		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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 Facility 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

IDPA ID Number: 371119686001

Date of Initial License for Current Owners: 10/10/82

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 **Telephone Number:** (618) 549-8331
JAMESTOWN MGMT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 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: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
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: 01/01/03 Ending: 12/31/03

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: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		2,601	738	3,339	8
9	SNF/PED					9
10	ICF	15,081	4,800		19,881	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,081	7,401	738	23,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.97%

D. How many bed-hold days during this year were paid by Public Aid?
1 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 738

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/02 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: 01/01/03 Ending: 12/31/03

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	105,313	5,395	6,233	116,941		116,941		116,941			1
2	Food Purchase		77,558		77,558	2,608	80,166	(253)	79,913			2
3	Housekeeping	54,240	5,635		59,875	791	60,666		60,666			3
4	Laundry	38,129	5,860		43,989		43,989		43,989			4
5	Heat and Other Utilities			59,503	59,503	332	59,835		59,835			5
6	Maintenance	25,565	8,559	32,290	66,414		66,414	(7,187)	59,227			6
7	Other (specify):*											7
8	**TOTAL General Services**	223,247	103,007	98,026	424,280	3,731	428,011	(7,440)	420,571			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	661,715	22,972	94,825	779,512	(4,539)	774,973		774,973			10
10a	Therapy	17,187		4,720	21,907		21,907		21,907			10a
11	Activities	30,022	2,108	2,160	34,290		34,290		34,290			11
12	Social Services	23,135		2,160	25,295		25,295		25,295			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	732,059	25,080	104,765	861,904	(4,539)	857,365		857,365			16
	C. General Administration											
17	Administrative	50,218			50,218	46,722	96,940		96,940			17
18	Directors Fees											18
19	Professional Services			142,109	142,109	(81,704)	60,405	(53,010)	7,395			19
20	Dues, Fees, Subscriptions & Promotions			9,577	9,577	184	9,761	(2,368)	7,393			20
21	Clerical & General Office Expenses	23,719	6,154	5,606	35,479	16,313	51,792	(486)	51,306			21
22	Employee Benefits & Payroll Taxes			156,259	156,259	10,440	166,699		166,699			22
23	Inservice Training & Education			257	257		257		257			23
24	Travel and Seminar			3,085	3,085	210	3,295		3,295			24
25	Other Admin. Staff Transportation					1,262	1,262		1,262			25
26	Insurance-Prop.Liab.Malpractice			37,152	37,152	1,185	38,337		38,337			26
27	Other (specify):*											27
28	**TOTAL General Administration**	73,937	6,154	354,045	434,136	(5,388)	428,748	(55,864)	372,884			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,029,243	134,241	556,836	1,720,320	(6,196)	1,714,124	(63,304)	1,650,820			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: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,070	11,070	2,127	13,197	23,465	36,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					482	482	14,601	15,083			33
34	Rent-Facility & Grounds			138,000	138,000	3,587	141,587	(138,000)	3,587			34
35	Rent-Equipment & Vehicles			171	171		171		171			35
36	Other (specify):*											36
37	**TOTAL Ownership**			149,241	149,241	6,196	155,437	(99,934)	55,503			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,800	42,349	80,149		80,149		80,149			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**		37,800	82,864	120,664		120,664		120,664			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,029,243	172,041	788,941	1,990,225		1,990,225	(163,238)	1,826,987			45

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

STATE OF ILLINOIS

FAIR ACRES NURSING HOME

ID# 0027367

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 SCH VI	$		1
2	ELIMINATE ONE YEAR OF TWO YEAR	(200)	20	2
3	IDPH LICENSE			3
4				4
5				5
6	DEFERRED PAINTING SCH XIX	(7,187)	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**	(7,387)		49

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 OHF 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	13,419	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	(253)	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	(161)	21		18
19	Entertainment				19
20	Contributions	(325)	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	(1,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(518)	20		28
29	Other-Attach Schedule	(7,387)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,125		$	30

OHF 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)	(166,363)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (166,363)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (163,238)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(253)	0	0	0	0	0	0	0	0	0	0	(253)	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	(7,187)	0	0	0	0	0	0	0	0	0	0	(7,187)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,440)	0	0	0	0	0	0	0	0	0	0	(7,440)	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	Nurse Aide 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	(53,010)	0	0	0	0	0	0	0	0	0	(53,010)	19
20	Fees, Subscriptions & Promotions	(2,368)	0	0	0	0	0	0	0	0	0	0	(2,368)	20
21	Clerical & General Office Expenses	(486)	0	0	0	0	0	0	0	0	0	0	(486)	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**	(2,854)	(53,010)	0	0	0	0	0	0	0	0	0	(55,864)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,294)	(53,010)	0	0	0	0	0	0	0	0	0	(63,304)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

