

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	29	Skilled (SNF)	29	10,585	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	873	3,070	1,005	4,948	8
9	SNF/PED					9
10	ICF	9,334	1,261		10,595	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,207	4,331	1,005	15,543	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.55%

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)

N/A

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

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

YES NO

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

Date started 1966

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 29 and days of care provided 1,005

Medicare Intermediary CGS JURISDICTION 15

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: _____

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

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	100,593	5,847	5,556	111,996		111,996		111,996		1
2	Food Purchase		76,355		76,355	4,610	80,965	(237)	80,728		2
3	Housekeeping	49,963	5,691		55,654	1,395	57,049		57,049		3
4	Laundry	35,928	3,829		39,757		39,757		39,757		4
5	Heat and Other Utilities			59,188	59,188	480	59,668		59,668		5
6	Maintenance	34,383	23,052	40,123	97,558		97,558		97,558		6
7	Other (specify):*										7
8	TOTAL General Services	220,867	114,774	104,867	440,508	6,485	446,993	(237)	446,756		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	628,012	29,262	87,987	745,261	(4,610)	740,651		740,651		10
10a	Therapy										10a
11	Activities	21,115	1,381	1,408	23,904		23,904		23,904		11
12	Social Services	27,365		1,408	28,773		28,773		28,773		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	676,492	30,643	92,003	799,138	(4,610)	794,528		794,528		16
	C. General Administration										
17	Administrative	63,734			63,734	27,501	91,235		91,235		17
18	Directors Fees										18
19	Professional Services			130,697	130,697	(73,147)	57,550	(55,433)	2,117		19
20	Dues, Fees, Subscriptions & Promotions			11,007	11,007	162	11,169	(6,225)	4,944		20
21	Clerical & General Office Expenses	24,988	8,113	7,867	40,968	21,896	62,864	(2,297)	60,567		21
22	Employee Benefits & Payroll Taxes			139,826	139,826	7,664	147,490		147,490		22
23	Inservice Training & Education			79	79		79		79		23
24	Travel and Seminar			1,830	1,830	133	1,963		1,963		24
25	Other Admin. Staff Transportation					1,543	1,543		1,543		25
26	Insurance-Prop.Liab.Malpractice			40,802	40,802	1,443	42,245		42,245		26
27	Other (specify):*										27
28	TOTAL General Administration	88,722	8,113	332,108	428,943	(12,805)	416,138	(63,955)	352,183		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	986,081	153,530	528,978	1,668,589	(10,930)	1,657,659	(64,192)	1,593,467		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIR ACRES NURSING HOME

#0027367

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			12,353	12,353	5,153	17,506	13,078	30,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,508	1,508		1,508	(1,508)				32
33	Real Estate Taxes					1,316	1,316	19,084	20,400			33
34	Rent-Facility & Grounds			54,000	54,000	4,461	58,461	(54,000)	4,461			34
35	Rent-Equipment & Vehicles			7,625	7,625		7,625		7,625			35
36	Other (specify):*											36
37	TOTAL Ownership			75,486	75,486	10,930	86,416	(23,346)	63,070			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,997	110,170	142,167		142,167		142,167			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,697	130,697		130,697		130,697			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		31,997	240,867	272,864		272,864		272,864			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	986,081	185,527	845,331	2,016,939		2,016,939	(87,538)	1,929,401			45

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

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,218	30		9
10	Interest and Other Investment Income	(1,508)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,671)	21		18
19	Entertainment				19
20	Contributions	(626)	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	(4,998)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,227)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,049)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(80,489)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (80,489)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (87,538)		37

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

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

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

FAIR ACRES NURSING HOME

ID# 0027367

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(237)	0	0	0	0	0	0	0	0	0	0	(237)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(237)	0	0	0	0	0	0	0	0	0	0	(237)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(55,433)	0	0	0	0	0	0	0	0	0	(55,433)	19
20	Fees, Subscriptions & Promotions	(6,225)	0	0	0	0	0	0	0	0	0	0	(6,225)	20
21	Clerical & General Office Expenses	(2,297)	0	0	0	0	0	0	0	0	0	0	(2,297)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,522)	(55,433)	0	(63,955)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,759)	(55,433)	0	(64,192)	29								

