FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0027367

Facility Name: FAIR ACRES NURSING HOME

Address: 514 EAST 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 BAGLEY
JAMESTOWN MANAGEMENT
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 01/01/2012 to 01/31/2012 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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	10,614	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	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	1,789	1,733	1,890	5,412	8
9	SNF/PED					9
10	ICF	9,356	3,022		12,378	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,145	4,755	1,890	17,790	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.68%

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 1,890

Medicare Intermediary CGS JURISDICTION 15

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: _____

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	97,951	5,258	5,792	109,001		109,001		109,001			1
2	Food Purchase		84,004		84,004	3,868	87,872	(254)	87,618			2
3	Housekeeping	46,988	6,804		53,792	1,296	55,088		55,088			3
4	Laundry	43,829	4,375		48,204		48,204		48,204			4
5	Heat and Other Utilities			58,263	58,263	595	58,858		58,858			5
6	Maintenance	32,763	18,930	47,827	99,520		99,520		99,520			6
7	Other (specify):*											7
8	TOTAL General Services	221,531	119,371	111,882	452,784	5,759	458,543	(254)	458,289			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	673,317	27,455	82,593	783,365	(3,868)	779,497		779,497			10
10a	Therapy											10a
11	Activities	20,786	2,085	1,552	24,423		24,423		24,423			11
12	Social Services	30,032		1,552	31,584		31,584		31,584			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	724,135	29,540	86,897	840,572	(3,868)	836,704		836,704			16
	C. General Administration											
17	Administrative	62,585			62,585	31,468	94,053		94,053			17
18	Directors Fees											18
19	Professional Services			161,296	161,296	(78,667)	82,629	(81,325)	1,304			19
20	Dues, Fees, Subscriptions & Promotions			13,366	13,366	161	13,527	(7,558)	5,969			20
21	Clerical & General Office Expenses	20,068	9,565	6,504	36,137	22,042	58,179	(1,482)	56,697			21
22	Employee Benefits & Payroll Taxes			151,876	151,876	9,348	161,224		161,224			22
23	Inservice Training & Education			276	276		276		276			23
24	Travel and Seminar			3,897	3,897	204	4,101		4,101			24
25	Other Admin. Staff Transportation					1,923	1,923		1,923			25
26	Insurance-Prop.Liab.Malpractice			36,509	36,509	1,910	38,419		38,419			26
27	Other (specify):*											27
28	TOTAL General Administration	82,653	9,565	373,724	465,942	(11,611)	454,331	(90,365)	363,966			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,028,319	158,476	572,503	1,759,298	(9,720)	1,749,578	(90,619)	1,658,959			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIR ACRES NURSING HOME #0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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			55,067	55,067	3,564	58,631	(30,678)	27,953			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					1,354	1,354	18,725	20,079			33
34	Rent-Facility & Grounds			54,000	54,000	4,802	58,802	(54,000)	4,802			34
35	Rent-Equipment & Vehicles			4,825	4,825		4,825		4,825			35
36	Other (specify):*											36
37	TOTAL Ownership			113,892	113,892	9,720	123,612	(65,953)	57,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,214	153,023	212,237		212,237		212,237			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,544	136,544		136,544		136,544			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,214	289,567	348,781		348,781		348,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,028,319	217,690	975,962	2,221,971		2,221,971	(156,572)	2,065,399			45

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	(40,538)	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	(254)	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	(782)	21		18
19	Entertainment				19
20	Contributions	(700)	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	(6,304)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,254)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,832)		$	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			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (106,740)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (156,572)		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

ID# 0027367

Report Period Beginning: 01/01/2012

Ending: 01/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/2012 **Ending:** 01/31/2012

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	(254)	0	0	0	0	0	0	0	0	0	0	(254)	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**	(254)	0	0	0	0	0	0	0	0	0	0	(254)	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	(81,325)	0	0	0	0	0	0	0	0	0	(81,325)	19
20	Fees, Subscriptions & Promotions	(7,558)	0	0	0	0	0	0	0	0	0	0	(7,558)	20
21	Clerical & General Office Expenses	(1,482)	0	0	0	0	0	0	0	0	0	0	(1,482)	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**	(9,040)	(81,325)	0	0	0	0	0	0	0	0	0	(90,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,294)	(81,325)	0	0	0	0	0	0	0	0	0	(90,619)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/2012 **Ending:** 01/31/2012

