

		FOR OFF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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:** 0040915

**Facility Name:** Fair Oaks Health Care Center

**Address:** 471 West Terra Cotta Avenue Crystal Lake 60014  
 Number City Zip Code

**County:** McHenry

**Telephone Number:** 815-455-0550 **Fax #** 815-455-0608

**IDPA ID Number:** 364016275001

**Date of Initial License for Current Owners:** 05/01/95

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501 (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Joyce Surdick **Telephone Number:** 815-455-0550

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 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) Joyce Surdick

(Title) Administrator

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) Barbara DeBaere Poppy, CPA

(Firm Name & Address) Poppy CPA  
816 Church Street, Wisconsin Dells, WI 53965-1411

(Telephone) 608-253-2100 Fax # 608-253-2729

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center# 0040915 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,790</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>46</u>	TOTALS	<u>46</u>	<u>16,790</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,533</u>	<u>9,407</u>	<u>3,206</u>	<u>15,146</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,533</u>	<u>9,407</u>	<u>3,206</u>	<u>15,146</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.21%

D. How many bed-hold days during this year were paid by the Department?

\_\_\_\_\_  
(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)

NoneF. Does the facility maintain a daily midnight census? Yes

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

YES  NO 

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

YES  NO 

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

Date started 05/95

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

YES  Date 05/95 NO 

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

YES  NO  If YES, enter number of beds certified 40 and days of care provided 3,206Medicare Intermediary Administar Federal/IL

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31 Fiscal Year: 12/31

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center # 0040915 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	121,094	5,906	13,901	140,901		140,901	140,901			1
2	Food Purchase		71,443		71,443		71,443	71,443			2
3	Housekeeping	72,969	5,349	4,191	82,509		82,509	82,509			3
4	Laundry	6,567	2,799	3,508	12,874		12,874	12,874			4
5	Heat and Other Utilities			45,910	45,910		45,910	45,910			5
6	Maintenance	47,416	15,698	16,135	79,249		79,249	79,249			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>248,046</b>	<b>101,195</b>	<b>83,645</b>	<b>432,886</b>		<b>432,886</b>	<b>432,886</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,200	11,200		11,200	11,200			9
10	Nursing and Medical Records	986,716	42,518	30,645	1,059,879		1,059,879	1,059,879			10
10a	Therapy	145,795	1,821	1,932	149,548		149,548	149,548			10a
11	Activities	46,215	1,497	3,740	51,452		51,452	51,452			11
12	Social Services	33,304	124	684	34,112		34,112	34,112			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,212,030</b>	<b>45,960</b>	<b>48,201</b>	<b>1,306,191</b>		<b>1,306,191</b>	<b>1,306,191</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	86,098			86,098		86,098	86,098			17
18	Directors Fees										18
19	Professional Services			190,996	190,996		190,996	190,996			19
20	Dues, Fees, Subscriptions & Promotions			5,634	5,634		5,634	5,634			20
21	Clerical & General Office Expenses	40,938	3,070	29,051	73,059		73,059	(17)	73,042		21
22	Employee Benefits & Payroll Taxes			307,815	307,815		307,815	307,815			22
23	Inservice Training & Education			1,715	1,715		1,715	1,715			23
24	Travel and Seminar			9,846	9,846		9,846	9,846			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,972	29,972		29,972	29,972			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>127,036</b>	<b>3,070</b>	<b>575,029</b>	<b>705,135</b>		<b>705,135</b>	<b>(17)</b>	<b>705,118</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,587,112</b>	<b>150,225</b>	<b>706,875</b>	<b>2,444,212</b>		<b>2,444,212</b>	<b>(17)</b>	<b>2,444,195</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Oaks Health Care Center #0040915 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			117,055	117,055		117,055		117,055		30
31	Amortization of Pre-Op. & Org.			2,791	2,791		2,791		2,791		31
32	Interest			132,886	132,886		132,886		132,886		32
33	Real Estate Taxes			43,904	43,904		43,904		43,904		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			296,636	296,636		296,636		296,636		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		91,471	18,299	109,770		109,770		109,770		39
40	Barber and Beauty Shops			9,305	9,305		9,305		9,305		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			25,185	25,185		25,185		25,185		42
43	Other (specify):* <b>Non-patient related</b>			45,610	45,610		45,610	(45,610)			43
44	<b>TOTAL Special Cost Centers</b>		91,471	98,399	189,870		189,870	(45,610)	144,260		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,587,112	241,696	1,101,910	2,930,718		2,930,718	(45,627)	2,885,091		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				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				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				18
19	Entertainment	(3,288)	43		19
20	Contributions	(17)	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	(39,887)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,435)	43		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,627)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (45,627)		37