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	13,419	10,046	0	0	0	0	0	0	0	0	0	23,465	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	14,601	0	0	0	0	0	0	0	0	0	14,601	33
34	Rent-Facility & Grounds	0	(138,000)	0	0	0	0	0	0	0	0	0	(138,000)	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**	13,419	(113,353)	0	0	0	0	0	0	0	0	0	(99,934)	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)**	3,125	(166,363)	0	0	0	0	0	0	0	0	0	(163,238)	45

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SENIOR MANOR NURSING CENTER	SPARTA	Twin Willows	DuQuoin	Real estate rental
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Land Trust		
		FAIRVIEW NURSING CENTER	DUQUOIN	Jamestown	Carbondale	Management
				Mgmt Corp		

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	$ 138,000	TWIN WILLOWS LAND TRUST	100.00%	$	$ (138,000)	1
2	V	30	DEPRECIATION		TWIN WILLOWS LAND TRUST	100.00%	10,046	10,046	2
3	V	33	REAL ESTATE TAXES		TWIN WILLOWS LAND TRUST	100.00%	14,601	14,601	3
4	V	19	JAMESTOWN MGMT FEE	134,938	JAMESTOWN MANAGEMENT CORP	0.00%	81,928	(53,010)	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			$ 272,938			$ 106,575	$ * (166,363)	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: 01/01/03 Ending: 12/31/03

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 CORP
Street Address: 1001 E MAIN BLDG 4A
City / State / Zip Code: CARBONDALE, IL 62901
Phone Number: ((618) 549-8331
Fax Number: ((618) 549-0133

	1 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	18,158		$ 5,822	$	2,467	$ 791	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,445		2,467	332	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	11,484		343,946	343,946	1,560	46,722	3
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	18,158		1,652		2,467	224	4
5	20	LICENSES AND DUES	HOURS OF SERVICE	18,158		1,355		2,467	184	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	6,674		110,867	110,867	907	15,067	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	18,158		9,170		2,467	1,246	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	18,158		62,630		2,467	8,509	8
9	24	SEMINARS	HOURS OF SERVICE	11,484		1,546		1,560	210	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	11,484		9,288		1,560	1,262	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		8,724		2,467	1,185	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		15,654		2,467	2,127	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		3,545		2,467	482	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		2,467	3,587	14
15										15
16										16
17										17
18		*** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO THE COST REPORT.								18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 603,044	$ 454,813		$ 81,928	25

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 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.)	$ 14,601	2
3. Under or (over) accrual (line 2 minus line 1).	$ 14,601	3
4. Real Estate Tax accrual used for 2003 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.	$ 14,601	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	13,989	8
1999	14,204	9
2000	14,331	10
2001	14,258	11
2002	14,601	12

Line 7 does not agree with the amount of SCH V line 33 because line 7 does not include the Jamestown allocation of $482 from SCH VIII page 8. To reconcile R.E. tax on pg 4 line 33, add line 7 $14601 + Jamestown allocation of $482 = total R.E. tax of $15083.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 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 2002 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 2002.

	(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 s sw sw ne	$ 14,601.00	$ 14,601.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 14,601.00	$ 14,601.00

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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

