FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 North Pulaski Road (Number) Chicago (City) 60630 (Zip Code)

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

HFS ID Number:

Date of Initial License for Current Owners: 11th May 1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2010 to 31-Dec-2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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 None

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,167	710	7,804	15,681	8
9	SNF/PED					9
10	ICF	39,139	2,624	113	41,876	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,306	3,334	7,917	57,557	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.60%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11th May 1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11th May 1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 7,409

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31st Dec 2010 Fiscal Year: 31st Dec 2010

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	515,939	86,842	20,872	623,653		623,653		623,653			1
2	Food Purchase		424,921		424,921	(30,008)	394,913	(246)	394,667			2
3	Housekeeping	361,043	46,806		407,849		407,849		407,849			3
4	Laundry	97,001	25,629		122,630		122,630		122,630			4
5	Heat and Other Utilities			257,973	257,973		257,973		257,973			5
6	Maintenance	82,854	43,036	201,468	327,358		327,358	2,146	329,504			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,056,837	627,234	480,313	2,164,384	(30,008)	2,134,376	1,900	2,136,276			8
	B. Health Care and Programs											
9	Medical Director			52,700	52,700		52,700		52,700			9
10	Nursing and Medical Records	3,840,533	326,635	84,555	4,251,723		4,251,723		4,251,723			10
10a	Therapy		10,706	22,393	33,099		33,099		33,099			10a
11	Activities	174,836	16,967		191,803		191,803		191,803			11
12	Social Services	97,586		2,715	100,301		100,301		100,301			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* *Dental Service**			925	925		925		925			15
16	**TOTAL Health Care and Programs**	4,112,955	354,308	163,288	4,630,551		4,630,551		4,630,551			16
	C. General Administration											
17	Administrative	71,504		316,800	388,304		388,304	(112,200)	276,104			17
18	Directors Fees											18
19	Professional Services			75,524	75,524		75,524	13,057	88,581			19
20	Dues, Fees, Subscriptions & Promotions			74,510	74,510		74,510	(18,258)	56,252			20
21	Clerical & General Office Expenses	164,174	55,798	170,574	390,546		390,546	3,424	393,970			21
22	Employee Benefits & Payroll Taxes			851,331	851,331	30,008	881,339	7,405	888,744			22
23	Inservice Training & Education			1,970	1,970		1,970		1,970			23
24	Travel and Seminar			1,462	1,462		1,462	429	1,891			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,791	13,791		13,791		13,791			26
27	Other (specify):* *Payroll Taxes (Sch VII)							28,067	28,067			27
28	**TOTAL General Administration**	235,678	55,798	1,505,962	1,797,438	30,008	1,827,446	(78,076)	1,749,370			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,405,470	1,037,340	2,149,563	8,592,373		8,592,373	(76,176)	8,516,197			29

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

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

Facility Name & ID Number Fairmont Care Centre #0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			203,296	203,296		203,296	404,339	607,635			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,191	1,191		1,191	806,189	807,380			32
33	Real Estate Taxes			264,340	264,340		264,340		264,340			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,320,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,788,827	1,788,827		1,788,827	(109,472)	1,679,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		415,404	665,099	1,080,503		1,080,503		1,080,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		415,404	761,459	1,176,863		1,176,863		1,176,863			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,405,470	1,452,744	4,699,849	11,558,063		11,558,063	(185,648)	11,372,415			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 Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	194,856	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(246)	2		13
14	Non-Care Related Interest	(415)	32		14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(160)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,197)	21		24
25	Fund Raising, Advertising and Promotional	(80,798)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,981)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule Page 5A attached	808	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,133)		$	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 Amount	2 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)	(178,515)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (178,515)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (185,648)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-2010

