

Facility Name & ID Number Fairmont Care Centre

0040493 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-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	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	8,629	845	8,279	17,753	8
9	SNF/PED					9
10	ICF	32,530	2,052	116	34,698	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,159	2,897	8,395	52,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.65%

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 11th May 1995

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11th May 1995 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 104 and days of care provided 7,923

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: 31st Dec 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-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	521,807	69,005	18,820	609,632		609,632		609,632		1
2	Food Purchase		347,101		347,101	(24,222)	322,879	(178)	322,701		2
3	Housekeeping	365,182	55,980		421,162		421,162		421,162		3
4	Laundry	101,225	16,526		117,751		117,751		117,751		4
5	Heat and Other Utilities			245,557	245,557		245,557		245,557		5
6	Maintenance	75,793	49,718	189,516	315,027		315,027	3,331	318,358		6
7	Other (specify):*										7
8	TOTAL General Services	1,064,007	538,330	453,893	2,056,230	(24,222)	2,032,008	3,153	2,035,161		8
	B. Health Care and Programs										
9	Medical Director			54,550	54,550		54,550		54,550		9
10	Nursing and Medical Records	3,499,782	349,804	221,288	4,070,874		4,070,874		4,070,874		10
10a	Therapy		12,711	19,079	31,790		31,790		31,790		10a
11	Activities	203,550	16,180		219,730		219,730		219,730		11
12	Social Services	92,591		1,681	94,272		94,272		94,272		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* *Dental Service**			625	625		625		625		15
16	TOTAL Health Care and Programs	3,795,923	378,695	297,223	4,471,841		4,471,841		4,471,841		16
	C. General Administration										
17	Administrative	60,174		295,680	355,854		355,854	(170,376)	185,478		17
18	Directors Fees										18
19	Professional Services			53,230	53,230		53,230	6,427	59,657		19
20	Dues, Fees, Subscriptions & Promotions			31,158	31,158		31,158	(10,556)	20,602		20
21	Clerical & General Office Expenses	158,040	46,147	105,677	309,864		309,864	33,892	343,756		21
22	Employee Benefits & Payroll Taxes			767,371	767,371	24,222	791,593	10,076	801,669		22
23	Inservice Training & Education			5,887	5,887		5,887	3,304	9,191		23
24	Travel and Seminar			3,874	3,874		3,874	1,426	5,300		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,465	9,465		9,465		9,465		26
27	Other (specify):* *Payroll Taxes (Sch VII)							21,560	21,560		27
28	TOTAL General Administration	218,214	46,147	1,272,342	1,536,703	24,222	1,560,925	(104,247)	1,456,678		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,078,144	963,172	2,023,458	8,064,774		8,064,774	(101,094)	7,963,680		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

Fairmont Care Centre

#0040493

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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			125,666	125,666		125,666	464,768	590,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,396	5,396		5,396	802,109	807,505			32
33	Real Estate Taxes			180,502	180,502		180,502		180,502			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,320,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,631,564	1,631,564		1,631,564	(53,123)	1,578,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		343,518	733,181	1,076,699		1,076,699		1,076,699			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		343,518	829,541	1,173,059		1,173,059		1,173,059			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,078,144	1,306,690	4,484,563	10,869,397		10,869,397	(154,217)	10,715,180			45

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

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	267,515	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(178)	2		13
14	Non-Care Related Interest	(278)	32		14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,530)	21		24
25	Fund Raising, Advertising and Promotional	(70,871)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,709)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule Page 5A attached	780	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 128,629		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(282,846)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (282,846)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (154,217)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2008)	\$ (2,909)	6	1
2	Deferred Maintenance Cost (allocated for 2008)	3,689	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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	780		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre# 0040493

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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	(178)	0	0	0	0	0	0	0	0	0	0	(178)	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	780	2,551	0	0	0	0	0	0	0	0	0	3,331	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	602	2,551	0	0	0	0	0	0	0	0	0	3,153	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	(170,376)	0	0	0	0	0	0	0	0	0	(170,376)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,227	2,200	0	0	0	0	0	0	0	0	6,427	19
20	Fees, Subscriptions & Promotions	(70,971)	60,415	0	0	0	0	0	0	0	0	0	(10,556)	20
21	Clerical & General Office Expenses	(68,239)	98,422	3,709	0	0	0	0	0	0	0	0	33,892	21
22	Employee Benefits & Payroll Taxes	0	10,076	0	0	0	0	0	0	0	0	0	10,076	22
23	Inservice Training & Education	0	3,304	0	0	0	0	0	0	0	0	0	3,304	23
24	Travel and Seminar	0	1,426	0	0	0	0	0	0	0	0	0	1,426	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	21,560	0	0	0	0	0	0	0	0	0	21,560	27
28	TOTAL General Administration	(139,210)	29,054	5,909	0	(104,247)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(138,608)	31,605	5,909	0	(101,094)	29							

