FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0027367

Facility Name: FAIR ACRES NURSING HOME INC

Address: 514 E JACKSON (Number) DUQUOIN (City) 62832 (Zip Code)

County: PERRY

Telephone Number: (618) 542-4731 **Fax #** (618) 542-4732

HFS ID Number:

Date of Initial License for Current Owners: 10/10/1982

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY
JAMESTOWN MGMT CORP
Telephone Number: (618) 549-8331
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 01/01/2011 to 12/31/2011 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) ROGER W. BAGLEY

(Title) CONTROLLER

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 FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,466	2,248	1,356	5,070	8
9	SNF/PED					9
10	ICF	8,276	3,840		12,116	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,742	6,088	1,356	17,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.63%

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 [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 1966

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 1,356

Medicare Intermediary CGS JURSIDICTION 15

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: _____

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

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	96,886	6,535	6,628	110,049		110,049		110,049			1
2	Food Purchase		83,592		83,592	2,992	86,584	(292)	86,292			2
3	Housekeeping	51,648	6,742		58,390	1,108	59,498		59,498			3
4	Laundry	42,881	6,670		49,551		49,551		49,551			4
5	Heat and Other Utilities			61,967	61,967	488	62,455		62,455			5
6	Maintenance	30,006	17,723	34,203	81,932		81,932		81,932			6
7	Other (specify):*											7
8	TOTAL General Services	221,421	121,262	102,798	445,481	4,588	450,069	(292)	449,777			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	689,021	27,059	89,697	805,777	(2,992)	802,785		802,785			10
10a	Therapy											10a
11	Activities	22,443	1,197	1,508	25,148		25,148		25,148			11
12	Social Services	28,840		1,508	30,348		30,348		30,348			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	740,304	28,256	93,913	862,473	(2,992)	859,481		859,481			16
	C. General Administration											
17	Administrative	60,942			60,942	33,441	94,383		94,383			17
18	Directors Fees											18
19	Professional Services			142,155	142,155	(75,604)	66,551	(65,305)	1,246			19
20	Dues, Fees, Subscriptions & Promotions			8,507	8,507	167	8,674	(5,341)	3,333			20
21	Clerical & General Office Expenses	21,597	7,982	9,862	39,441	20,034	59,475	(4,210)	55,265			21
22	Employee Benefits & Payroll Taxes			177,377	177,377	8,396	185,773		185,773			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,175	4,175	225	4,400		4,400			24
25	Other Admin. Staff Transportation					2,279	2,279		2,279			25
26	Insurance-Prop.Liab.Malpractice			21,480	21,480	1,529	23,009		23,009			26
27	Other (specify):*											27
28	TOTAL General Administration	82,539	7,982	363,556	454,077	(9,533)	444,544	(74,856)	369,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,044,264	157,500	560,267	1,762,031	(7,937)	1,754,094	(75,148)	1,678,946			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 INC #0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			24,341	24,341	2,515	26,856	(396)	26,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					1,167	1,167	18,023	19,190			33
34	Rent-Facility & Grounds			54,000	54,000	4,255	58,255	(54,000)	4,255			34
35	Rent-Equipment & Vehicles			947	947		947		947			35
36	Other (specify):*											36
37	**TOTAL Ownership**			79,288	79,288	7,937	87,225	(36,373)	50,852			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,664	115,544	168,208		168,208		168,208			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52,664	156,059	208,723		208,723		208,723			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,044,264	210,164	795,614	2,050,042		2,050,042	(111,521)	1,938,521			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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(10,256)	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	(292)	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	(3,660)	21		18
19	Entertainment				19
20	Contributions	(550)	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	(4,165)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,176)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,099)		$	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)			34
35	Other- Attach Schedule	(91,422)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (91,422)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (111,521)		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.		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 INC

ID# 0027367

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(292)	0	0	0	0	0	0	0	0	0	0	(292)	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**	(292)	0	0	0	0	0	0	0	0	0	0	(292)	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	(65,305)	0	0	0	0	0	0	0	0	0	(65,305)	19
20	Fees, Subscriptions & Promotions	(5,341)	0	0	0	0	0	0	0	0	0	0	(5,341)	20
21	Clerical & General Office Expenses	(4,210)	0	0	0	0	0	0	0	0	0	0	(4,210)	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**	(9,551)	(65,305)	0	0	0	0	0	0	0	0	0	(74,856)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,843)	(65,305)	0	0	0	0	0	0	0	0	0	(75,148)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(10,256)	9,860	0	0	0	0	0	0	0	0	0	(396)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	18,023	0	0	0	0	0	0	0	0	0	18,023	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**	(10,256)	(26,117)	0	0	0	0	0	0	0	0	0	(36,373)	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)**	(20,099)	(91,422)	0	0	0	0	0	0	0	0	0	(111,521)	45