STATE OF ILLINOIS

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,218	9,860	0	0	0	0	0	0	0	0	0	13,078	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,508)	0	0	0	0	0	0	0	0	0	0	(1,508)	32
33	Real Estate Taxes	0	19,084	0	0	0	0	0	0	0	0	0	19,084	33
34	Rent-Facility & Grounds	0	(54,000)	0	0	0	0	0	0	0	0	0	(54,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,710	(25,056)	0	(23,346)	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)	(7,049)	(80,489)	0	0	0	0	0	0	0	0	0	(87,538)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David McGanney	9.94	FAIRVIEW NURSING CENTER	DUQUOIN	Twin Willows	DuQuoin	Real Estate Rental
Hudson T. Byrd Rev Trust	6.335			Land Trust		
Hugh Hunter Byrd Rev Trust	5.450			Jamestown Mgmt	Carbondale	Management
Nelson M. Byrd Rev Trust	6.335					
Esther Appleton	3.30					
Franklin Howard Groff Trust	6.61					
Sydell T. Hollman & Michael S. Hollman	5.7					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 54,000	TWIN WILLOWS LAND TRUST	100.00%	\$	\$(54,000)	1
2	V	30 DEPRECIATION		TWIN WILLOWS LAND TRUST	100.00%	9,860	9,860	2
3	V	33 REAL ESTATE TAXES		TWIN WILLOWS LAND TRUST	100.00%	19,084	19,084	3
4	V	19 JAMESTOWN MGMT FEES	128,788	JAMESTOWN MANAGEMENT CORPORATION	0.00%	73,355	(55,433)	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		\$ 182,788			\$ 102,299	\$ * (80,489)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Richard T. Parrish	1.585						1
2	Theodore Ross Exempt Trust	.95						2
3	Theodore Ross Exempt Trust	.95						3
4	Theodore Ross Exempt Trust	.95						4
5	William Arthur Parrish III	6.61						5
6	Robert Potashnick Trust	5.7						6
7	Rose Lee Deutsch	2.85						7
8	Bernard H. Ross Living Trust	2.85						8
9	Benedict & John Brougham Living Trust	6.61						9
10	Johnson Family Revocable Trust	1.425						10
11	Roger K. Parrish	1.425						11
12	Teresa Parrish Buhs	1.425						12
13	Cynthia L. Allen	1.9						13
14	Scott Frederick Nolen	1.9						14
15	Gerard A. Nester, Conservator for	1.9						15
16	Patricia Nolen							16
17	Lucinda Bain	8.65						17
18	Coletta S. McClary	8.65						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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	13,403	\$ 8,257	\$	2,265	\$ 1,395	1
2	5	UTILITIES	HOURS OF SERVICE	13,403	2,843		2,265	480	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,060	162,746	162,746	1,362	27,501	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,403	1,229		2,265	208	4
5	20	LICENSES & DUES	HOURS OF SERVICE	13,403	959		2,265	162	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,343	102,637	102,637	903	17,346	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	13,403	26,924		2,265	4,550	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,403	45,354		2,265	7,664	8
9	24	SEMINARS	HOURS OF SERVICE	8,060	787		1,362	133	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,060	9,130		1,362	1,543	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,403	8,538		2,265	1,443	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,403	30,495		2,265	5,153	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,403	7,789		2,265	1,316	13
14	34	RENT	HOURS OF SERVICE	13,403	26,400		2,265	4,461	14
15									15
16									16
17									17
18									18
19	***EXCESS SALARIES OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO COST REPORT***								
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 434,088	\$ 265,383		\$ 73,355	25

Facility Name & ID Number

FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	BANTERRA BANK		X	LINE OF CREDIT		1/25/2013	200,000		01/24/2014	0.0475	1,508					
7																
8																
9	TOTAL Facility Related						\$ 200,000	\$			\$ 1,508					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 200,000	\$			\$ 1,508					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	19,084		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	19,084		3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.		\$	19,084		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	15,746	8	FOR BHF USE ONLY		
	2009	16,811	9			
	2010	18,023	10			
	2011	18,725	11			
	2012	19,084	12			
Line 7 does not agree with the amount of SCH V line 33 because line 7 does not include the Jamestown allocation of \$1316 From SCH VIII page 8. To reconcile RE tax on page line 33, add line 7 \$19084 And Jamestown allocation of \$1316 to total RE Tax of \$20400.				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIR ACRES NURSING HOME COUNTY PERRY
 FACILITY IDPH LICENSE NUMBER 0027367
 CONTACT PERSON REGARDING THIS REPORT BRENDA CULLUM
 TELEPHONE 618-549-8331 FAX #: 618-549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1-61-0270-010</u>	<u>SEC 17 TWP 06 RNG 01</u>	\$ <u>19,084.48</u>	\$ <u>19,084.48</u>
2. _____	<u>S SW SW NE 07109</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>19,084.48</u></u>	\$ <u><u>19,084.48</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,703 B. General Construction Type: Exterior MASONRY Frame MASONRY & STEEL Number of Stories 1