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	(40,538)	9,860	0	0	0	0	0	0	0	0	0	(30,678)	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	18,725	0	0	0	0	0	0	0	0	0	18,725	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	(40,538)	(25,415)	0	0	0	0	0	0	0	0	0	(65,953)	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)	(49,832)	(106,740)	0	0	0	0	0	0	0	0	0	(156,572)	45

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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 Manageme	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%	18,725	18,725	3
4	V	19	JAMESTOWN MGMT FEES	160,213	JAMESTOWN MANAGEMENT CORPORATION	0.00%	78,888	(81,325)	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			$ 214,213			$ 107,473	$ * (106,740)	14

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	1.9						15
16	SCOTT FREDERICK NOLEN	1.9						16
17	PATRICIAL 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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT***								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 1/31/2012

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	HOUSEKEEPING	HOURS OF SERVICE	13,531		$ 7,128	$	2,461	$ 1,296	1
2	5	UTILITIES	HOURS OF SERVICE	13,531		3,269		2,461	595	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,320		173,045	173,045	1,513	31,468	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,531		1,213		2,461	221	4
5	20	LICENSES & DUES	HOURS OF SERVICE	13,531		883		2,461	161	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,211		106,884	106,884	948	19,445	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	13,531		14,280		2,461	2,597	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,531		51,397		2,461	9,348	8
9	24	SEMINARS	HOURS OF SERVICE	8,320		1,124		1,513	204	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320		10,575		1,513	1,923	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,531		10,501		2,461	1,910	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,531		19,596		2,461	3,564	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,531		7,447		2,461	1,354	13
14	34	RENT	HOURS OF SERVICE	13,531		26,400		2,461	4,802	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					$ 433,742	$ 279,929		$ 78,888	25

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)		$ 18,725	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,725	3
4. Real Estate Tax accrual used for 2012 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.		$ 18,725	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	14,918	8
	2008	15,746	9
	2009	16,811	10
	2010	18,023	11
	2011	18,725	12

Line 7 does not agree with the amount of SCH V line 33 because line 7 does not include the Jamestown allocation of $1354 from SCH VIII page 8. To reconcile RE tax on page 4 line 33, add line 7 $18725 and Jamestown allocation of $1354 to total RE tax of $20079.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIR ACRES NURSING HOME COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0027367

CONTACT PERSON REGARDING THIS REPORT 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 2011 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 2011.

	(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	$ 18,725.00	$ 18,725.00
2.		S SW SW NE 07109	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,725.00	$ 18,725.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	167,917	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	31	20		(31)	13,711	18
19	SEWER REPAIR			1987	1,330	40	15		(40)	1,330	19
20	PARKING LOT & PLUMBING			1988	14,182	77	15 TO 20	339	262	14,016	20
21	A/C COMPRESSOR & ROOF			1989	23,834		15 TO 30	764	764	18,109	21
22	ROOF REPAIR			1990	18,354		30	612	612	13,770	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	108	10		(108)	2,638	26
27	WALL A/C UNITS INSTALLED			1996	1,976		15			1,976	27
28	REPAIRS TO GASOLINE			1997	3,786	189	20	189		2,930	28
29	REPLACED CARPETING			1997	795		5			795	29
30	INSTALLED 2 PT AC AIR & HEAT UNITS			1997	2,376		15	84	84	2,376	30
31	WATER HEATER & INSTALLATION			1998	780		10			780	31
32	ENTRANCE SIGN			1999	1,002		5			1,002	32
33	GAZEBO WITH RAMP & RAILING			1999	3,377	169	20	169		2,281	33
34	LANDSCAPING			1999	978		5			978	34
35	Repairs to damaged asphalt, seal & stripe parking lot			1999	2,101		10			2,101	35
36	INSTALL TILE FLOORING			2000	22,927		10			22,927	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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		8,085	40
41	REPLACE BATHROOM FLOOR TILES ON A & B HALLS	2001	2,994		10			2,994	41
42	REPLACE FLOORTILES IN 3 BATHROOMS	2002	7,989	399	10	399		7,989	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346	664	10	664		13,346	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	268	10	268		2,546	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		1,887	46
47	SEAL & PATCH PARKING LOT	2005	2,027	203	8	253	50	1,898	47
48	Replace hotwater storage tank & circulating pump	2005	7,100	355	20	355		2,663	48
49	INSTALL TILE & COVE BASE IN LAUNDRY	2005	1,186	119	10	119		892	49
50	REPAIR NORTH WING ROOF	2005	4,096	410	10	410		3,075	50
51	REPLACE 100 GAL HOT WATER HEATER	2005	4,900	490	10	490		3,675	51
52	Resurface counter and desk tops at nurses station and	2006	2,578	172	15	172		1,118	52
53	replace bumper edge								53
54	POURED SIDEWAL FOR EMER EXIT ON B WING	2007	2,000	133	15	133		732	54
55	INSTALLED HEAT EXCHNAGE IN KITCHEN	2010	3,894	260	15	260		650	55
56	INSTALLED LINOLEUM FLOORING IN BATHROOMS	2010	6,046	863	7	864	1	2,160	56
57	REPAIR DOOR JAMBS	2011	2,598		5	520	520	780	57
58	INSTALL FIRE RATED CARPET ON WALLS	2011	6,419		5	1,284	1,284	1,926	58
59	PARKING LOT SEAL & STRIPE	2011	1,790		5	358	358	537	59
60	INSTALL SPRINKLER SYSTEM	2012	61,100	32,078	25	1,222	(30,856)	1,222	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)		$ 956,142	$ 37,991		$ 17,438	$ (20,553)	$ 760,912	70