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	CANTERBURY MANOR NURSING CENTER	WATERLOO	Twin Willows	DuQuoin	Real Estate Rental
THOMAS SWAYNE BYRD REV TRUST	12.67	FAIRVIEW NURSING CENTER	DUQUOIN	Land Trust		
HUGH HUNTER BYRD REV TRUST	5.45			Jamestown MgmtCorp	Carbondale	Management
ESTHER APPLETON	3.3					
FRANKLIN HOWARD GROFF TRUST	6.61					
SYDELL T. HOLLMAN & MICHAEL S.	5.7					
HOLLMAN CO -TRUSTEES						

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	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%	18,023	18,023	3
4	V	19	JAMESTOWN MGMT FEES	141,037	JAMESTOWN MANAGEMENT CORPORATION	0.00%	75,732	(65,305)	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			$ 195,037			$ 103,615	$ * (91,422)	14

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

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 & JOAN BROUGHAM	6.61						9
10	LIVING TRUST							10
11	JOHNSON FAMILY REVOCABLE	1.425						11
12	TRUST							12
13	ROGER K. PARRISH	1.425						13
14	TERESA PARRISH BUHS	1.425						14
15	CYNTHIA L. ALLEN	1.90						15
16	SCOTT FREDERICK NOLEN	1.90						16
17	PATRICIA LEE NOLEN	1.9						17
18	LUCINDA J BAIN	8.65						18
19	COLETTA SUE MCCLARY	8.65						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
						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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: 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

	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	3	HOUSEKEEING	HOURS OF SERVICE	13,302		$ 6,874	$	2,144	$ 1,108	1
2	5	UTILITIES	HOURS OF SERVICE	13,302		3,026		2,144	488	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	7,530		207,425	207,425	1,214	33,441	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,302		795		2,144	128	4
5	20	LICENSES & DUES	HOURS OF SERVICE	13,302		1,039		2,144	167	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,772		110,779	110,779	930	17,849	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	13,302		13,556		2,144	2,185	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,302		52,094		2,144	8,396	8
9	24	SEMINARS	HOURS OF SERVICE	7,530		1,397		1,214	225	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	7,530		14,136		1,214	2,279	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,302		9,487		2,144	1,529	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,302		15,602		2,144	2,515	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,302		7,242		2,144	1,167	13
14	34	RENT	HOURS OF SERVICE	13,302		26,400		2,144	4,255	14
15										15
16										16
17										17
18		***EXCESS SALARIES OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO COST REPORT.***								18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 469,852	$ 318,204		$ 75,732	25

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 18,023	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,023	3
4. Real Estate Tax accrual used for 2011 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.		$ 18,023	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	15,667	8
	2007	14,918	9
	2008	15,746	10
	2009	16,811	11
	2010	18,023	12

Line 7 does not agree with the amoung of SCH Vline 33 because line 7 does not include the Jamestown allocation of $1167 from SCH VIII page 8. To reconcile RE tax on page 4 linee 33, add line 7 $18023 and Jamestown allocation of $1197 to total RE tax of $19190.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIR ACRES NURSING HOME INC COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0027367