Ending: 31-Dec-2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2010)	$ (2,704)	6	1
2	Deferred Maintenance Cost (allocated for 2010)	3,512	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	808		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(246)	0	0	0	0	0	0	0	0	0	0	(246)	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	808	1,338	0	0	0	0	0	0	0	0	0	2,146	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	562	1,338	0	0	0	0	0	0	0	0	0	1,900	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	(112,200)	0	0	0	0	0	0	0	0	0	(112,200)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,482	1,575	0	0	0	0	0	0	0	0	13,057	19
20	Fees, Subscriptions & Promotions	(80,958)	62,700	0	0	0	0	0	0	0	0	0	(18,258)	20
21	Clerical & General Office Expenses	(121,178)	122,621	1,981	0	0	0	0	0	0	0	0	3,424	21
22	Employee Benefits & Payroll Taxes	0	7,405	0	0	0	0	0	0	0	0	0	7,405	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	429	0	0	0	0	0	0	0	0	0	429	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	28,067	0	0	0	0	0	0	0	0	0	28,067	27
28	**TOTAL General Administration**	(202,136)	120,504	3,556	0	0	0	0	0	0	0	0	(78,076)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(201,574)	121,842	3,556	0	0	0	0	0	0	0	0	(76,176)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	194,856	4,313	205,170	0	0	0	0	0	0	0	0	404,339	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(415)	21,801	784,803	0	0	0	0	0	0	0	0	806,189	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,320,000)	0	0	0	0	0	0	0	0	(1,320,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	194,441	26,114	(330,027)	0	0	0	0	0	0	0	0	(109,472)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(7,133)	147,956	(326,471)	0	0	0	0	0	0	0	0	(185,648)	45

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee Income	$ 316,800	Lancaster, Ltd.	100.00%	$	$ (316,800)	1
2	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	54,948	54,948	2
3	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	28,067	28,067	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	11,482	11,482	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	122,621	122,621	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	7,405	7,405	6
7	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	429	429	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	149,652	149,652	8
9	V	20	Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	62,700	62,700	9
10	V	30	Depreciation		Lancaster, Ltd.	100.00%	4,313	4,313	10
11	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	1,338	1,338	11
12	V	32	Interest		Lancaster, Ltd.	100.00%	7,795	7,795	12
13	V	32	**Direct Interest**		Lancaster, Ltd.	100.00%	14,006	14,006	13
14	Total			$ 316,800			$ 464,756	$ * 147,956	14

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,320,000	Fairmont Property LLC		$	$ (1,320,000)	15
16	V	32	Interest	15,197	Fairmont Property LLC		800,000	784,803	16
17	V	30	Depreciation		Fairmont Property LLC		205,170	205,170	17
18	V	21	State Replacement Tax		Fairmont Property LLC		1,981	1,981	18
19	V	19	Professional Fees		Fairmont Property LLC		1,575	1,575	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,335,197			$ 1,008,726	$ * (326,471)	39

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Christopher Vicere	VP-Finance	Administrative		see attached	7.75	16.15	Lancaster	$ 27,474	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	7.75	16.15	Lancaster	27,474	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 54,948		13

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

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: -Dec-2010

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 [X] NO [ ]

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

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)604-4416
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Christopher Vicere	Hours Worked	48	4	$ 170,160	$ 170,160	8	$ 27,474	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	9,439		8	1,524	2
3	17	Cheryl Morris	Hours Worked	48	4	170,160	170,160	8	27,474	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	9,420		8	1,521	4
5										5
6										6
7	19	Professional Services	Census Days	311,995	4	62,241		57,557	11,482	7
8	21	Clerical Expenses	Census Days	311,995	4	664,683	623,280	57,557	122,621	8
9	22	Employee Benefits	Census Days	311,995	4	40,140		57,557	7,405	9
10	24	Seminars and Travel	Census Days	311,995	4	2,324		57,557	429	10
11	17	Administrative Consulting	Census Days	311,995	4	811,207	811,207	57,557	149,652	11
12	20	Marketing Fees	Census Days	311,995	4	332,596	327,507	57,557	61,358	12
13	20	Dues, Fees and Subscriptions	Census Days	311,995	4	7,277		57,557	1,342	13
14	30	Depreciation	Census Days	311,995	4	23,380		57,557	4,313	14
15	6	Repairs and Maintenance	Census Days	311,995	4	7,255		57,557	1,338	15
16	27	Payroll Taxes	Census Days	311,995	4	135,636		57,557	25,022	16
17	32	Interest	Census Days	311,995	4	42,252		57,557	7,795	17
18										18
19										19
20	32	**Direct Interest**								20
21									14,006	21
22										22
23										23
24										24
25	TOTALS					$ 2,488,169	$ 2,102,314		$ 464,756	25

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Harston Investments		X	Long Term Loan			$	$			$ 800,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase Bank		X	Working Capital							7,795	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 807,795	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 807,795	15
									Set off Interest Income		(415)	
											807,380	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

Page 4 Line 32 col. 8

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

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

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 182,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 221,340	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,340	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 225,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 264,340	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	181,283	8
	2006	181,110	9
	2007	178,943	10
	2008	180,502	11
	2009	221,340	12