not 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: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	$ 4,485	$ 4,485	$ 168,187	4
5			1966	1966	175,379		20			175,379	5
6			1987	1987	263,386		40	6,585	6,585	108,652	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	386	386	13,517	18
19	SEWER REPAIR			1987	1,330		15			1,330	19
20	PARKING LOT & PLUMBING			1988	14,182	77	15 TO 25	525	448	10,965	20
21	A/C COMPRESSOR & ROOF			1989	23,834	61	15 TO 30	825	764	11,199	21
22	ROOF REPAIR			1990	18,354		30	612	612	8,262	22
23	WATER HEATER & A/C UNITS			1990	4,675	38	15	312	274	4,211	23
24	CABINETS & NURSES STATION			1992	6,893	460	15	460		5,290	24
25	PARKING LOT SEALED AND STRIPED			1994	4,138	414	15	276	(138)	2,622	25
26	HEAT EXCHANGE OF ROOF TOP UNITS INSTALLED			1995	2,638	264	10	264		2,244	26
27	WALL A/C UNITS INSTALLEDD			1996	1,976		15	132	132	990	27
28	REPAIRS TO GASLINE			1997	3,786	189	20	189		1,229	28
29	REPLACED CARPETING			1997	795		5			795	29
30	INSTALLED 2 PT AC AIR & HEAT UNITS			1997	2,376		15	158	158	1,028	30
31	WATER HEATER & INSTALLATION			1998	780		10	78	78	429	31
32	ENTRANCE SIGN			1999	1,002	200	5	200		900	32
33	GAZEBO WITH RAMP & RAILING			1999	3,377	169	20	169		760	33
34	LANDSCAPING			1999	978	196	5	196		882	34
35	Repairs to damaged asphalt, seal/stripe parking lot			1999	2,101	210	10	210		945	35
36	INSTALL TILE FLOORING			2000	22,927	2,293	10	2,293		8,025	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: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL SHOWER FAUCET REPLACEMENTS	2000	$ 1,731	$ 173	10	$ 173	$	$ 606	37
38	INSTALL CARPET ON WALLS	2000	4,898	980	10	980		3,430	38
39	WATER GARDEN	2000	922	92	5	92		322	39
40	Remove & replace damaged asphalt & fill cracks in parking lot	2001	10,546	703	15	703		1,758	40
41	REPLACE BATHROOM FLOOR TILES ON A & B HALLS	2001	2,994	299	10	299		748	41
42	REPLACE FLLOR TILE IN 3 BATHROOMS	2002	7,989	799	10	799		1,198	42
43	INSTALL NEW GREASE TRAP AND WET WELL	2002	13,346	1,335	10	1,335		2,002	43
44	REPAIR WEST SIDE OF SOUTHWING ROOF	2003	2,680	134	10	134		134	44
45	INSTALL CABLE WIRING FOR TV CABLE	2003	1,220	122	5	122		122	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									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)		$ 848,188	$ 9,208		$ 22,992	$ 13,784	$ 592,024	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: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 114,733	$ 1,545	$ 11,400	$ 9,855	VARIOUS	$ 72,015	71
72	Current Year Purchases	2,217	317	143	(174)	VARIOUS	143	72
73	Fully Depreciated Assets	113,412				VARIOUS	113,412	73
74								74
75	TOTALS	$ 230,362	$ 1,862	$ 11,543	$ 9,681		$ 185,570	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			$	$ 2,127	$ 2,127	$		$ 15,952	76
77										77
78										78
79										79
80	TOTALS			$	$ 2,127	$ 2,127	$		$ 15,952	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)	$ 1,097,342	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,197	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,662	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,465	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 793,546	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	MINE SUBSIDENCE REPAIR	$ 675	92
93			93
94			94
95		$ 675	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: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

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 Date of Lease	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.	/2004	$
13.	/2005	$
14.	/2006	$

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: $ 171 Description: STORAGE 171
(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: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED AIDES 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 AIDE ____

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

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	Nurse Aide 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 aides from other facilities.

$

D. NUMBER OF AIDES 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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	$	143	$ 9,248	$ 222	143	$ 9,470	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		145	10,628		145	10,628	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		312	19,780		312	19,780	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				25,105		25,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	medical supplies, tube feeding, oxygen Other (specify): IV, and labs	39/2 &39/3				2,693	12,473		15,166	13
14	TOTAL			$	600	$ 42,349	$ 37,800	600	$ 80,149	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 nurse aides, 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: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (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	$ 62,121	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	196,765		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	172,566		5
6	Prepaid Insurance	388		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INCOME TAX DEPOSIT	4,195		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 436,035	$	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	122,386		15
16	Equipment, at Historical Cost	197,851		16
17	Accumulated Depreciation (book methods)	(254,632)		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): Construction in progress	675		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 66,280	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 502,315	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,591	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,888		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,701		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	12,015		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 91,195	$	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)**	$ 91,195	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 411,120	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 502,315	$	48

***(See instructions.)**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 506,298	1
2	Restatements (describe):		2
3	REFUND OF FEDERAL INCOME TAX	9,537	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 515,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(104,715)	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)**	$ (104,715)	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)**	$ 411,120	24 *

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

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	$ 1,778,685	1
2	Discounts and Allowances for all Levels	(2,923)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,775,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	103,795	6
7	Oxygen	3,876	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 107,671	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	1,190	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,190	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	888	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 888	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,885,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	424,281	31
32	Health Care	861,904	32
33	General Administration	434,136	33
	B. Capital Expense		
34	Ownership	149,241	34
	C. Ancillary Expense		
35	Special Cost Centers	80,149	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)***	$ 1,990,226	40
41	**Income before Income Taxes (line 30 minus line 40)****	(104,715)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (104,715)	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 deducted on fed retu**