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

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

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

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	BUILDING	125,722		\$ 18,792	1
2					2
3	TOTALS	125,722		\$ 18,792	3

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74	1966	1966	\$ 179,381	\$	40	\$	\$	\$ 179,381	4
5		1966	1966	175,379		20			175,379	5
6		1987	1987	263,386		40	6,585		174,502	6
7										7
8										8
	Improvement Type**									
9	FULLY DEPRECIATED		1974	15,221					15,221	9
10	FULLY DEPRECIATED		1980	5,082					5,082	10
11	BUILDING IMPROVEMENT		1971	2,768					2,768	11
12	BUILDING IMPROVEMENT		1972	1,823					1,823	12
13	BUILDING IMPROVEMENT		1973	9,170					9,170	13
14	BUILDING IMPROVEMENT		1981	1,158		10 TO 15			1,158	14
15	ROOF		1982	3,890		15			3,890	15
16	LAND IMPROVEMENT		1982	10,400		15			10,400	16
17	FIRE ALARM & SEAL PARKING LOT		1983	4,351		10 TO 15			4,351	17
18	A/C ROOFTOP, WATERLINE, STORAGE BUILDING		1984	13,711		20			13,711	18
19	SEWER REPAIR		1987	1,330		15			1,330	19
20	PARKING LOT & PLUMBING		1988	14,182	77	15 TO 20	166	89	14,182	20
21	A/C COMPRESSOR & ROOF		1989	23,834		15 TO 30	764	764	18,873	21
22	ROOF REPAIR		1990	18,354		30	612	612	14,382	22
23	WATER HEATER & A/C UNITS		1990	4,675	38	15		(38)	4,675	23
24	CABINETS & NURSES STATION		1992	6,893		15			6,893	24
25	PARKING LOT SEALED AND STRIPED		1994	4,138		15			4,138	25
26	HEAT EXCHANGE ON ROOF TOP UNITS INSTALLED		1995	2,638		10			2,638	26
27	WALL A/C UNITS INSTALLED		1996	1,976		15			1,976	27
28	REPAIRS TO GASOLINE		1997	3,786	189	20	189		3,119	28
29	REPLACED CARPETING		1997	795		5			795	29
30	INSTALLED 2 PT AC AIR & HEAT UNITS		1997	2,376		15			2,376	30
31	WATER HEATER & INSTALLATION		1998	780		10			780	31
32	ENTRANCE SIGN		1999	1,002		5			1,002	32
33	GAZEBO WITH RAMP & RAILING		1999	3,377	169	20	169		2,450	33
34	LANDSCAPING		1999	978		5			978	34
35	Repairs to damaged asphalt, seal & stripe parking lot		1999	2,101		10			2,101	35
36	INSTALL TILE FLOORING		2000	22,927		10			22,927	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL SHOWER FAUCET REPLACEMENTS	2000	\$ 1,731	\$	10	\$	\$	\$ 1,731	37
38	INSTALL CARPET ON WALLS	2000	4,898		10			4,898	38
39	WATER GARDEN	2000	922		5			922	39
40	Remove & replace damaged asphalt & fill cracks in parking lot	2001	10,546	703	15		(703)	8,788	40
41	REPLACE BATHROOM FLOOR TILES ON A & B HALLS	2001	2,994		10	703	703	2,994	41
42	REPLACE FLOORTILES IN 3 BATHROOMS	2002	7,989		10			7,989	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346		10			13,346	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	134	10	134		2,680	44
45	INSTALL CABLE WIRING FOR CABLE TV	2003	1,220		5			1,220	45
46	INSTALL MIXING VALVE	2004	2,220	222	10	222		2,109	46
47	SEAL & PATCH PARKING LOT	2005	2,027	203	8	129	(74)	2,027	47
48	Replace hotwater storage tank & circulating pump	2005	7,100	355	20	355		3,018	48
49	INSTALL TILE & COVE BASE IN LAUNDRY	2005	1,186	119	10	119		1,011	49
50	REPAIR NORTH WING ROOF	2005	4,096	410	10	410		3,485	50
51	REPLACE 100 GAL HOT WATER HEATER	2005	4,900	490	10	490		4,165	51
52	Resurface counter and desk tops at nurses station and	2006	2,578	172	15	172		1,290	52
53	replace bumper edge								53
54	POURED SIDEWAL FOR EMER EXIT ON B WING	2007	2,000	133	15	133		865	54
55	INSTALLED HEAT EXCHANGE IN KITCHEN	2010	3,894	260	15	260		910	55
56	INSTALLED LINOLEUM FLOORING IN BATHROOM	2010	6,046	864	7	864		3,024	56
57	REPAIR DOOR JAMBS	2011	2,598		5	520	520	1,300	57
58	INSTALL FIRE RATED CARPET ON WALLS	2011	6,419		5	1,284	1,284	3,210	58
59	PARKING LOT SEAL & STRIPE	2011	1,790		5	358	358	895	59
60	INSTALL SPRINKLER SYSTEM	2012	61,100	2,902	25	2,444	(458)	3,666	60
61	INSTALL CONTROL VALVE ON BACKFLOW	2013	3,348	478	15	112	(366)	112	61
62	FIRE ALARM PANEL	2013	5,176	740	10	259	(481)	259	62
63	PATIO	2013	3,796	126	5	380	254	380	63
64	SPRINKLER BRACING AND SPRINKLER HEADS	2013	2,954	422	10	148	(274)	148	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 971,416	\$ 9,206		\$ 17,981	\$ 2,190	\$ 778,893	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 55,836	\$ 1,480	\$ 6,689	\$ 5,209	VARIOUS	\$ 31,351	71
72	Current Year Purchases	11,666	1,667	761	(906)	VARIOUS	761	72
73	Fully Depreciated Assets	249,164					249,164	73
74								74
75	TOTALS	\$ 316,666	\$ 3,147	\$ 7,450	\$ 4,303		\$ 281,276	75

D. Vehicle Costs. (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			\$	\$ 5,153	\$ 5,153	\$		\$ 39,811	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 5,153	\$ 5,153	\$		\$ 39,811	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)	\$ 1,306,874	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,506	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,584	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,078	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,099,980	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 7,625 Description: STORAGE 348, DISHMACHINE 992, WOUND VAC 6225, TANK 60

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>WE ONLY HIRE TRAINED AIDES.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	\$	604	\$ 37,038	\$	604	\$ 37,038	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		126	10,122		126	10,122	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		826	48,730	18	826	48,748	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				25,055		25,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med supp, tube feed, oxygen Other (specify): IV, labs, xray	39/2 & 39/3				14,280	6,924		21,204	13
14	TOTAL			\$	1,556	\$ 110,170	\$ 31,997	1,556	\$ 142,167	14

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

Facility Name & ID Number **FAIR ACRES NURSING HOME**# **0027367**Report Period Beginning: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(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	\$ 154,529	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	705,648		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	17,243		5
6	Prepaid Insurance	317		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): IL Taxes Deposited	440		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 878,177	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	253,178		15
16	Equipment, at Historical Cost	276,590		16
17	Accumulated Depreciation (book methods)	(459,827)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,941	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 948,118	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,395	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	313,000		29
30	Accrued Salaries Payable	30,411		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,298		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401k LIABILITY	8,771		36
37	ACC LIC BED TAX	22,344		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 451,219	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 451,219	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 496,899	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 948,118	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 649,162	1
2	Restatements (describe):		2
3	STATE TAX PAID FOR 2012 IN 2013	(404)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 648,758	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(151,859)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (151,859)	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)	\$ 496,899	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,626,129	1
2	Discounts and Allowances for all Levels	25,728	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,651,857	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	193,500	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 193,500	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,549	19
20	Radiology and X-Ray	156	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,705	23
D. Non-Operating Revenue			
24	Contributions	250	24
25	Interest and Other Investment Income***	14,768	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,018	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,865,080	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	440,507	31
32	Health Care	799,139	32
33	General Administration	428,943	33
B. Capital Expense			
34	Ownership	75,486	34
C. Ancillary Expense			
35	Special Cost Centers	142,167	35
36	Provider Participation Fee	130,697	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,016,939	40
41	Income before Income Taxes (line 30 minus line 40)**	(151,859)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (151,859)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 911,364	44
45	Private Pay - Net Inpatient Revenue	563,543	45
46	Medicare - Net Inpatient Revenue	182,755	46
47	Other-(specify) Vending Income & Prior Year Adjustments	(5,805)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,651,857	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

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

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

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

0027367

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	2,008	2,080	\$ 49,100	\$ 23.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,546	4,814	107,912	22.42	3
4	Licensed Practical Nurses	10,274	11,144	184,284	16.54	4
5	CNAs & Orderlies	23,942	25,856	259,852	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,746	1,897	21,115	11.13	9
10	Activity Assistants					10
11	Social Service Workers	1,560	1,819	27,365	15.04	11
12	Dietician					12
13	Food Service Supervisor	1,727	1,898	23,136	12.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,749	8,344	77,457	9.28	15
16	Dishwashers					16
17	Maintenance Workers	1,846	1,981	34,383	17.36	17
18	Housekeepers	4,917	5,227	49,963	9.56	18
19	Laundry	2,860	3,219	35,928	11.16	19
20	Administrator	1,856	2,080	63,734	30.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,590	1,741	24,988	14.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>ward clerk</u>	1,858	2,038	26,864	13.18	33
34	TOTAL (lines 1 - 33)	68,479	74,138	\$ 986,081 *	\$ 13.30	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	98	\$ 5,556	L1/C3	35
36	Medical Director		1,200	L9/C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,551	L10/C3	39
40	Physical Therapy Consultant	2	125	L10/C3	40
41	Occupational Therapy Consultant	12	555	L10/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,408	L11/C3	44
45	Social Service Consultant	21	1,408	L12/C3	45
46	Other(specify) <u>UR REVIEW</u>		1,200	L10/C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 13,003		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	39	\$ 1,843	L10/C3	50
51	Licensed Practical Nurses	1,041	38,386	L10/C3	51
52	Certified Nurse Assistants/Aides	2,145	44,327	L10/C3	52
53	TOTAL (lines 50 - 52)	3,225	\$ 84,556		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
LANDEE SLOVER	ADMINISTRATOR	0	\$ 63,734	Workers' Compensation Insurance	\$ 34,233	IDPH License Fee	\$ 1,988		
				Unemployment Compensation Insurance	3,787	Advertising: Employee Recruitment	1,278		
				FICA Taxes	75,435	Health Care Worker Background Check			
				Employee Health Insurance	6,052	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	35 420		
				Illinois Municipal Retirement Fund (IMRF)*		JAMESTOWN ALLOCATION	162		
				LIFE INSURANCE	96	INHAA 100; FOOD SERV 70	170		
				VACCINES	534	CORP FEES 677; SUBS 54	731		
				401K EXPENSE	11,243	OTHER ADV 6225; FS SANIT 100	6,325		
				AWARDS, INCENTIVES, ECT	8,446	STATE FIRE MARSHALL CERT	95		
				JAMESTOWN ALLOCATION	7,664	Less: Public Relations Expense	(4,998)		
						Non-allowable advertising	()		
						Yellow page advertising	(1,227)		
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)		
\$ 63,734				\$ 147,490			\$ 4,944		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel	330	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		1,500
\$				\$			JAMESTOWN ALLOCATION		133
C. Professional Services							Entertainment Expense		
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)		
JAMESTOWN MGMT CORP	MANAGEMENT	\$ 128,788					TOTAL		\$ 1,963
BARNETT & LEVINE	ACCOUNTING	1,367							
HENDRICKS & HAGAN	LEGAL	126							
SANDBERG & PHOENIX	LEGAL	416							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 130,697				\$					

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2004	\$ 6,156	3	\$ 1,026	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 6,156		\$ 1,026	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number FAIR ACRES NURSING HOME

0027367

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 8
- (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. \$ 130,697
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. \$ 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? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

FAIR ACRES NURSING HOME
 SCHEDULE OF RECLASSIFICATION FOR PAGES 3&4 COL 5
 12/31/2013

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	4610	
10	MEDICAL SUPPLIES		4610
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	73355	
19	PROFESSIONAL SERVICES		73355
	RECLASSIFY SCHEDULEVIII FOR BREAKDOWN		