** Accrual is based on 2009 Taxes, adjusted for inflation**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604 - 4416 FAX #: (773) 478 - 1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-009-0000	Long-Term Healthcare	$ 221,339.72	$ 221,339.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 221,339.72	$ 221,339.72

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1995	$ 685,000	1
2	Addition to Land - Reclaimed on Demolition		2007	46,500	2
3	TOTALS			$ 731,500	3

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1995		$ 2,240,980	$ 55,916	20	$ 55,916	$	$ 908,465	4
5			2007		(60,256)					(24,290)	5
6											6
7											7
8											8
	Improvement Type**										
9	Canopy and Awning			1995	3,300	85	20	85		1,945	9
10	Intercom System			1995	1,844	47	20	47		1,054	10
11	Roof Exhausters			1996	2,136	55	20	55		1,116	11
12	Permanent Signage			1997	16,625	982	15	982		16,446	12
13	Fire Alarm			1997	68,600	1,759	20	1,759		32,080	13
14	Parking Lot Excavation			1997	45,000	2,657	15	2,657		44,881	14
15	Parking Lot Asphalt			1997	68,000	4,015	15	4,015		49,970	15
16	Concrete Curbs			1997	18,000	1,063	15	1,063		13,229	16
17	Phase I Expansion-Landscaping			1997	41,000	2,421	15	2,421		30,131	17
18	Site Sewer			1997	28,500	1,683	15	1,683		20,945	18
19	Phase I Expansion-Building			1997	1,218,394	27,835	20	108,561	80,726	977,057	19
20	Ceramic Tiled Hallway			1998	10,603	272	15	272		4,649	20
21	Electrical Enhancements			1998	6,210	159	15	159		2,721	21
22	Phase II-Landscape			1999	15,000	886	15	886		11,902	22
23	Site Sewer			1999	40,376	2,384	15	2,384		32,031	23
24	Fire Protection			1999	43,440	1,114	20	1,114		12,579	24
25	Excavation			1999	49,650	2,932	15	2,932		39,392	25
26	Phase II Expansion			1999	2,281,933	55,008	20	214,541	159,533	1,930,866	26
27	Electrical-Courtyard			2001	6,520	167	15	167		1,663	27
28	Building Roofing			2001	21,919	562	20	562		5,175	28
29	Garage Roofing			2001	7,500	192	20	192		1,768	29
30	Heating System			2001	17,965	461	15	461		4,245	30
31	Addition to Heating System			2002	8,561		20	856	856	7,062	31
32	Improvement to Heating System			2002	11,688		20	1,169	1,169	9,546	32
33	Parking Lot Expansion			2002	31,500	1,300	20	3,150	1,850	25,725	33
34	Garden Pond			2003	5,000	148	20	333	185	2,498	34
35	Installation of Boiler & Heating Pipes			2003	54,886	1,407	20	4,574	3,167	33,159	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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	
37	Fire Rated Wooden Door	2006	$ 1,440	$ 37	15	$ 144	$ 107	$ 612	37
38	3rd floor Renovation Framework & ceiling	2007	11,500	295	20	1,150	855	4,504	38
39	3rd floor Renovation Electrical Installations	2007	3,000	77	20	300	223	1,175	39
40	3rd floor Renovation Carpeting	2007	2,500	288	20	500	212	1,958	40
41	Improvements to Dining Room	2007	97,863	11,274	20	19,572	8,298	70,134	41
42	Cabinets, Installation & Decorations for Dining Room	2007	97,862	2,509	20	9,786	7,277	35,067	42
43	Asphalt Coated Parking Lot	2007	61,905	4,767	20	4,127	(640)	15,820	43
44	Electrical Installations	2007	11,100		20	1,110	1,110	3,885	44
45	Town Square Construction - Interior & Exterior	2008	472,376	12,775	20	46,309	33,534	115,772	45
46	Corner Parking Lot Construction	2008	22,350	955	20	1,490	535	3,725	46
47	Electronic Telephone exchange	2008	21,165	2,032	10	4,233	2,201	12,699	47
48	Main Entrance Brickwork	2009	2,180	104	15	145	41	266	48
49	Building Roofing	2009	41,000	1,051	10	4,100	3,049	7,517	49
50	Condensing Unit	2009	16,882	433	10	1,688	1,255	3,236	50
51	Reconstruction of Resident Baths	2009	19,625	503	10	1,963	1,460	3,598	51
52	Stone/Brick Entrance Sign	2009	4,500	214	15	300	86	525	52
53	Concrete walkaway at Reception Exit	2009	4,300	204	15	287	83	383	53
54	Replace windows for 16 Resident Rooms	2009	25,000	641	10	2,500	1,859	2,917	54
55	Security Alarm System for Reception Area	2010	11,960	294	10	1,196	902	1,196	55
56	Digital Paging System	2010	4,940	2,841	5	412	(2,429)	412	56
57	High Wattage Berkay Heater	2010	7,325	149	10	610	461	610	57
58	Windows changed for whole facility	2010	94,900	305	10	1,582	1,277	1,582	58
59	Renovate 8 Resident Rooms-Tiles,Flooring,Ceiling,Lighting	2010	122,641	394	10	2,044	1,650	2,044	59
60	2 Carrier Roof Top Air conditioning Units for 8 Rooms	2010	24,970	27	10	208	181	208	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,488,158	$ 207,679		$ 518,752	$ 311,073	$ 4,487,855	70

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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	$ 709,526	$ 36,935	$ 69,916	$ 32,981	5	$ 272,488	71
72	Current Year Purchases	168,595	162,611	9,878	(152,733)	5	9,878	72
73	Fully Depreciated Assets	1,265,626	1,241	4,776	3,535	5	1,265,626	73
74	**Lancaster Allocation**		4,313	4,313			23,192	74
75	TOTALS	$ 2,143,747	$ 205,100	$ 88,883	$ (116,217)		$ 1,571,184	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,363,405	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 412,779	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 607,635	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 194,856	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,059,039	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.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: *** Fairmont Property, LLC (a related entity)***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ None Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	None				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.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fairmont Care Centre

STATE OF ILLINOIS
0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 282,466	$		$ 282,466	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			117,245			117,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			264,419			264,419	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-3	hrs			969			969	8
9	Pharmacy	39-2	# of prescrpts				321,656		321,656	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					28,739		28,739	12
13	Other (specify): **Speciality Beds**	39-2					65,009		65,009	13
14	TOTAL			$		$ 665,099	$ 415,404		$ 1,080,503	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.

STATE OF ILLINOIS

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100	$ 1,100	1
2	Cash-Patient Deposits	69,324	69,324	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,433,745	1,433,745	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,864	36,864	6
7	Other Prepaid Expenses	21,024	21,024	7
8	Accounts Receivable (owners or related parties)	303,086	3,326,318	8
9	Other(specify): **Employee Loans**	50	50	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,865,193	$ 4,888,425	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		731,500	13
14	Buildings, at Historical Cost		2,180,724	14
15	Leasehold Improvements, at Historical Cost	746,255	5,027,033	15
16	Equipment, at Historical Cost	1,666,417	1,880,925	16
17	Accumulated Depreciation (book methods)	(2,031,388)	(4,035,893)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**		74,229	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 381,284	$ 5,858,518	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,246,477	$ 10,746,943	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 311,795	$ 359,704	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,324	69,324	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	529,442	529,442	30
31	Accrued Taxes Payable (excluding real estate taxes)	61,499	61,499	31
32	Accrued Real Estate Taxes(Sch.IX-B)	225,000	225,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,197,060	$ 1,244,969	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,200,000	9,200,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,200,000	$ 9,200,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,397,060	$ 10,444,969	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (150,583)	$ 301,974	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,246,477	$ 10,746,943	48

***(See instructions.)**

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,440,385)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,440,385)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,144	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	10,000	9
10	Stock Options Exercised		10
11	Contributions and Grants	1,206,658	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,289,802	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)**	$ (150,583)	24 *

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

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,314,299)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,314,299)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	399,615	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	10,000	9
10	Stock Options Exercised		10
11	Contributions and Grants	1,206,658	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,616,273	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)**	$ 301,974	24 *

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,164,380	1
2	Discounts and Allowances for all Levels	(2,569,273)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,595,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,477,426	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,477,426	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	300,560	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,034	19
20	Radiology and X-Ray	12,849	20
21	Other Medical Services	67,516	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 387,959	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	415	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 415	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Rental Income**	170,300	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 170,300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,631,207	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,164,384	31
32	Health Care	4,630,551	32
33	General Administration	1,797,438	33
	B. Capital Expense		
34	Ownership	1,788,827	34
	C. Ancillary Expense		
35	Special Cost Centers	1,080,503	35
36	Provider Participation Fee	96,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,558,063	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,144	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 73,144	43

