



Facility Name & ID Number FAIRVIEW NURSING CENTER

# 0024992 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	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	4 Private Pay	Other	Total	
8	SNF	2,772	628	1,487	4,887	8
9	SNF/PED					9
10	ICF	9,203	4,078		13,281	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,975	4,706	1,487	18,168	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.49%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 20 and days of care provided 1,487

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: 12/31/09 Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number **FAIRVIEW NURSING CENTER** # **0024992** Report Period Beginning: **01/01/09** Ending: **12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	102,154	5,130	6,051	113,335		113,335		113,335		1
2	Food Purchase		68,723		68,723	4,269	72,992	(183)	72,809		2
3	Housekeeping	62,232	8,929		71,161	120	71,281		71,281		3
4	Laundry	37,743	6,937		44,680		44,680		44,680		4
5	Heat and Other Utilities			60,317	60,317	519	60,836		60,836		5
6	Maintenance	21,753	19,381	35,209	76,343		76,343		76,343		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	223,882	109,100	101,577	434,559	4,908	439,467	(183)	439,284		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			825	825		825		825		9
10	Nursing and Medical Records	649,650	23,146	67,880	740,676	(1,740)	738,936		738,936		10
10a	Therapy										10a
11	Activities	36,956	3,500	1,526	41,982	(2,111)	39,871		39,871		11
12	Social Services	21,019		1,526	22,545		22,545		22,545		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	707,625	26,646	71,757	806,028	(3,851)	802,177		802,177		16
	<b>C. General Administration</b>										
17	Administrative	49,652		7,232	56,884	40,309	97,193		97,193		17
18	Directors Fees										18
19	Professional Services			154,431	154,431	(79,189)	75,242	(70,875)	4,367		19
20	Dues, Fees, Subscriptions & Promotions			10,478	10,478	155	10,633	(7,846)	2,787		20
21	Clerical & General Office Expenses	26,268	7,182	7,660	41,110	18,176	59,286	(410)	58,876		21
22	Employee Benefits & Payroll Taxes			150,276	150,276	8,648	158,924		158,924		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,041	5,041	526	5,567		5,567		24
25	Other Admin. Staff Transportation					1,832	1,832		1,832		25
26	Insurance-Prop.Liab.Malpractice			44,902	44,902	1,507	46,409		46,409		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	75,920	7,182	380,020	463,122	(8,036)	455,086	(79,131)	375,955		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,007,427	142,928	553,354	1,703,709	(6,979)	1,696,730	(79,314)	1,617,416		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,811	19,811	1,357	21,168	22,943	44,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			15,731	15,731	1,108	16,839		16,839			33
34	Rent-Facility & Grounds			59,901	59,901	4,514	64,415	(59,901)	4,514			34
35	Rent-Equipment & Vehicles			1,085	1,085		1,085		1,085			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			96,528	96,528	6,979	103,507	(36,958)	66,549			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,970	109,121	177,091		177,091		177,091			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		67,970	150,731	218,701		218,701		218,701			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,007,427	210,898	800,613	2,018,938		2,018,938	(116,272)	1,902,666			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	13,032	30		9
10	Interest and Other Investment Income	(8,216)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(383)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,104)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(642)	20		28
29	Other-Attach Schedule	(127)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,623)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)			34
35	Other- Attach Schedule	(112,649)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (112,649)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (116,272)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

