	365,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,037,353	152,460	610,836	1,800,649	(7,510)	1,793,139	(85,335)	1,707,804		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

FAIR ACRES NURSING HOME

#0027367

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			23,273	23,273	1,460	24,733	6,264	30,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75	75		75	(75)				32
33	Real Estate Taxes					1,192	1,192	15,746	16,938			33
34	Rent-Facility & Grounds			162,000	162,000	4,858	166,858	(162,000)	4,858			34
35	Rent-Equipment & Vehicles			999	999		999		999			35
36	Other (specify):*											36
37	TOTAL Ownership			186,347	186,347	7,510	193,857	(140,065)	53,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,795	131,994	189,789		189,789		189,789			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	TOTAL Special Cost Centers		57,795	172,509	230,304		230,304		230,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,037,353	210,255	969,692	2,217,300		2,217,300	(225,400)	1,991,900			45

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

FAIR ACRES NURSING HOME

ID# 0027367

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1	SCHEDULE VI LINE 29			1
2				2
3	CHAMBER OF COMMERCE DUES 2009-2010	(200)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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	(200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(280)	0	0	0	0	0	0	0	0	0	0	(280)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(280)	0	0	0	0	0	0	0	0	0	0	(280)	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	(76,473)	0	0	0	0	0	0	0	0	0	(76,473)	19
20	Fees, Subscriptions & Promotions	(7,793)	0	0	0	0	0	0	0	0	0	0	(7,793)	20
21	Clerical & General Office Expenses	(789)	0	0	0	0	0	0	0	0	0	0	(789)	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	(8,582)	(76,473)	0	(85,055)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,862)	(76,473)	0	(85,335)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,596)	9,860	0	0	0	0	0	0	0	0	0	6,264	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(75)	0	0	0	0	0	0	0	0	0	0	(75)	32
33	Real Estate Taxes	0	15,746	0	0	0	0	0	0	0	0	0	15,746	33
34	Rent-Facility & Grounds	0	(162,000)	0	0	0	0	0	0	0	0	0	(162,000)	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	TOTAL Ownership	(3,671)	(136,394)	0	(140,065)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(12,533)	(212,867)	0	0	0	0	0	0	0	0	0	(225,400)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		CANTERBURY MANOR NURSING CENTER	WATERLOO	Twin Willows	DuQuoin	Real Estate Rental
		FAIRVIEW NURSING CENTER	DUQUOIN	Land Trust		
				Jamestown Mgmt Cor	Carbondale	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 162,000	TWIN WILLOWS LAND TRUST	100.00%	\$	\$ (162,000)	1
2	V	30 DEPRECIATION		TWIN WILLOWS LAND TRUST	100.00%	9,860	9,860	2
3	V	33 REAL ESTATE TAXES		TWIN WILLOWS LAND TRUST	100.00%	15,746	15,746	3
4	V	19 JAMESTOWN MGMT FEES	161,861	JAMESTOWN MANAGEMENT CORPORATION	0.00%	85,388	(76,473)	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		\$ 323,861			\$ 110,994	\$ * (212,867)	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: **01/01/2009** Ending: **12/31/2009**

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATIOON HAS BEEN ELIMINATED PRIOR TO COST REPORT***									
2										1
3										2
4										3
5										4
6										5
7										6
8										7
9										8
10										9
11										10
12										11
13							TOTAL	\$		12
										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:

01/01/2009

Ending: 2/31/2009

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 East 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	13,172	\$ 5,881	\$	2,424	\$ 1,082	1
2	5	UTILITIES	HOURS OF SERVICE	13,172	3,035		2,424	559	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,320	235,680	235,680	1,531	43,369	3
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	13,172	970		2,424	179	4
5	20	LICENSES AND DUES	HOURS OF SERVICE	13,172	907		2,424	167	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	4,852	90,374	90,374	893	16,633	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	13,172	13,154		2,424	2,421	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,172	50,581		2,424	9,308	8
9	24	SEMINARS	HOURS OF SERVICE	8,320	3,075		1,531	566	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320	10,714		1,531	1,972	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,172	8,816		2,424	1,622	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,172	7,935		2,424	1,460	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,172	6,480		2,424	1,192	13
14	34	RENT	HOURS OF SERVICE	13,172	26,400		2,424	4,858	14
15									15
16									16
17									17
18									18
19	***EXCESS SALARIES OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO COST REPORT***								
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 464,002	\$ 326,054		\$ 85,388	25