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	$ 51,036	$ 1,917	$ 6,110	$ 4,193	VARIOUS	$ 34,180	71
72	Current Year Purchases	15,159	15,159	841	(14,318)	VARIOUS	841	72
73	Fully Depreciated Assets	238,805					238,805	73
74								74
75	TOTALS	$ 305,000	$ 17,076	$ 6,951	$ (10,125)		$ 273,826	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			$	$ 3,564	$ 3,564	$		$ 34,658	76
77										77
78										78
79										79
80	TOTALS			$	$ 3,564	$ 3,564	$		$ 34,658	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)	$ 1,279,934	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,631	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,953	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30,678)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,069,396	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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 4,825 Description: STORAGE 187, DISHMACHINE 788, ICE MACHINE 25, WOUND VAC 3825
    (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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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 # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	$	981	$ 53,682	$	981	$ 53,682	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		124	9,783	21	124	9,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		1,289	77,842	223	1,289	78,065	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				46,743		46,743	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	med supp, tube feed, oxygen Other (specify): IV, LABS, XRAY	39/2 & 39/3				11,716	12,227		23,943	13
14	TOTAL			$	2,394	$ 153,023	$ 59,214	2,394	$ 212,237	14

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/2012 (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	$ 34,389	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	981,081		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	17,213		5
6	Prepaid Insurance	17		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,032,700	$	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	237,904		15
16	Equipment, at Historical Cost	264,924		16
17	Accumulated Depreciation (book methods)	(447,474)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 55,354	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,088,054	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 55,487	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	283,000		29
30	Accrued Salaries Payable	28,846		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,512		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	10,214		36
37	ACC LIC BED TAX	48,833		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 438,892	$	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)**	$ 438,892	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 649,162	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,088,054	$	48

***(See instructions.)**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 663,204	1
2	Restatements (describe):		2
3	ADJUST 2011 FOR DPA RATE INC 5/11	32,006	3
4	ADJUST 2011 FOR NEW OCCUPIED BED TAX 7/11	(47,220)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 647,990	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,172	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,172	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)**	$ 649,162	24 *

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,847,754	1
2	Discounts and Allowances for all Levels	57,412	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,905,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	296,245	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 296,245	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	19,045	19
20	Radiology and X-Ray	1,826	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,871	23
	D. Non-Operating Revenue		
24	Contributions	456	24
25	Interest and Other Investment Income***	405	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 861	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)**	$ 2,223,143	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	452,784	31
32	Health Care	840,572	32
33	General Administration	465,942	33
	B. Capital Expense		
34	Ownership	113,892	34
	C. Ancillary Expense		
35	Special Cost Centers	212,237	35
36	Provider Participation Fee	136,544	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,221,971	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,172	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,172	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,003,479	44
45	Private Pay - Net Inpatient Revenue	565,108	45
46	Medicare - Net Inpatient Revenue	339,137	46
47	Other-(specify) VENDING INC & PRIOR YEAR ADJ	(3,587)	47
48	Other-(specify) OXIMETER INCOME	1,029	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,905,166	49