FAIRVIEW NURSING CENTER

ID# 0024992

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1	DETAIL FOR LINE 39 SCH VI			1
2	ELIMINATE CHAMBER OF COMMERCE DUES	(100)	20	2
3				3
4	ELIMINATE ACTIVITY CONTRIBUTION	(27)	21	4
5	EXPENSE PER INCOME			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	(127)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(183)	0	0	0	0	0	0	0	0	0	0	(183)	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	<b>TOTAL General Services</b>	<b>(183)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(183)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(70,875)	0	0	0	0	0	0	0	0	0	(70,875)	19
20	Fees, Subscriptions & Promotions	(7,846)	0	0	0	0	0	0	0	0	0	0	(7,846)	20
21	Clerical & General Office Expenses	(410)	0	0	0	0	0	0	0	0	0	0	(410)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(8,256)</b>	<b>(70,875)</b>	<b>0</b>	<b>(79,131)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(8,439)</b>	<b>(70,875)</b>	<b>0</b>	<b>(79,314)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING CENTER# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	13,032	9,911	0	0	0	0	0	0	0	0	0	22,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,216)	8,216	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(59,901)	0	0	0	0	0	0	0	0	0	(59,901)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>4,816</b>	<b>(41,774)</b>	<b>0</b>	<b>(36,958)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(3,623)	(112,649)	0	0	0	0	0	0	0	0	0	(116,272)	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
<u>LIST ATTACHED</u>		<u>FAIR ACRES NURSING HOME</u>	<u>DUQUOIN</u>	<u>Jamestown Mgmt</u>	<u>Carbondale</u>	<u>Management</u>
		<u>CANTERBURY MANOR NURSING HOME</u>	<u>WATERLOO</u>	<u>Fairview Residential</u>	<u>DuQuoin</u>	<u>Owens Building</u>
				<u>Land Trust</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	19	MANAGEMENT FEES	\$ 150,230	JAMESTOWN MANAGEMENT CORPORATION	100.00%	\$ 79,355	\$ (70,875)	1
2	V	30	DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%	9,911	9,911	2
3	V	34	RENT	59,901	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%		(59,901)	3
4	V	32	INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	39.70%	8,216	8,216	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		\$ 210,131			\$ 97,482	\$ *	(112,649)	14

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

Facility Name & ID Number **FAIRVIEW NURSING CENTER** # **0024992** Report Period Beginning: **01/01/09** Ending: **12/31/09**

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	<b>***OWNER'S COMPENSATIOON HAS BEEN ELIMINATED PRIOR TO COST REPORT***</b>									
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 FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization Jamestown Management Corp  
 Street Address 1001 E Main Bldg 4a  
 City / State / Zip Code Carbondale, IL 62901  
 Phone Number (618) 549-8331  
 Fax Number (618) 549-0133

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	13,172	\$ 5,881	\$	2,252	\$ 1,005	1
2	5	UTILITIES	HOURS OF SERVICE	13,172	3,035		2,252	519	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,320	235,680	235,680	1,423	40,309	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,172	970		2,252	166	4
5	20	LICENSE & DUES	HOURS OF SERVICE	13,172	907		2,252	155	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	4,852	90,374	90,374	830	15,460	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	13,172	13,154		2,252	2,249	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	13,172	50,581		2,252	8,648	8
9	24	SEMINARS	HOURS OF SERVICE	8,320	3,075		1,423	526	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320	10,714		1,423	1,832	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,172	8,816		2,252	1,507	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,172	7,935		2,252	1,357	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,172	6,480		2,252	1,108	13
14	34	RENT	HOURS OF SERVICE	13,172	26,400		2,252	4,514	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 464,002	\$ 326,054		\$ 79,355	25

Facility Name & ID Number

FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	FAIRVIEW NURSING CENTE	X		FINANCE CONSTRUCTION	\$3,922.00	3/1/07	\$ 220,000	\$ 115,705	09/01/2012	0.0600	\$ 8,216	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				<b>\$3,922.00</b>		<b>\$ 220,000</b>	<b>\$ 115,705</b>			<b>\$ 8,216</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 220,000</b>	<b>\$ 115,705</b>			<b>\$ 8,216</b>	<b>15</b>								

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

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

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





Facility Name & ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>BUILDING</u>	<u>76,230</u>	<u>1968</u>	<u>\$ 3,996</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>76,230</b>		<b>\$ 3,996</b>	<b>3</b>