STATE OF ILLINOIS

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-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	267,515	3,400	193,853	0	0	0	0	0	0	0	0	464,768	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(278)	31,322	771,065	0	0	0	0	0	0	0	0	802,109	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,320,000)	0	0	0	0	0	0	0	0	(1,320,000)	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	267,237	34,722	(355,082)	0	(53,123)	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)	128,629	66,327	(349,173)	0	0	0	0	0	0	0	0	(154,217)	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

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	17 Management Fee Income	\$ 295,680	Lancaster, Ltd.	100.00%	\$	(295,680)	1	
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	35,872	35,872	2	
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	21,560	21,560	3	
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	4,227	4,227	4	
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	98,422	98,422	5	
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	10,076	10,076	6	
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	1,426	1,426	7	
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	89,432	89,432	8	
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	60,415	60,415	9	
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	3,400	3,400	10	
11	V	32 Interest-Incl. Direct Interest		Lancaster, Ltd.	100.00%	31,322	31,322	11	
12	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	3,304	3,304	12	
13	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	2,551	2,551	13	
14	Total		\$ 295,680			\$ 362,007	\$ *	66,327	14

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

VII. RELATED PARTIES (continued)

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)
15	V	34 Rental	\$ 1,320,000	Fairmont Property LLC		\$	\$(1,320,000)
16	V	32 Interest	28,935	Fairmont Property LLC		800,000	771,065
17	V	30 Depreciation		Fairmont Property LLC		193,853	193,853
18	V	21 State Replacement Tax		Fairmont Property LLC		3,709	3,709
19	V	19 Professional Fees		Fairmont Property LLC		2,200	2,200
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,348,935			\$ 999,762	\$ * (349,173)

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

Facility Name & ID Number

Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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 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	Christopher Vicere	VP-Finance	Administrative		see attached	5	10.42	Lancaster	\$ 17,936	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	5	10.42	Lancaster	17,936	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 35,872		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 Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009

Ending: -Dec-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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)604-4416
 Fax Number (773)478.1192

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	17	Christopher Vicere	Hours Worked	48	7	\$ 172,189	\$ 172,189	5	\$ 17,936	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		5	970	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	5	17,936	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		5	970	4
5										5
6										6
7										7
8	19	Professional Services	Management Fees	2,190,720	7	31,315		295,680	4,227	8
9	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	295,680	98,422	9
10	22	Employee Benefits	Management Fees	2,190,720	7	74,654		295,680	10,076	10
11	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		295,680	1,426	11
12	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	295,680	89,432	12
13	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	295,680	58,117	13
14	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		295,680	2,298	14
15	30	Depreciation	Management Fees	2,190,720	7	25,194		295,680	3,400	15
16	32	Interest	Management Fees	2,190,720	7	57,668		295,680	7,783	16
17	23	Education & Inservice	Management Fees	2,190,720	7	24,476		295,680	3,304	17
18	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		295,680	2,551	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		295,680	19,620	19
20										20
21	32	*Direct Interest*							23,539	21
22										22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 362,007	25

Facility Name & ID Number

Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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	7	8	9	10										
										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	Harston Investments		X	Long Term Loan						\$ 800,000	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	JP Morgan Chase Bank		X	Working Capital						7,783	6								
7											7								
8											8								
9	TOTAL Facility Related						\$	\$		\$ 807,783	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$	14								
15	TOTALS (line 9+line14)						\$	\$		\$ 807,783	15								

Set off Interest Income (278)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ None

Line #

N/A

807,505

Page 4 Line 32 col. 8

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

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.		\$	182,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	180,502	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,498)	3	
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	182,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	180,502	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	179,455	8	FOR BHF USE ONLY	
	2005	181,283	9		
	2006	181,110	10		
	2007	178,943	11		
	2008	180,502	12		
** Accrual is based on 2008 Taxes, adjusted for inflation**					
				13	FROM R. E. TAX STATEMENT FOR 2008 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

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

Facility Name & ID Number Fairmont Care Centre

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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).