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

****** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpaye

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

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,086	$ 93,245	$ 44.70	1
2	Assistant Director of Nursing	1,953	2,126	82,229	38.68	2
3	Registered Nurses	67,171	70,292	1,977,158	28.13	3
4	Licensed Practical Nurses	7,121	7,491	178,588	23.84	4
5	CNAs & Orderlies	113,708	123,795	1,417,012	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,727	1,874	26,537	14.16	9
10	Activity Assistants	12,995	14,559	148,299	10.19	10
11	Social Service Workers	6,067	6,568	97,586	14.86	11
12	Dietician					12
13	Food Service Supervisor	1,901	2,173	49,843	22.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,084	40,377	466,096	11.54	15
16	Dishwashers					16
17	Maintenance Workers	3,932	4,429	82,854	18.71	17
18	Housekeepers	27,867	31,051	361,043	11.63	18
19	Laundry	7,955	8,767	97,001	11.06	19
20	Administrator	1,985	2,040	71,504	35.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,876	9,501	164,174	17.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,123	4,395	92,301	21.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	306,494	331,524	$ 5,405,470 *	$ 16.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	600	$ 20,872	1-3	35
36	Medical Director	1,650	52,700	9-3	36
37	Medical Records Consultant	160	4,784	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	1,150	29,959	10-3	39
40	Physical Therapy Consultant	188	4,932	10a-3	40
41	Occupational Therapy Consultant	93	2,511	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	483	14,950	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	97	2,715	12-3	45
46	Other(specify) **Dental Service**	37	925	15-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,458	$ 134,348		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,668	$ 49,812	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,668	$ 49,812		53

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joanne Ventrella	Administrator	N/A	$ 71,504
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,504

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 316,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 316,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 7,470
Accu-Med Services Inc	Data Processing	4,554
E-Health Solutions Inc	Data Processing	3,748
LTCAC Inc.	Data Processing	1,089
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,750
Personnel Planners, Inc.	Payroll Tax Consultant	1,979
Law Office of Carter Korey	Legal	12,785
Myers & Miller LLC	Legal	15,457
Kenneth A. Henry	Legal	24,442
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 75,524

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,537
Unemployment Compensation Insurance	37,867
FICA Taxes	401,978
Employee Health Insurance	243,510
Employee Meals	30,008
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	10,567
Uniform Allowance	533
Retirement Plan Contribution	51,629
Dental Insurance	6,810
Employment Fees	34,900
Lancaster Allocation	7,405
TOTAL (agree to Schedule V, line 22, col.8)	$ 888,744

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,100
Advertising: Employee Recruitment	3,475
Health Care Worker Background Check	
(Indicate # of checks performed 173)	2,595
Patient Background Checks 105	1,575
Licenses & Fees	47,507
Promotional Advertising	18,258
Dues & Subscriptions	0
Lancaster Allocation	62,700
Less: Public Relations Expense	(18,258)
Non-allowable advertising	(62,700)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	599
Seminar Expense	863
Lancaster Allocation	429
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,891

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting and Decorating	Feb-04	$ 2,742	3	$ 457	$	$	$	$	$	$	$	$
2	Painting and Decorating	Sep-04	1,973	3	330								
3	Painting and Decorating	May-05	3,784	3	1,261	631							
4	Painting and Decorating	Aug-05	3,735	3	1,245	623							
5	Painting and Decorating	Oct-06	4,767	3	1,589	1,589	795						
6	Painting and Decorating	Mar 07	350	3	116	118	116						
7	Painting and Decorating	Aug-07	1,200	3	200	400	400	200					
8	Painting and Decorating	Aug-08	3,850	3		642	1,283	1,283	642				
9	Painting and Decorating	Dec-08	1,829	3			610	609	610				
10	Painting and Decorating	May-09	1,550	3			259	516	516	259			
11	Painting and Decorating	Oct-09	1,359	3			226	453	453	227			
12	Painting and Decorating	Jun-10	2,704	3				451	901	901	451		
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 29,843		$ 5,198	$ 4,003	$ 3,689	$ 3,512	$ 3,122	$ 1,387	$ 451	$	$

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-201(

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **76,590** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,360**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **30,008** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.