Facility Name &amp; ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	42		1968	1968	\$ 94,863	\$	40	\$	\$	\$ 94,863	4
5			1968	1968	61,381		20			61,381	5
6			1970	1970	3,953		20			3,953	6
7	18		1970	1970	26,047		38			26,047	7
8	16		1976	1976	177,922		30			177,922	8
	<b>Improvement Type**</b>										
9		FIRE ALARM	1981		1,190		10			1,190	9
10		SEWER LINE	1982		1,056		10			1,056	10
11		PLUMBING IMPROVEMENTS	1984		1,193		10			1,193	11
12		ROOF & LANDSCAPING	1984		1,488		10			1,488	12
13		ACTIVITY ROOM	1986		15,306		20			15,306	13
14		ACTIVITY ROOM	1987		5,223		20			5,223	14
15		ROOF & LANDSCAPING	1987		9,775		10			9,775	15
16		PARKING LOT	1987		18,960		15			18,960	16
17		SECURITY SYSTEM	1988		2,583		15			2,583	17
18		RENOVATIONS	1989		2,723		15			2,723	18
19		HOT WATER HEATER	1990		4,128		15			4,128	19
20		6 WALL A/C UNITS	1990		7,205		8			7,205	20
21		LANDSCAPING	1990		495		10			495	21
22		SHOWERS/CUBICLE TRACKS	1990		8,459	119	15		(119)	8,459	22
23		ROOF & LANDSCAPING	1990		13,831	439	25	553	114	10,784	23
24		TELEPHONE	1991		3,274		20	164	164	3,034	24
25		WATER HEATER	1991		1,945		15			1,945	25
26		EMERGENCY LIGHTS	1992		960		15			960	26
27		SEAL & STRIPE PARKING LOT	1994		1,421		5			1,421	27
28		EMERGENCY LIGHTS	1995		994		15			994	28
29		HOT WATER HEATER	1995		7,433		15	496	496	7,192	29
30		SUBPANELS & CIRCUITS INSTALLED TO A/C	1996		2,394		10			2,394	30
31		PT A/C UNIT	1996		1,163		10			1,163	31
32		A/C UNIT	1996		1,071		10			1,075	32
33		INSTALLED SERVICE CABLE	1997		7,666	511	15	511		6,388	33
34		A/C UNITS	1998		698		10			698	34
35		HOT WATER HEATER	1998		2,985		15	199	199	2,289	35
36		OVERBED LIGHTING	1998		8,932		15	595		6,843	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 &amp; ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CARPET	1998	\$ 588	\$	5	\$	\$	\$ 588	37
38	INSTALL BASEBOARD HEATING	1998	3,599		15	240	240	2,760	38
39	CABINETS & COUNTERTOPS	1998	708		5			708	39
40	WALLPAPER & INSTALLATION	1998	9,457		5			9,457	40
41	PAINTING	1998	11,779		5			11,779	41
42	Trim, pictures, mirrors, permanent decorative fixtures	1998	2,007		5			2,007	42
43	FLOOR COVE BASE	1998	901		5			901	43
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	2,741	44
45	BUILDING ADDTION	1998	239,137		15	15,942	15,942	167,391	45
46	PARKING LOT	1998	13,916		15	928	928	10,672	46
47	FLOORING - ADJUSTMENT TO 1998 BUILDING ADDTION	1999	737		5			737	47
48	DOOR ALARM SYSTEM	1999	6,691		10	335	335	6,691	48
49	WALLPAPER & PAINTING	1999	8,314		5			8,314	49
50	INSTALL BOOKCASE IN ADMIN OFFICE	1999	333		10			333	50
51	LANDSCAPING	1999	5,931	199	10	297	98	5,931	51
52	SEAL COATED & STRIPED PARKING LOT	1999	1,646		8			1,646	52
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777		5			777	53
54	MOVE PHONE LINES	1999	328		5			328	54
55	ENTRANCE SIGN	1999	1,000		5			1,000	55
56	PAINT WINDOW GRIDS	1999	175		5			175	56
57	INSTALLATION OF FLOORING	1999	8,949	521	10	447	(74)	8,949	57
58	FOUNTAIN & LIGHT	1999	1,774		5			1,774	58
59	balance of trim, mirrors, permanent decorative fixtures to refurbish the building	1999	3,952		5			3,952	59
60									60
61	AWNINGS	1999	420		5			420	61
62	Labor & materials to remove existing wall & rebuild new wall	1999	8,559	427	10	427		8,559	62
63	relocate plumbing & electrical services, install cabinetry, & countertops, and installed new tile flooring. Labor & materials to gut an existing bathroom and rehab room to create 2 new bathrooms and storage area for housekeeping and dietary (to be completed in 2000). Labor & materials to install new cabinets, relocated plumbing& electrical, repair drywall & paint the breakroom.								63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 2,340		\$ 21,395	\$ 18,460	\$ 749,720	70