 None

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

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

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>Nursing Care Facility</u>		<u>1995</u>	<u>\$ 685,000</u>	<u>1</u>
2	<u>Addition to Land - Reclaimed on Demolition</u>		<u>2007</u>	<u>46,500</u>	<u>2</u>
3	TOTALS			\$ 731,500	3

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009 Ending:

31-Dec-2009

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	176	1995		\$ 2,240,980	\$ 55,916	20	\$ 55,916	\$	\$ 1,272,734	4
5		2007		(60,256)					(24,290)	5
6										6
7										7
8										8
Improvement Type**										
9	Canopy and Awning	1995		3,300	85	20	85		1,860	9
10	Intercom System	1995		1,844	47	20	47		1,007	10
11	Roof Exhausters	1996		2,136	55	20	55		1,061	11
12	Permanent Signage	1997		16,625	982	15	982		15,464	12
13	Fire Alarm	1997		68,600	1,759	20	1,759		30,321	13
14	Parking Lot Excavation	1997		45,000	2,657	15	2,657		42,224	14
15	Parking Lot Asphalt	1997		68,000	4,015	15	4,015		45,955	15
16	Concrete Curbs	1997		18,000	1,063	15	1,063		12,166	16
17	Phase I Expansion-Landscaping	1997		41,000	2,421	15	2,421		27,710	17
18	Site Sewer	1997		28,500	1,683	15	1,683		19,262	18
19	Phase I Expansion-Building	1997		1,218,394	27,835	20	108,562	80,727	1,127,406	19
20	Ceramic Tiled Hallway	1998		10,603	272	15	272		4,377	20
21	Electrical Enhancements	1998		6,210	159	15	159		2,562	21
22	Phase II-Landscape	1999		15,000	886	15	886		11,016	22
23	Site Sewer	1999		40,376	2,384	15	2,384		29,647	23
24	Fire Protection	1999		43,440	1,114	20	1,114		11,465	24
25	Excavation	1999		49,650	2,932	15	2,932		36,460	25
26	Phase II Expansion	1999		2,281,933	55,008	20	214,541	159,533	1,852,854	26
27	Electrical-Courtyard	2001		6,520	167	15	167		1,496	27
28	Building Roofing	2001		21,919	562	20	562		4,613	28
29	Garage Roofing	2001		7,500	192	20	192		1,576	29
30	Heating System	2001		17,965	461	15	461		3,784	30
31	Addition to Heating System	2002		8,561		20	856	856	6,206	31
32	Improvement to Heating System	2002		11,688		20	1,169	1,169	8,377	32
33	Parking Lot Expansion	2002		31,500	1,301	20	3,150	1,849	22,575	33
34	Garden Pond	2003		5,000	148	20	333	185	2,165	34
35	Installation of Boiler & Heating Pipes	2003		54,886	1,407	20	4,574	3,167	28,585	35
36										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 Fairmont Care Centre

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Report Period Beginning:

1-Jan-2009 Ending: 31-Dec-2009

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	Fire Rated Wooden Door	2006	\$ 1,440	\$ 37	15	\$ 144	\$ 107	\$ 468	37
38	3rd floor Renovation Framework & ceiling	2007	11,500	295	20	1,150	855	3,354	38
39	3rd floor Renovation Electrical Installations	2007	3,000	77	20	300	223	875	39
40	3rd floor Renovation Carpeting	2007	2,500	480	20	500	20	1,458	40
41	Improvements to Dining Room	2007	97,863	18,789	20	19,572	783	50,562	41
42	Cabinets, Installation & Decorations for Dining Room	2007	97,862	2,509	20	9,786	7,277	25,281	42
43	Asphalt Coated Parking Lot	2007	61,905	5,293	20	4,127	(1,166)	11,693	43
44	Electrical Installations	2007	11,100		20	1,110	1,110	2,775	44
45	Town Square Construction - Interior & Exterior	2008	472,376	13,025	20	46,308	33,283	69,463	45
46	Corner Parking Lot Construction	2008	22,350	1,062	20	1,490	428	2,235	46
47	Electronic Telephone exchange	2008	21,165	3,386	10	4,233	847	8,466	47
48	Main Entrance Brickwork	2009	2,180	1,145	15	121	(1,024)	121	48
49	Building Roofing	2009	41,000	834	10	3,417	2,583	3,417	49
50	Condensing Unit	2009	16,882	379	10	1,548	1,169	1,548	50
51	Reconstruction of Resident Baths	2009	19,625	399	10	1,635	1,236	1,635	51
52	Stone/Brick Entrance Sign	2009	4,500	2,363	15	225	(2,138)	225	52
53	Concrete walkaway at Reception Exit	2009	4,300	2,258	15	96	(2,162)	96	53
54	Replace windows for 16 Resident Rooms	2009	25,000	80	10	417	337	417	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)		\$ 7,221,422	\$ 217,922		\$ 509,176	\$ 291,254	\$ 4,784,727	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	\$ 673,178	\$ 40,223	\$ 60,215	\$ 19,992	5	\$ 239,555	71
72	Current Year Purchases	100,389	60,233	13,077	(47,156)	5	13,077	72
73	Fully Depreciated Assets	1,201,585	1,141	4,566	3,425	5	1,201,585	73
74	**Lancaster Allocation**		3,400	3,400			18,879	74
75	TOTALS	\$ 1,975,152	\$ 104,997	\$ 81,258	\$ (23,739)		\$ 1,473,096	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,928,074	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 322,919	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 590,434	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 267,515	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,257,823	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: *** Fairmont Property, LLC (a related entity)***