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

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

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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Fair Oaks Health Care Center

ID# 0040915

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(17)	0	0	0	0	0	0	0	0	0	0	(17)	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	<b>TOTAL General Administration</b>	(17)	0	0	0	0	0	0	0	0	0	0	(17)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(17)	0	0	0	0	0	0	0	0	0	0	(17)	29

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(45,610)	0	0	0	0	0	0	0	0	0	0	(45,610)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(45,610)</b>	<b>0</b>	<b>(45,610)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(45,627)</b>	<b>0</b>	<b>(45,627)</b>	<b>45</b>									

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

**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
Wisconsin Illinois Senior Housing Inc	100	Geneva Lake Manor	Lake Geneva, WI			
		Wild Rose Manor	Wild Rose, WI			
		Holton Manor	Elkhorn, WI			
		Sheltered Village	Ripon, WI			
		Montello Care Center	Montello, WI			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Home Office Costs	\$ 29,193	Wisconsin Illinois Senior Housing, Inc	100.00%	\$ 29,193	\$	1
2	V							2
3	V							3
4	V							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		\$ 29,193			\$ 29,193	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center # 0040915 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005

Ending:

2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Series A/B		x	Purchase Bldg & Equip	\$23,717.00	8/20/1999	\$ 2,657,461	\$ 1,880,855	8/1/2029	7.0000	\$ 132,886	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,717.00		\$ 2,657,461	\$ 1,880,855			\$ 132,886	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,657,461	\$ 1,880,855			\$ 132,886	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 42,110	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.)		\$ 43,577	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,467	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 42,437	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 43,904	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	38,383	8
	2001	40,173	9
	2002	40,521	10
	2003	42,110	11
	2004	43,577	12
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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:

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Fair Oaks Health Care Center COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0040915

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE 815-455-0550 FAX #: 815-356-3856

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-31-426-020</u>	<u>LT 1</u>	\$ <u>43,576.86</u>	\$ <u>43,576.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>43,576.86</u>	\$ <u>43,576.86</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,629 B. General Construction Type: Exterior Frame Number of Stories           

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

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF		1999	\$ 200,000	1
2					2
3	TOTALS			\$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