*** **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: 01/01/03 Ending: 12/31/03

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	872	1,008	$ 30,222	$ 29.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,184	6,662	90,505	13.59	3
4	Licensed Practical Nurses	10,216	11,200	162,542	14.51	4
5	Nurse Aides & Orderlies	32,846	36,004	362,446	10.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,684	1,812	17,187	9.49	8
9	Activity Director	2,695	2,965	30,022	10.13	9
10	Activity Assistants					10
11	Social Service Workers	1,717	1,903	23,135	12.16	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,260	26,274	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,212	9,826	79,039	8.04	15
16	Dishwashers					16
17	Maintenance Workers	1,846	1,974	25,565	12.95	17
18	Housekeepers	5,551	5,882	54,240	9.22	18
19	Laundry	3,813	3,998	38,129	9.54	19
20	Administrator	1,856	2,080	50,218	24.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,754	1,972	23,719	12.03	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	1,528	1,592	16,000	10.05	33
34	TOTAL (lines 1 - 33)	83,798	91,138	$ 1,029,243 *	$ 11.29	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	120	$ 6,233	L1/C3	35
36	Medical Director		900	L9/C3	36
37	Medical Records Consultant		400	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	L10/C3	39
40	Physical Therapy Consultant	70	4,159	L10A/C3	40
41	Occupational Therapy Consultant	1	59	L10A/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	502	L10A/C3	43
44	Activity Consultant	42	2,160	L11/C3	44
45	Social Service Consultant	42	2,160	L12/C3	45
46	Other(specify) UR REVIEW		900	L10/C3	46
47	PURCHASING CONSULTANT		582	L19/3	47
48					48
49	TOTAL (lines 35 - 48)	283	$ 18,475		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				51
52	Nurse Aides	5,338	93,105	L10/3	52
53	TOTAL (lines 50 - 52)	5,338	$ 93,105		53

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDEE SLOVER	ADMINISTRATOR	0	$ 50,218
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 50,218

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
M.E.S.	PURCHASING CONS	$ 582
ADP	PAYROLL	573
BARNETT & LEVINE	ACCOUNTING	2,045
JAMESTOWN MGMT CORP	MANAGEMENT	134,938
BENEFIT PLANNING CONS	401k SERVICES	1,991
MIKRON	COMPUTER CONS	1,980
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 142,109

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,753
Unemployment Compensation Insurance	3,703
FICA Taxes	78,737
Employee Health Insurance	11,270
Employee Meals	1,931
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	175
VACCINES	276
401k MATCHING FUNDS	13,057
AWARDS, INCENTIVES, PRIZES, ETC	6,288
JAMESTOWN ALLOCATION	8,509
TOTAL (agree to Schedule V, line 22, col.8)	$ 166,699

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	$ 400
Advertising: Employee Recruitment	4,228
Health Care Worker Background Check	120
(Indicate # of checks performed 10)	
NAGNA (2093); IAPA (30)	2,123
CORP FEES	390
NOTARY DUES 70; SUBSCRIPT 78	148
ELIM ONE YEAR OF IDPH LICENSE	(200)
JAMESTOWN ALLOCATION	184
OTHER ADVERT	2,168
Less: Public Relations Expense	( )
Non-allowable advertising	(1,650)
Yellow page advertising	(518)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,393

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	578
Seminar Expense	2,507
JAMESTOWN ALLOCATION	210
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,295

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/03 Ending: 12/31/03

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								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING	2003	$ 8,624	3	$	$	$	$ 1,437	$ 2,875	$ 2,875	$ 1,437	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,624		$	$	$	$ 1,437	$ 2,875	$ 2,875	$ 1,437	$	$

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7.5 years**

(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 of Public Aid 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 to the Department of Public Aid, 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. $ **1,931** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

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

(19) If total legal fees are in excess of $2500, 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 COLUMN 5
12/31/2003

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	1931	
2	FOOD PURCHASES		1931
	RECLASSIFY EMPLOYEE MEALS		
2	FOOD PURCHASES	4539	
10	NURSING & MEDICAL RECORDS		4539
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	81928	
19	PROFESSIONAL SERVICES		81928
	SEE SCH V111 FOR BREAKDOWN		