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: \$ None Description: N/A

(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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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>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	hrs	\$		\$ 272,427	\$		\$ 272,427	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			156,539			156,539	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			304,215			304,215	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs							8
9	Pharmacy	39-2	# of prescripts				299,825		299,825	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					27,486		27,486	12
13	Other (specify): **Speciality Beds**	39-2					16,207		16,207	13
14	TOTAL			\$		\$ 733,181	\$ 343,518		\$ 1,076,699	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.

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2009

(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	\$ 1,911	\$ 1,911	1
2	Cash-Patient Deposits	68,731	68,731	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,997,785	1,997,785	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,148	39,148	6
7	Other Prepaid Expenses	1,100	1,100	7
8	Accounts Receivable (owners or related parties)		2,132,709	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,108,675	\$ 4,241,384	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		731,500	13
14	Buildings, at Historical Cost		2,180,724	14
15	Leasehold Improvements, at Historical Cost	683,982	4,722,250	15
16	Equipment, at Historical Cost	1,562,661	1,750,375	16
17	Accumulated Depreciation (book methods)	(1,828,092)	(3,627,427)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**	18,104	92,333	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 436,655	\$ 5,849,755	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,545,330	\$ 10,091,139	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 231,720	\$ 231,720	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,761	68,761	28
29	Short-Term Notes Payable	580,278		29
30	Accrued Salaries Payable	450,134	450,134	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,164	56,164	31
32	Accrued Real Estate Taxes(Sch.IX-B)	182,000	182,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,569,057	\$ 988,779	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,200,000	9,200,000	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)	\$ 1,200,000	\$ 9,200,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,769,057	\$ 10,188,779	46
47	TOTAL EQUITY(page 18, line 24)	\$ (223,727)	\$ (97,640)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,545,330	\$ 10,091,139	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,249,795)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,249,795)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(190,590)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	10,000	9
10	Stock Options Exercised		10
11	Contributions and Grants	1,206,658	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,026,068	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)	\$ (223,727)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,472,881)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,472,881)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,583	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	10,000	9
10	Stock Options Exercised		10
11	Contributions and Grants	1,206,658	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,375,241	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)	\$ (97,640)	24 *

* This must agree with page 17, line 47.

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	\$ 11,392,023	1
2	Discounts and Allowances for all Levels	(2,885,224)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,506,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,627,572	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,627,572	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	281,061	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,555	19
20	Radiology and X-Ray	14,294	20
21	Other Medical Services	70,848	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 373,758	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	278	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 278	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	170,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 170,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,678,807	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,056,230	31
32	Health Care	4,471,841	32
33	General Administration	1,536,703	33
B. Capital Expense			
34	Ownership	1,631,564	34
C. Ancillary Expense			
35	Special Cost Centers	1,076,699	35
36	Provider Participation Fee	96,360	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,869,397	40
41	Income before Income Taxes (line 30 minus line 40)**	(190,590)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (190,590)	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. **Cash Basis Taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **Set off on Pg 9 & 5A

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

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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	1,977	2,254	\$ 91,519	\$ 40.60	1
2	Assistant Director of Nursing	7,213	7,757	244,126	31.47	2
3	Registered Nurses	52,078	55,008	1,525,780	27.74	3
4	Licensed Practical Nurses	6,743	6,949	159,580	22.96	4
5	CNAs & Orderlies	109,455	118,997	1,393,561	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,795	1,889	32,428	17.17	9
10	Activity Assistants	15,382	16,852	171,122	10.15	10
11	Social Service Workers	5,984	6,383	92,591	14.51	11
12	Dietician					12
13	Food Service Supervisor	1,997	2,086	48,568	23.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,968	40,165	473,239	11.78	15
16	Dishwashers					16
17	Maintenance Workers	3,945	4,171	75,793	18.17	17
18	Housekeepers	29,627	32,368	365,182	11.28	18
19	Laundry	8,154	9,266	101,225	10.92	19
20	Administrator	1,443	1,999	60,174	30.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,468	9,164	158,040	17.25	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	4,076	4,468	85,216	19.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	294,305	319,776	\$ 5,078,144 *	\$ 15.88	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	537	\$ 18,820	1-3	35
36	Medical Director	1,700	54,550	9-3	36
37	Medical Records Consultant	144	4,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	326	8,482	10-3	39
40	Physical Therapy Consultant	143	3,569	10a-3	40
41	Occupational Therapy Consultant	100	2,676	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	414	12,834	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	60	1,681	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,424	\$ 106,932		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,808	\$ 208,486	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,808	\$ 208,486		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	
William Pfeiffer (through 3/26/09)	Administrator	N/A	\$ 29,194	Workers' Compensation Insurance	\$ 72,646	IDPH License Fee	\$ 995	
Barbara Dabrowski (eff. 3/27/09)	Administrator	N/A	30,980	Unemployment Compensation Insurance	39,491	Advertising: Employee Recruitment	4,916	
				FICA Taxes	379,952	Health Care Worker Background Check		
				Employee Health Insurance	211,472	(Indicate # of checks performed 123)	1,230	
				Employee Meals	24,222	Patient Background Checks	1,770	
				Illinois Municipal Retirement Fund (IMRF)*		**Licenses & Fees**	6,491	
				Miscellaneous Employee Benefits	8,321	**Promotional Advertising**	15,556	
				Uniform Allowance	799	**Dues & Subscriptions**	200	
				Retirement Plan Contribution	46,382			
				Dental Insurance	7,608	**Lancaster Allocation**	60,415	
				Employment Fees	700	Less: Public Relations Expense	(10,556)	
				Lancaster Allocation	10,076	Non-allowable advertising	(60,415)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,174	TOTAL (agree to Schedule V, line 22, col.8)	\$ 801,669	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,602	
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
Management Fees - Lancaster, Ltd.			\$ 295,680				Out-of-State Travel	\$
							In-State Travel	322
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 295,680				Seminar Expense	3,552
							Lancaster Allocation	1,426
C. Professional Services								
Vendor/Payee	Type		Amount					
Health Data Systems, Inc.	Data Processing		\$ 7,188					
Accu-Med Services Inc	Data Processing		4,260					
Sigma Care Services	Data Processing		1,800					
LTCAC	Data Processing		281					
Richard Peelo & Associates	Accounting		2,250					
Frost Ruttenberg & Rothblatt	Accounting		1,750					
Personnel Planners, Inc.	Payroll Tax Consultant		2,919					
Law Office of Carter Korey	Legal		9,288					
Myers & Miller LLC	Legal		957					
Kenneth Henry	Legal		22,537					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 53,230	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	\$ 5,300

* Attach copy of IMRF notifications

**See instructions.

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							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting and Decorating	Feb-04	\$ 2,742	3	\$ 914	\$ 457																		
2	Painting and Decorating	Sep-04	1,973	3	657	330																		
3	Painting and Decorating	May-05	3,784	3	1,261	1,261	631																	
4	Painting and Decorating	Aug-05	3,735	3	1,245	1,245	623																	
5	Painting and Decorating	Oct-06	4,767	3	794	1,589	1,589	795																
6	Painting and Decorating	Mar 07	350	3		116	118	116																
7	Painting and Decorating	Aug-07	1,200	3		200	400	400	200															
8	Painting and Decorating	Aug-08	3,850	3			642	1,283	1,283	642														
9	Painting and Decorating	Dec-08	1,829	3				610	609	610														
10	Painting and Decorating	May-09	1,550	3				259	516	516	259													
11	Painting and Decorating	Oct-09	1,359	3				226	453	453	227													
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 27,139		\$ 4,871	\$ 5,198	\$ 4,003	\$ 3,689	\$ 3,061	\$ 2,221	\$ 486	\$	\$											

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,258 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 96,360
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? N/A 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. \$ 24,222 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.