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-61-0270-010	SEC 17 TWP 06 RNG 01	$ 18,023.00	$ 18,023.00
2.		S SW SW NE 07109	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,023.00	$ 18,023.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 [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? [ ] (a) Own the Equipment [X] (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 [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	74		1966	1966	$ 179,381	$	40	$	$	$ 179,381	4
5			1966	1966	175,379		20			175,379	5
6			1987	1987	263,386		40	6,585	6,585	161,332	6
7											7
8											8
	Improvement Type**										
9	FULLY DEPRECIATED			1974	15,221					15,221	9
10	FULLY DEPRECIATED			1980	5,082					5,082	10
11	BUILDING IMPROVEMENT			1971	2,768					2,768	11
12	BUILDING IMPROVEMENT			1972	1,823					1,823	12
13	BUILDING IMPROVEMENT			1973	9,170					9,170	13
14	BUILDING IMPROVEMENT			1981	1,158		10 TO 15			1,158	14
15	ROOF			1982	3,890		15			3,890	15
16	LAND IMPROVEMENT			1982	10,400		15			10,400	16
17	FIRE ALARM & SEAL PARKING LOT			1983	4,351		10 TO 15			4,351	17
18	A/C ROOFTOP, WATERLINE, STORAGE BUILDING			1984	13,711		20			13,711	18
19	SEWER REPAIR			1987	1,330		15			1,330	19
20	PARKING LOT & PLUMBING			1988	14,182	77	15 TO 25	339	262	13,677	20
21	A/C COMPRESSOR & ROOF			1989	23,834		15 TO 30	764	764	17,345	21
22	ROOF REPAIR			1990	18,354		30	612	612	13,158	22
23	WATER HEATER & A/C UNITS			1990	4,675	38	15		(38)	4,675	23
24	CABINETS & NURSES STATION			1992	6,893		15			6,893	24
25	PARKING LOT SEALED & STRIPED			1994	4,138		15			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	62	62	1,976	27
28	REPAIRS TO GASOLINE			1997	3,786	189	20	189		2,741	28
29	REPLACED CARPETING			1997	795		5			795	29
30	INSTALLED 2 PT AC AIR & HEAT UNITS			1997	2,376		15	158	158	2,292	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		2,112	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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	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		7,382	40
41	REPLACE BATHROOM FLOOR TILES ON A&B HALLS	2001	2,994	153	10	153		2,994	41
42	REPLACE FLOORTILES IN 3 BATHROOMS	2002	7,989	799	10	799		7,590	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346	1,335	10	1,335		12,682	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	268	10	268		2,278	44
45	INSTALL CABLE WIRING FOR CABLE TV	2003	1,220		5			1,220	45
46	INSTALL MIXING VALVE	2004	2,220	222	10	222		1,665	46
47	SEAL & PATCH PARKING LOT	2005	2,027	203	8	253	50	1,645	47
48	Replace hotwater storage tank & circulating pump	2005	7,100	355	20	355		2,308	48
49	INSTALL TILE & COVE BASE IN LAUNDRY	2005	1,186	119	10	119		773	49
50	REPAIR NORTH WING ROOF	2005	4,096	410	10	410		2,665	50
51	REPLACE 100 GAL HOT WATER HEATER	2005	4,900	490	10	490		3,185	51
52	Resurface counter and desk tops at nurses station and	2006	2,578	172	15	172		946	52
53	replace bumper edge								53
54	POURED SIDEWALK FOR EMER EXIT ON B WING	2007	2,000	133	15	133		599	54
55	INSTALLED HEAT EXCHANGE IN KITCHEN	2010	3,894	260	15	260		390	55
56	INSTALLED LINOLEUM FLOORING IN BATHROOMS	2010	6,046	864	7	864		1,296	56
57	REPAIR DOOR JAMBS	2011	2,598	2,598	5	260	(2,338)	260	57
58	INSTALL FIRE RATED CARPET ON WALLS	2011	6,419	6,419	5	642	(5,777)	642	58
59	PARKING LOT SEAL & STRIPE	2011	1,790	1,790	5	179	(1,611)	179	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 895,042	$ 17,766		$ 16,495	$ (1,271)	$ 743,474	70

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

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 59,631	$ 1,913	$ 7,099	$ 5,186	VARIOUS	$ 40,976	71
72	Current Year Purchases		4,662	351	(4,311)	VARIOUS	351	72
73	Fully Depreciated Assets	225,548					225,548	73
74								74
75	TOTALS	$ 285,179	$ 6,575	$ 7,450	$ 875		$ 266,875	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			$	$ 2,515	$ 2,515	$		$ 31,094	76
77										77
78										78
79										79
80	TOTALS			$	$ 2,515	$ 2,515	$		$ 31,094	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)	$ 1,199,013	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,856	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,460	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (396)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,041,443	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 FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 947 Description: STORAGE 188, DISHMACHINE 759
(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.

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

   WE ONLY HIRE TRAINED AIDES.

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 FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3 &39/2	hrs	$	691	$ 38,704	$ 157	691	$ 38,861	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		233	18,437		233	18,437	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		865	48,729	258	865	48,987	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				43,778		43,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med sup, tube feed, oxygen Other (specify): IV, LABS, XRAY	39/2 & 39/3				9,674	8,471		18,145	13
14	TOTAL			$	1,789	$ 115,544	$ 52,664	1,789	$ 168,208	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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 41,378	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	655,356		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	17,113		5
6	Prepaid Insurance	(1,935)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INCOME TAX DEPOSITS	8,585		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 720,497	$	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	176,806		15
16	Equipment, at Historical Cost	249,763		16
17	Accumulated Depreciation (book methods)	(392,407)		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)**	$ 34,162	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 754,659	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,467	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,710		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,233		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	9,045		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 91,455	$	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)**	$ 91,455	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 663,204	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 754,659	$	48