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

Facility Name &amp; ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 834,312	\$ 2,340		\$ 21,395	\$ 19,055	\$ 749,720	1
2	Labor & materials to complete 1999 bathroom project	2000	20,296	2,030	10	2,030		19,285	2
3	Installed ceramic tile, sinks, toilet stool, showers, and								3
4	lighting fixtures								4
5	Labor & materials to remove existing wall in order to convert	2000	11,212	1,121	10	1,121		10,650	5
6	storage room into a resident room. Removed existing								6
7	closets, installed shower area, relocated doors, electrical,								7
8	and plumbing services, repaired and painted drywall &								8
9	relocated call lights.								9
10	Excavate & replace driveway asphalt & fill in cracks with tar	2001	3,075	205	15	205		1,743	10
11	Reinforce & raise sinking floor on B wing	2001	7,380	492	15	492		4,182	11
12	Gut beauty shop area and construct a new handicapped	2001	16,165	1,078	15	1,078		9,163	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet,								13
14	sink, door, sprinkler heads, cubicle tracks, & curtains, and								14
15	cove base								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete &	2001	2,800	187	15	187		1,589	16
17	replaced deteriorated sewer line, install new line, and new								17
18	clean out and pour new floor.								18
19	Relocate beauty shop to PT area. Installed lines, clean out	2001	1,223	82	15	82		697	19
20	& shut off valves, drill & knock out outside brick wall,								20
21	install fan, finish drywall, paint, install tile on drywall,								21
22	install sink & shelves.								22
23	Convert existing bathroom to handicapped bathroom.	2001	7,124	475	15	475		4,037	23
24	Remove tile, install box for call lights, tear out & reconstruct								24
25	showers, tile wall & showers, install handrails in tub &								25
26	showers, hang tracks & curtains, put new lever handle door								26
27	lever.								27
28	Add fan to isolation room for Medicare compliance.	2001	386	26	15	26		221	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	23	15	23		195	29
30	Upgrade emergency lighting & moved annunciator panel	2001	15,138	1,514	10	1,514		12,869	30
31	& smoke detector								31
32	Upgraded nurses call station	2001	645	65	10	65		552	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 920,094	\$ 9,638		\$ 28,693	\$ 19,055	\$ 814,903	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 920,094	\$ 9,638		\$ 28,693	\$ 19,055	\$ 814,903	1
2	Install grease trap and wet well	2002	13,224	1,322	10	1,322		9,915	2
3	Replaced rusted out main line drain in B hallway &	2002	3,494	349	10	349		2,172	3
4	reinstalled drain to connect to mainline in B hall bath								4
5	Removed old flooring and replaced with ceramic tile in	2002	1,706	171	10	171		1,728	5
6	A hall bathroom.								6
7	Repair roof over front dining room and activity room	2002	8,230	823	10	823		6,173	7
8	LANDSCAPING OF COURTYARD	2004	1,109	111	10	111		610	8
9	Remove, repair, and install tile flooring in dining room.	2005	7,222	722	10	722		3,249	9
10	Replace tile in hall, TV room, and small hallway	2008	3,310		10	331	331	497	10
11	Replace roof over kitchen and dining room and repairs to	2009	7,615	544	10	381	(163)	381	11
12	A & B hall								12
13	5'x6' entrance sign	2009	1,599	1,599	5	160	(1,439)	160	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 967,603	\$ 15,279		\$ 33,063	\$ 17,784	\$ 839,788	34