**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	46		1999		\$ 1,328,800	\$ 34,072		\$ 34,072	\$	\$ 216,888	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		New Concrete		2000	5,500	367		367		1,894	9
10		Removal of tree debris		2000	660	44		44		227	10
11		Removal and replacement of concrete		2000	5,500	275		275		1,398	11
12		Shed		2001	3,671	524		524		2,141	12
13		Wood Floor (Carpet One)		2001	405	81		81		384	13
14		Carpeting (Affordable Flooring)		2001	589	118		118		560	14
15		Vertical Blinds (Home Depot)		2001	1,002	200		200		952	15
16		New Floor (Do-A 1 Floor Co)		2001	8,560	1,223		1,223		5,707	16
17		Mansard Door Canopy (Hunzinger Awning)		2001	521	104		104		486	17
18		Building Sirvey for Bond Issue, required every 5 years (Melkey)		2001	948	189		189		932	18
19		New Carpet (Carpet One)		2001	1,524	305		305		1,499	19
20		Reception Counter (Cabinet Count)		2001	1,125	225		225		1,106	20
21		New Wooden Floor (Carpet One Int)		2001	10,385	1,484		1,484		7,171	21
22		Nursing Station (CCM)		2001	1,525	218		218		1,053	22
23		Hand Rails		2001	1,946	389		389		1,751	23
24		New Carpeting (Affordable Flooring)		2001	4,888	488		488		2,159	24
25		Wall Coverings (Home Depot)		2001	1,075	153		153		665	25
26		Lights for dinning room ( City Light Plus)		2001	620					620	26
27		Improving/upgrading light fixtures		2001	12,644	1,264		1,264		5,268	27
28		Carpet for patient room/office & 31 laminate sheet for doors		2002	2,337	467		467		1,714	28
29		Plumbing work ( Builders Plumbers)		2003	2,612	522		522		1,350	29
30		Plexiwals (Decorative Surfaces)		2003	3,588	718		718		1,794	30
31		Flooring - resident rooms (Affordable Flooring)		2003	1,706	569		569		1,612	31
32		Countertops (Menards)		2003	6,951	695		695		1,564	32
33		Bathroom Fixtures		2003	880	88		88		191	33
34		Flooring 12x80		2003	2,293	459		459		955	34
35		Black top - Parking lot		2004	15,000	750		750		1,125	35
36		Sprinkler System		2004	72,000						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Carpet	2005	\$ 7,541	\$ 808		\$ 808	\$	\$ 808	37
38 Fire Alarm SystemControl Panel	2005	5,289	315		315		315	38
39 Room Furnishings	2005	5,784	757		757		757	39
40								40
41								41
42								42
43								43
44								44
45								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)		\$ 1,517,869	\$ 47,871		\$ 47,871	\$	\$ 265,046	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 407,525	\$ 62,360	\$ 62,360	\$		\$ 358,165	71
72	Current Year Purchases	16,591						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 424,116	\$ 62,360	\$ 62,360	\$		\$ 358,165	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		Ford Van 2001	2001	\$ 34,120	\$ 6,824	\$ 6,824	\$		\$ 30,139	76
77										77
78										78
79										79
80	TOTALS			\$ 34,120	\$ 6,824	\$ 6,824	\$		\$ 30,139	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,176,105	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,055	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,055	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 653,350	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$ _____	\$ _____	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.