Facility Name & ID Number

FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

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

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

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

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	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	TOTALS	125,722		\$ 18,792	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	148,162	6
7										7
8										8
	Improvement Type**									
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		10 TO 15			1,158	14
15	ROOF		1982	3,890		15			3,890	15
16	LAND IMPROVEMENT		1982	10,400		15			10,400	16
17	FIRE ALARM & SEAL PARKING LOT		1983	4,351		10 TO 15			4,351	17
18	A/C ROOFTOP, WATERLINE, STORAGE BUILDING		1984	13,711		20			13,711	18
19	SEWER REPAIR		1987	1,330		15			1,330	19
20	PARKING LOT & PLUMBING		1988	14,182	77	15 TO 25	339	262	12,999	20
21	A/C COMPRESSOR & ROOF		1989	23,834		15 TO 30	764	764	15,817	21
22	ROOF REPAIR		1990	18,354		30	612	612	11,934	22
23	WATER HEATER & A/C UNITS		1990	4,675	38	15		(38)	4,675	23
24	CABINETS & NURSES STATION		1992	6,893		15			6,893	24
25	PARKING LOT SEALED & STRIPED		1994	4,138		15	136	136	4,138	25
26	HEAT EXCHANGE ON ROOF TOP UNITS INSTALLED		1995	2,638		10			2,638	26
27	WALL A/C UNITS INSTALLED		1996	1,976		15	132	132	1,782	27
28	REPAIRS TO GASOLINE		1997	3,786	189	20	189		2,363	28
29	REPLACED CARPETING		1997	795		5			795	29
30	INSTALLED 2 PT AC AIR & HEAT UNITS		1997	2,376		15	158	158	1,976	30
31	WATER HEATER & INSTALLATION		1998	780		10			780	31
32	ENTRANCE SIGN		1999	1,002		5			1,002	32
33	GAZEBO WITH RAMP & RAILING		1999	3,377	169	20	169		1,774	33
34	LANDSCAPING		1999	978		5			978	34
35	Repairs to damaged asphalt, seal & stripe parking lot		1999	2,101	106	10	106		2,101	35
36	INSTALL TILE FLOORING		2000	22,927	2,293	10	2,293		21,783	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

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 FACUET REPLACEMENTS	2000	\$ 1,731	\$ 173	10	\$ 173		\$ 1,644	37
38	INSTALL CARPET ON WALLS	2000	4,898		10			4,898	38
39	WATER GARDEN	2000	922	92	5	92		874	39
40	Remove & replace damaged asphalt & fill cracks in parking lot	2001	10,546	703	15	703		5,976	40
41	REPLACE BATHROOM FLOOR TILES ON a & b HALLS	2001	2,994	299	10	299		2,542	41
42	REPLACE FLOORTILES IN 3 BATHROOMS	2002	7,989	799	10	799		5,992	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346	1,335	10	1,335		10,012	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	268	10	268		1,742	44
45	INSTALL CABLE WIRING FOR CABLE TV	2003	1,220		5			1,220	45
46	INSTALL MIXING VALVE	2004	2,220	222	10	222		1,221	46
47	SEAL & PATCH PARKING LOT	2005	2,027	203	8	253	50	1,139	47
48	Replace hotwater storage tank & circulating pump	2005	7,100	355	20	355		1,598	48
49	INSTALL TILE & COVE BASE IN LAUNDRY	2005	1,186	119	10	119		535	49
50	REPAIR NORTH WING ROOF	2005	4,096	410	10	410		1,845	50
51	REPLACE 100 GAL HOTWATER HEATER	2005	4,900	490	10	490		2,205	51
52	Resurface counter and desk tops at nurses station and	2006	2,578	172	15	172		602	52
53	replaced bumper edge								53
54	POURED SIDEWALK FOR EMER EXIT ON B WING	2007	2,000	133	15	133		333	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	\$ 8,645		\$ 17,306	\$ 8,661	\$ 710,632	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	\$ 96,610	\$ 5,794	\$ 11,347	\$ 5,553	VARIOUS	\$ 67,903	71
72	Current Year Purchases	8,834	8,834	884	(7,950)	VARIOUS	884	72
73	Fully Depreciated Assets	179,735				VARIOUS	179,735	73
74								74
75	TOTALS	\$ 285,179	\$ 14,628	\$ 12,231	\$ (2,397)		\$ 248,522	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			\$	\$ 1,460	\$ 1,460	\$		\$ 27,214	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,460	\$ 1,460	\$		\$ 27,214	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)	\$ 1,178,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,733	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,997	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,264	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 986,368	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	TOTAL				\$ _____			7

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: \$ **999** Description: **STORAGE 188; DISH MACHINE 690; CARPET CLEANER 121**