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 89,308	\$ 1,869	\$ 9,558	\$ 7,689	various	\$ 60,211	71
72	Current Year Purchases	2,663	2,663	133	(2,530)	various	133	72
73	Fully Depreciated Assets	230,183					230,183	73
74								74
75	<b>TOTALS</b>	\$ 322,154	\$ 4,532	\$ 9,691	\$ 5,159		\$ 290,527	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			\$	\$ 1,357	\$ 1,357	\$		\$ 25,796	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$ 1,357	\$ 1,357	\$		\$ 25,796	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)	\$ 1,293,753	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,111	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,943	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,156,111	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	PARKING LOT 1968	\$ 3,720	\$	\$ 3,720	86
87	ROOF 1968	7,440		7,440	87
88	FIRE ALARM 1969	130		130	88
89	EQUIPMENT VAR	24,719		24,719	89
90	Assets no longer in use (obsolete)				90
91	<b>TOTALS</b>	\$ 36,009	\$	\$ 36,009	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 1,085 Description: storage 188; dishmachine 828; carpet cleaner 69

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><b><u>WE ONLY HIRE TRAINED AIDES.</u></b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	\$	651	\$ 37,062	\$ 50	651	\$ 37,112	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		146	12,185		146	12,185	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		920	52,928	338	920	53,266	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				51,646		51,646	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med sup, tube feed, oxygen Other (specify): lab, xray, other	39/2 39/3				6,946	15,936		22,882	13
14	<b>TOTAL</b>			\$	1,717	\$ 109,121	\$ 67,970	1,717	\$ 177,091	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 **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 22,011	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	528,263		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	396,511		5
6	Prepaid Insurance	7,048		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>INVESTMENT</b>	6,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 959,833	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	172,895		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	438,220		16
17	Accumulated Depreciation (book methods)	(559,474)		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): <b>MORTGAGE RECEIVABLE</b>	115,705		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 167,346	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,127,179	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 45,772	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,854		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,080		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>401K LIABILITY</b>	8,018		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 99,724	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 99,724	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,027,455	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,127,179	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>977,947</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2008 IL REPLACEMENT TAX</b>	<b>(2,987)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>974,960</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>116,960</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(50,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>EXCESS SALARIES ELIMINATED</b>	<b>(14,465)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>52,495</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,027,455</b>	<b>24</b> *

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

Facility Name &amp; ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,823,606	1
2	Discounts and Allowances for all Levels	80,145	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,903,751	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	208,620	6
7	Oxygen	9,827	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 218,447	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,058	19
20	Radiology and X-Ray	774	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,832	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,291	24
25	Interest and Other Investment Income***	8,577	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,868	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,135,898	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	434,559	31
32	Health Care	806,028	32
33	General Administration	463,122	33
<b>B. Capital Expense</b>			
34	Ownership	96,528	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	177,091	35
36	Provider Participation Fee	41,610	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,018,938	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	116,960	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 116,960	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. IL Replacement tax is deducted on federal return.