***(See instructions.)**

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 694,813	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 694,813	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,175)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) RECORD 2010 INCOME TAXES	(6,434)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (31,609)	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)**	$ 663,204	24 *

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

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 1,711,629	1
2	Discounts and Allowances for all Levels	82,496	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,794,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	212,906	6
7	Oxygen	466	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 213,372	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	11,972	19
20	Radiology and X-Ray	1,337	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,309	23
	D. Non-Operating Revenue		
24	Contributions	250	24
25	Interest and Other Investment Income***	3,811	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,061	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,024,867	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	445,481	31
32	Health Care	862,473	32
33	General Administration	454,077	33
	B. Capital Expense		
34	Ownership	79,288	34
	C. Ancillary Expense		
35	Special Cost Centers	168,208	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,050,042	40
41	**Income before Income Taxes (line 30 minus line 40)****	(25,175)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (25,175)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. State taxes are deduc on Federal tax retur**

*** **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 INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,760	2,080	$ 53,725	$ 25.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,812	4,109	94,323	22.96	3
4	Licensed Practical Nurses	12,746	13,812	214,860	15.56	4
5	CNAs & Orderlies	28,661	31,114	301,199	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,889	2,037	22,443	11.02	9
10	Activity Assistants					10
11	Social Service Workers	1,825	1,994	28,840	14.46	11
12	Dietician					12
13	Food Service Supervisor	1,821	1,980	21,454	10.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,921	8,507	75,432	8.87	15
16	Dishwashers					16
17	Maintenance Workers	1,769	1,919	30,006	15.64	17
18	Housekeepers	5,329	5,725	51,648	9.02	18
19	Laundry	3,866	4,040	42,881	10.61	19
20	Administrator	1,952	2,080	60,942	29.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,278	1,502	21,597	14.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	1,758	2,006	24,914	12.42	33
34	TOTAL (lines 1 - 33)	76,387	82,905	$ 1,044,264 *	$ 12.60	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	121	$ 6,628	L1/C3	35
36	Medical Director		1,200	L9/C3	36
37	Medical Records Consultant		300	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,695	L10/C3	39
40	Physical Therapy Consultant	9	477	L10/C3	40
41	Occupational Therapy Consultant	9	428	L10/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,508	L11/C3	44
45	Social Service Consultant	21	1,508	L12/C3	45
46	Other(specify) UR REVIEW		1,200	L10/C3	46
47	BILLING CONSULTANT		323	L19/C3	47
48					48
49	TOTAL (lines 35 - 48)	181	$ 15,267		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	365	11,096	L10/C3	51
52	Certified Nurse Assistants/Aides	3,565	74,501	L10/C3	52
53	TOTAL (lines 50 - 52)	3,930	$ 85,597		53

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDEE SLOVER	ADMINISTRATOR	0	$ 60,942
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,942

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 141,037
BARNETT & LEVINE	ACCOUNTING	795
INNOVATIVE LTC SOLUTONS	BILLING CONSULTANT	323
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 142,155

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,515
Unemployment Compensation Insurance	8,258
FICA Taxes	79,886
Employee Health Insurance	6,068
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	96
VACCINES	619
401K EXPENSE	12,309
AWARDS, INCENTIVES, ECT.	4,626
JAMESTOWN ALLOCATION	8,396
TOTAL (agree to Schedule V, line 22, col.8)	$ 185,773

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 996
Advertising: Employee Recruitment	572
Health Care Worker Background Check	276
(Indicate # of checks performed 23)	
Patient Background Checks 31	372
JAMESTOWN ALLOCATION	167
INHAA (100) LTCNA DUES (50)	150
CORP FEES (623) SUBSCRIP (177)	800
OTHER ADV	5,341
Less: Public Relations Expense	(4,165)
Non-allowable advertising	( )
Yellow page advertising	(1,176)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,333

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	724
Seminar Expense	3,451
JAMESTOWN ALLOCATION	225
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,400

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2004	$ 6,156	3	$ 1,026	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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17													
18													
19													
20	TOTALS		$ 6,156		$ 1,026	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIR ACRES NURSING HOME INC # 0027367 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(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 fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,515**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. N/A
b. Do you have a separate contract with the Department to provide medical transportation fo 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 othe 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 INC #0027367
RECLASSIFICATION ON DPA COST REPORT
PAGES 3 & 4

12/31/2011

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
	FOOD PURCHASES	2992	
10	NURSING & MEDICAL RECORDS		2992
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	75732	
19	PROFESSIONAL SERVICES		75732
	SSEE SCH VIII FOR BREAKDOWN		