(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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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>WE ONLY HIRE TRAINED AIDES</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	\$	697	\$ 38,948	\$ 88	697	\$ 39,036	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		223	17,797	13	223	17,810	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		1,220	68,034	325	1,220	68,359	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescripts				42,689		42,689	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): IV, labs, xray	39/2 & 39/3				7,215	14,680		21,895	13
14	TOTAL			\$	2,140	\$ 131,994	\$ 57,795	2,140	\$ 189,789	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 27,789	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	652,694		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	34,712		5
6	Prepaid Insurance	3,882		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Income Tax Deposits	19,600		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 738,677	\$	10
B. Long-Term Assets				
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	245,102		16
17	Accumulated Depreciation (book methods)	(356,593)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,567	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 783,244	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 53,156	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,764		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,789		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
Other Current Liabilities(specify):				
36	401k liability	11,882		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 98,591	\$	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)	\$ 98,591	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 684,653	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 783,244	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 657,069	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 657,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,257	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) RECORD 2008 INCOME TAXES	(54,673)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 27,584	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)	\$ 684,653	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 1,904,784	1
2	Discounts and Allowances for all Levels	140,010	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,044,794	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,308	6
7	Oxygen	8,891	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 249,199	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	4,735	19
20	Radiology and X-Ray	298	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,033	23
D. Non-Operating Revenue			
24	Contributions	490	24
25	Interest and Other Investment Income***	41	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 531	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)	\$ 2,299,557	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	441,734	31
32	Health Care	899,627	32
33	General Administration	459,288	33
B. Capital Expense			
34	Ownership	186,347	34
C. Ancillary Expense			
35	Special Cost Centers	189,789	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,217,300	40
41	Income before Income Taxes (line 30 minus line 40)**	82,257	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 82,257	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: **01/01/2009**

Ending:

12/31/2009

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	1,824	2,080	\$ 52,728	\$ 25.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,871	4,276	97,986	22.92	3
4	Licensed Practical Nurses	11,145	12,102	186,951	15.45	4
5	CNAs & Orderlies	31,254	33,949	333,577	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	2,054	23,537	11.46	9
10	Activity Assistants					10
11	Social Service Workers	1,827	1,992	28,078	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,129	22,358	10.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,051	8,478	72,431	8.54	15
16	Dishwashers					16
17	Maintenance Workers	1,819	1,947	29,894	15.35	17
18	Housekeepers	4,337	4,704	42,900	9.12	18
19	Laundry	3,837	4,131	42,923	10.39	19
20	Administrator	1,920	2,080	59,358	28.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,317	1,507	20,934	13.89	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) WARD CLERK	1,830	1,963	23,698	12.07	33
34	TOTAL (lines 1 - 33)	76,958	83,392	\$ 1,037,353 *	\$ 12.44	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	111	\$ 6,106	L1/C3	35
36	Medical Director		900	L9/C3	36
37	Medical Records Consultant		200	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		550	L10/C3	39
40	Physical Therapy Consultant			L10A/C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,574	L11/C3	44
45	Social Service Consultant	24	1,574	L12/C3	45
46	Other(specify) UR REVIEW		900	L10/C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	159	\$ 11,804		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	0	\$	L10/C3	50
51	Licensed Practical Nurses	1,662	58,442	L10/C3	51
52	Certified Nurse Assistants/Aides	3,603	64,967	L10/C3	52
53	TOTAL (lines 50 - 52)	5,265	\$ 123,409		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LANDEE SLOVER	ADMINISTRATOR	0	\$ 59,358	Workers' Compensation Insurance	\$ 30,899	IDPH License Fee	\$ 992	
				Unemployment Compensation Insurance	7,894	Advertising: Employee Recruitment	529	
				FICA Taxes	79,358	Health Care Worker Background Check	312	
				Employee Health Insurance	5,699	(Indicate # of checks performed <u>26</u>)		
				Employee Meals		Patient Background Checks	37	
				Illinois Municipal Retirement Fund (IMRF)*		JAMESTOWN ALLOCATION	167	
				LIFE INSURANCE	88	INHAA(100) LTCNA dues(50)	150	
				VACCINES	944	Corp fees(576) Subscrip(192)	768	
				401K EXPENSE	14,257	Other advertising(7593) AANAC (110)	7,703	
				AWARDS, INCENTIVES, ECT	4,868	CHAM OF COMM (200) ELIM (200)	0	
				JAMESTOWN ALLOCATION	9,308	Less: Public Relations Expense	(6,940)	
						Non-allowable advertising	()	
						Yellow page advertising	(653)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 59,358				\$ 153,315			\$ 3,472	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	931
							Seminar Expense	3,846
							JAMESTOWN ALLOCATION	566
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 5,343	
C. Professional Services								
Vendor/Payee	Type	Amount						
JAMESTOWN MGMT CORP	MANAGEMENT	\$ 161,861						
BARNETT & LEVINE	ACCOUNTING	970						
INNOVATIVE LTC SOLUTIONS	BILLING CONSULTANT	2,512						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 165,343								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (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. \$ N/A
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: _____
- (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

12/31/2009

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	2868	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2868
VARIOUS	VARIOUS LINE ITEMS	85388	
19	PROFESSIONAL SERVICES SEE SCH VIII FOR BREAKDOWN		85388