* **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.**

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

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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	1,728	1,776	$ 42,807	$ 24.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,133	4,505	104,097	23.11	3
4	Licensed Practical Nurses	12,199	13,172	210,043	15.95	4
5	CNAs & Orderlies	26,246	27,943	289,310	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,786	1,898	20,786	10.95	9
10	Activity Assistants					10
11	Social Service Workers	1,859	2,024	30,032	14.84	11
12	Dietician					12
13	Food Service Supervisor	1,781	1,989	22,165	11.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,686	8,290	75,786	9.14	15
16	Dishwashers					16
17	Maintenance Workers	1,836	1,979	32,763	16.56	17
18	Housekeepers	4,712	5,132	46,988	9.16	18
19	Laundry	3,697	3,932	43,829	11.15	19
20	Administrator	1,840	2,080	62,585	30.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,239	1,370	20,068	14.65	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	1,918	2,083	27,060	12.99	33
34	TOTAL (lines 1 - 33)	72,660	78,173	$ 1,028,319 *	$ 13.15	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	103	$ 5,792	L1/C3	35
36	Medical Director		1,200	L9/C3	36
37	Medical Records Consultant		200	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,596	L10/C3	39
40	Physical Therapy Consultant	4	176	L10/C3	40
41	Occupational Therapy Consultant	9	410	L10/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,552	L11/C3	44
45	Social Service Consultant	21	1,552	L12/C3	45
46	Other(specify) UR REVIEW		1,200	L10/C3	46
47	BILLING CONSULTANT		233	L19/C3	47
48					48
49	TOTAL (lines 35 - 48)	158	$ 13,911		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 751	L10/C3	50
51	Licensed Practical Nurses	387	12,790	L10/C3	51
52	Certified Nurse Assistants/Aides	3,218	65,470	L10/C3	52
53	TOTAL (lines 50 - 52)	3,621	$ 79,011		53

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDEE SLOVER	ADMINISTRATOR	0	$ 62,585
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,585

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	$ 160,213
BARNETT & LEVINE	ACCOUNTING	850
INNOVATIVE SOLUTIONS	BILLING CONSULTANT	233
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 161,296

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,101
Unemployment Compensation Insurance	4,024
FICA Taxes	78,666
Employee Health Insurance	6,853
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	96
VACCINES	602
401K EXPENSE	12,854
AWARDS, INCENTIVES, ECT	3,680
JAMESTOWN ALLOCATION	9,348
TOTAL (agree to Schedule V, line 22, col.8)	$ 161,224

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,820
Advertising: Employee Recruitment	497
Health Care Worker Background Check	167
(Indicate # of checks performed 11)	
Patient Background Checks 46	552
JAMESTOWN ALLOCATION	161
INHAA(100) FOOD SERV CERT (70)	170
CORP FEES (631) SUBS(158)CLIA (150)	939
OTHER ADV(7558) MED REVALID(523)	8,081
STATE FIRE MARSHALL CERTIF	140
Less: Public Relations Expense	(6,304)
Non-allowable advertising	( )
Yellow page advertising	(1,254)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	824
Seminar Expense	3,073
JAMESTOWN ALLOCATION	204
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,101

**See instructions.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/2012 Ending: 01/31/2012

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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15													
16													
17													
18													
19													
20	TOTALS		$ 6,156		$ 1,026	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIR ACRES NURSING HOME **#** 0027367 **Report Period Beginning:** 01/01/2012 **Ending:** 01/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

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

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **9 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **136,544**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

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

FAIR ACRES NURSING HOME
SCHEDULE OF RECLASSIFICATION FOR PAGES 3&4 COL 5
12/31/2012

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	3868	
10	MEDICAL SUPPLIES		3868
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	78888	
19	PROFESSIONAL SERVICES		78888
	RECLASSIFY SCHEDULE VIII FOR BREAKDOWN		