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

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

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

# **0024992**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	1,924	2,080	\$ 46,899	\$ 22.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,370	2,456	47,911	19.51	3
4	Licensed Practical Nurses	10,947	11,997	183,541	15.30	4
5	CNAs & Orderlies	35,405	37,922	371,299	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,838	3,055	36,956	12.10	9
10	Activity Assistants					10
11	Social Service Workers	1,827	1,962	21,019	10.71	11
12	Dietician					12
13	Food Service Supervisor	2,156	2,316	29,108	12.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,104	8,674	73,046	8.42	15
16	Dishwashers					16
17	Maintenance Workers	1,818	1,951	21,753	11.15	17
18	Housekeepers	5,168	5,651	62,232	11.01	18
19	Laundry	2,888	3,144	37,743	12.00	19
20	Administrator	1,883	2,080	49,652	23.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,892	2,080	26,268	12.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,220	85,368	\$ 1,007,427 *	\$ 11.80	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	100	\$ 6,051	1/3	35
36	Medical Director		825	9/3	36
37	Medical Records Consultant		200	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		601	10/3	39
40	Physical Therapy Consultant			10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,526	11/3	44
45	Social Service Consultant	23	1,526	12/3	45
46	Other(specify) <u>MDS Consultant</u>		148	10/3	46
47	<u>Utilization Review</u>		825	10/3	47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 11,702		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10/3	50
51	Licensed Practical Nurses	2,108	63,208	10/3	51
52	Certified Nurse Assistants/Aides	146	2,898	10/3	52
53	TOTAL (lines 50 - 52)	2,254	\$ 66,106		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		
JENI MCCLANAHAN	ADMINISTRATOR	0	\$ 49,652	Workers' Compensation Insurance	\$ 37,249	IDPH License Fee	\$ 994		
				Unemployment Compensation Insurance	11,154	Advertising: Employee Recruitment	135		
				FICA Taxes	77,068	Health Care Worker Background Check			
				Employee Health Insurance	6,177	(Indicate # of checks performed <u>30</u> )	360		
				Employee Meals		Patient Background Checks <u>25</u>	300		
				Illinois Municipal Retirement Fund (IMRF)*		CHAMBER OF COMM(100) ELIM(-100)	0		
				VACCINES	255	CORP FEES (541) AANAC (110)	651		
				401K EXPENSE	10,263	SUBSCRIPTIONS	192		
				STAFF PARTIES, ATTENDANCE, AWARDS, E	8,110	OTHER ADVERTISING	7,746		
				JAMESTOWN ALLOCATION	8,648	JAMESTOWN ALLOCATION	155		
						Less: Public Relations Expense	(7,104)		
						Non-allowable advertising (			
						Yellow page advertising	(642)		
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)		
\$ 49,652				\$ 158,924			\$ 2,787		
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	
BONUS TO MANAGEMENT COMPANY EMPLOYEES			\$ 7,232				Out-of-State Travel	\$	
							In-State Travel	1,187	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		3,854
\$ 7,232				\$			JAMESTOWN ALLOCATION		526
C. Professional Services							Entertainment Expense (		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
JAMESTOWN MGMT CORP	MANAGEMENT		\$ 150,230				TOTAL		\$ 5,567
BARNETT & LEVINE	ACCOUNTING		970						
ELVIDGE KELLEY	LEGAL		2,630						
INNOVATIVE LTC SOLUTIONS	BILLING CONSULTANT		601						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 154,431									

\* 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	FY2014
1	<b>PAINTING</b>	<b>2005</b>	<b>\$ 3,498</b>		<b>\$ 1,166</b>	<b>\$ 1,166</b>	<b>\$ 583</b>	\$	\$	\$	\$	\$	\$
2													
3													
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19													
20	<b>TOTALS</b>		<b>\$ 3,498</b>		<b>\$ 1,166</b>	<b>\$ 1,166</b>	<b>\$ 583</b>	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number FAIRVIEW NURSING CENTER

# 0024992

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,610  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRVIEW NURSING CENTER INC

RECLASSIFICATIONS ON DPA COST REPORT

12/31/2009

PAGES 3 & 4 COLUMN 5

#0024992

LINE	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	2158	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2158
21	CLERICAL & GENERAL OFFICE EXPENSE	467	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		467
2	FOOD PURCHASES	2111	
11	ACTIVITIES RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPT		2111
10	NURSING & MEDICAL RECORDS	885	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		885
VARIOUS	VARIOUS LINE ITEMS	79355	
19	PROFESSIONAL SERVICES SEE SCHEDULE VIII FOR BREAKDOWN		79355