**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.)**

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	L 10A, C3	1723 hrs	\$ 64,836		\$	\$	1,723	\$ 64,836	1
2	Licensed Speech and Language Development Therapist	L 10A, C3	940 hrs	31,934				940	31,934	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C3	1809 hrs	49,025				1,809	49,025	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 145,795		\$	\$	4,472	\$ 145,795	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 306,582	\$ 306,582	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	326,312	326,312	3
4	Supply Inventory (priced at )	10,468	10,468	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	550	550	7
8	Accounts Receivable (owners or related parties)	791,655	791,655	8
9	Other(specify): <u>Patient Trust Funds</u>	1,513	1,513	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,437,080	\$ 1,437,080	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,515,868	1,515,868	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	460,237	460,237	16
17	Accumulated Depreciation (book methods)	(653,350)	(653,350)	17
18	Deferred Charges	66,061	66,061	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,588,816	\$ 1,588,816	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,025,896	\$ 3,025,896	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 37,145	\$ 37,145	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,987	181,987	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,257	44,257	32
33	Accrued Interest Payable	54,858	54,858	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Intercompany Loans</u>	9,554	9,554	36
37	<u>Patient Trust Liability</u>	1,513	1,513	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 329,314	\$ 329,314	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,880,855	1,880,855	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,880,855	\$ 1,880,855	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,210,169	\$ 2,210,169	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 815,727	\$ 815,727	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,025,896	\$ 3,025,896	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 740,101	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 740,101	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	75,626	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 75,626</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 815,727</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center# 0040915Report Period Beginning: 01/01/2005Ending: 12/31/2005**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,456,367	1
2	Discounts and Allowances for all Levels	232,410	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,688,777	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	161,729	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 161,729	8
<b>C. Other Operating Revenue</b>			
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	11,187	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,290	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,754	19
20	Radiology and X-Ray	4,185	20
21	Other Medical Services	31,365	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 149,781	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	100	24
25	Interest and Other Investment Income***	7,645	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,745	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending machine, etc.</b>	(1,688)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (1,688)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,006,344	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	432,886	31
32	Health Care	1,306,191	32
33	General Administration	705,135	33
<b>B. Capital Expense</b>			
34	Ownership	296,636	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	109,770	35
36	Provider Participation Fee	25,185	36
<b>D. Other Expenses (specify):</b>			
37	<b>Advertising and entertainment</b>	45,610	37
38	<b>Barber &amp; Beauty</b>	9,305	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,930,718	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	75,626	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 75,626	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,841	2,184	\$ 64,775	\$ 29.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,858	14,490	359,318	24.80	3
4	Licensed Practical Nurses	2,844	3,136	82,025	26.16	4
5	CNAs & Orderlies	32,532	35,473	453,631	12.79	5
6	CNA Trainees					6
7	Licensed Therapist	4,071	4,473	145,795	32.59	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,921	2,159	23,856	11.05	9
10	Activity Assistants	2,724	3,023	22,359	7.40	10
11	Social Service Workers	2,038	2,126	33,304	15.67	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,155	30,183	14.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,341	10,297	90,911	8.83	15
16	Dishwashers					16
17	Maintenance Workers	1,923	2,319	47,416	20.45	17
18	Housekeepers	8,513	9,207	72,969	7.93	18
19	Laundry	906	906	6,567	7.25	19
20	Administrator	1,976	2,207	86,098	39.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,700	2,005	40,938	20.42	23
24	Clerical					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	1,844	2,192	26,967	12.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,880	98,352	\$ 1,587,112 *	\$ 16.14	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	150	\$ 6,702	L1, C3	35
36	Medical Director	30	10,000	L9, C3	36
37	Medical Records Consultant	18	600	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,693	L11, C 3	44
45	Social Service Consultant	6	684	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	\$ 21,879		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

# 0040915

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joyce Surdick	Administrator		\$ 86,098	Workers' Compensation Insurance	\$ 85,557	IDPH License Fee	\$	
				Unemployment Compensation Insurance	7,459	Advertising: Employee Recruitment		
				FICA Taxes	113,460	Health Care Worker Background Check		
				Employee Health Insurance	95,558	(Indicate # of checks performed)		
				Employee Meals		IHCA	2,100	
				Illinois Municipal Retirement Fund (IMRF)*		All other	3,534	
				Employee Life Insurance	327			
				Pension and retirement	5,165			
				Other general benefits	289			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 86,098	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 307,815		\$ 5,634		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Seminar Expense	5,851
(Attach a copy of any management service agreement)							General Business Travel	1,820
C. Professional Services								
Vendor/Payee	Type	Amount						
	General Data Processing	\$ 22,273					Business Meals	
	Home Office Management	29,193					2,175	
	Legal Fees	6,010					Entertainment Expense	
	Accounting Fees	15,131					(agree to Sch. V, line 24, col. 8)	
	Management Fee	116,772					\$ 9,846	
	Other	1,617						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 190,996					
(If total legal fees exceed \$2500 attach copy of invoices.)								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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? Yes  
If YES, give association name and amount. IHCA \$2,100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 4
- (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. \$ 25,185  
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? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a  
c. What percent of all travel expense relates to transportation of nurses and patients? 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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Anderson, ZurMuehlen & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Consolidated audit in progress
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT