		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0008490

Facility Name: Fair Oaks

Address: 200 Health Care Drive (Number) Greenville (City) 62246 (Zip Code)

County: Bond

Telephone Number: 618-664-1230 **Fax #** 618-664-9750

HFS ID Number: 37-0792770003

Date of Initial License for Current Owners: 11/01/69

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501-C-3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jerry Graber Telephone Number: 618-664-1230 ext.3100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/06 to 12/31/06 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)	Jerry Graber
	(Title)	CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	None
	(Firm Name & Address)	
	(Telephone)	( ) Fax # ( )

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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 10/01/03

	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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,275	11,787	2,598	31,660	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,275	11,787	2,598	31,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.31%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/69

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 108 and days of care provided 2,579

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,804	35,984	15,268	310,056	(74,927)	235,129	123,004	358,133			1
2	Food Purchase		192,156		192,156		192,156		192,156			2
3	Housekeeping	90,489	20,933		111,422		111,422	28,166	139,588			3
4	Laundry	84,524	23,995		108,519		108,519	25,135	133,654			4
5	Heat and Other Utilities			189,962	189,962		189,962		189,962			5
6	Maintenance	89,361	59,359		148,720		148,720	50,346	199,066			6
7	Other (specify):* Support Svcs	40,316	4,381		44,697		44,697		44,697			7
8	TOTAL General Services	563,494	336,808	205,230	1,105,532	(74,927)	1,030,605	226,651	1,257,256			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	1,752,819	108,208		1,861,027		1,861,027		1,861,027			10
10a	Therapy			3,418	3,418		3,418		3,418			10a
11	Activities	44,147	6,449		50,596		50,596	(778)	49,818			11
12	Social Services	49,249	564	3,060	52,873		52,873		52,873			12
13	CNA Training	71,410	8,864		80,274	(44,020)	36,254	(35,130)	1,124			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,917,625	124,085	8,978	2,050,688	(44,020)	2,006,668	(35,908)	1,970,760			16
	C. General Administration											
17	Administrative	180,507	18,633		199,140	(16,460)	182,680		182,680			17
18	Directors Fees											18
19	Professional Services			2,320	2,320		2,320		2,320			19
20	Dues, Fees, Subscriptions & Promotions			13,534	13,534	16,460	29,994	(16,460)	13,534			20
21	Clerical & General Office Expenses	63,852	48,593		112,445		112,445	8,677	121,122			21
22	Employee Benefits & Payroll Taxes			611,235	611,235	74,927	686,162	(7,992)	678,170			22
23	Inservice Training & Education					44,020	44,020		44,020			23
24	Travel and Seminar			6,937	6,937		6,937		6,937			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,507	47,507		47,507		47,507			26
27	Other (specify):* PTO - HR	18,539	5,812		24,351		24,351		24,351			27
28	TOTAL General Administration	262,898	73,038	681,533	1,017,469	118,947	1,136,416	(15,775)	1,120,641			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,744,017	533,931	895,741	4,173,689		4,173,689	174,968	4,348,657			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 Oaks #0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			111,799	111,799		111,799	59,117	170,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Minor Equipment			2,167	2,167		2,167		2,167			36
37	TOTAL Ownership			113,966	113,966		113,966	59,117	173,083			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,903	1,200	3,103		3,103		3,103			39
40	Barber and Beauty Shops			7,296	7,296		7,296	(7,297)	(1)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,903	67,626	69,529		69,529	(7,297)	62,232			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,744,017	535,834	1,077,333	4,357,184		4,357,184	226,788	4,583,972			45

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	(22,456)	22		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)	(7,297)	40		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(778)	11		19
20	Contributions				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	(16,460)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(35,130)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (82,121)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	308,909	Page 6	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 308,909		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 226,788		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Fair Oaks

ID# 0008490

Report Period Beginning: 1/01/06

Ending: 12/31/06

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	123,004	0	0	0	0	0	0	0	0	0	123,004	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	28,166	0	0	0	0	0	0	0	0	0	28,166	3
4	Laundry	0	25,135	0	0	0	0	0	0	0	0	0	25,135	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	50,346	0	0	0	0	0	0	0	0	0	50,346	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	226,651	0	0	0	0	0	0	0	0	0	226,651	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	(778)	0	0	0	0	0	0	0	0	0	0	(778)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(35,130)	0	0	0	0	0	0	0	0	0	0	(35,130)	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**	(35,908)	0	0	0	0	0	0	0	0	0	0	(35,908)	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,460)	0	0	0	0	0	0	0	0	0	0	(16,460)	20
21	Clerical & General Office Expenses	0	8,677	0	0	0	0	0	0	0	0	0	8,677	21
22	Employee Benefits & Payroll Taxes	(22,456)	14,464	0	0	0	0	0	0	0	0	0	(7,992)	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**	(38,916)	23,141	0	0	0	0	0	0	0	0	0	(15,775)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,824)	249,792	0	0	0	0	0	0	0	0	0	174,968	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	0	59,117	0	0	0	0	0	0	0	0	0	59,117	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	**TOTAL Ownership**	0	59,117	0	0	0	0	0	0	0	0	0	59,117	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	(7,297)	0	0	0	0	0	0	0	0	0	0	(7,297)	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**	(7,297)	0	0	0	0	0	0	0	0	0	0	(7,297)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(82,121)	308,909	0	0	0	0	0	0	0	0	0	226,788	45

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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
Greenville Regional Hospital	100					

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	6	MAINTENANCE	$ 129,463			$ 179,809	$ 50,346	1
2	V	4	LAUNDRY	17,466			42,601	25,135	2
3	V	3	HOUSEKEEPING	68,294			96,460	28,166	3
4	V	1	DIETARY	103,523			226,527	123,004	4
5	V	21	TELEPHONE SYSTEM	78,088			86,765	8,677	5
6	V	22	BENEFITS-LAB&X-RAY SVCS	99,000			105,791	6,791	6
7	V	22	BENEFITS-PHARMACY	31,981			39,654	7,673	7
8	V	30	HOSPITAL SHARED AREA					94,410	8
9	V	30	FAIR OAKS SHARED AREA					(35,293)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 527,815			$ 777,607	$ * 308,909	14

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		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 Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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: Greenville Regional Hospital
Street Address: 200 Health Care Drive
City / State / Zip Code: Greenville, IL 62246
Phone Number: (618-664-1230
Fax Number: (618-664-9750

	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						$	$		$	1
2	Note:	Greenville Regional Hospital, Inc. operates Greenville Regional Hospital & Fair Oaks.								2
3		Fair Oaks is charged for all known direct costs of operation.								3
4		Fair Oaks shares cost with the hospital for certain services & therefore receives all allocations.								4
5										5
6		The following departments have costs allocated to Fair Oaks:								6
7										7
8		Maintenance of Plant								8
9		Laundry								9
10		Housekeeping								10
11		Dietary								11
12		Utilities & Telephone								12
13		Depreciation (Only of those departments that share services)								13
14		Administration and General								14
15		Financial Services								15
16		HR & Staff Benefits								16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	$ Non Profit	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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$ #VALUE!	3
4. Real Estate Tax accrual used for 2006 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.	$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
2001		8
2002		9
2003		10
2004		11
2005		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks COUNTY Bond

FACILITY IDPH LICENSE NUMBER 0008490

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,896 B. General Construction Type: Exterior Brick Frame Metal Number of Stories One

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

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		259,875	1957	$	1
2					2
3	TOTALS	259,875		$	3

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1969	1969	$ 992,165	$		$	$	$	4
5	49		1974	1974	367,348						5
6			1981	1981	59,093						6
7											7
8											8
	Improvement Type**										
9				1969	retired						9
10				1972	retired						10
11				1974	retired						11
12				1975	retired						12
13				1980	retired						13
14				1982	retired						14
15				1984	33,814						15
16				1985	7,721						16
17				1986	10,764						17
18				1987	30,588						18
19				1988	30,786						19
20				1989	15,099						20
21				1990	25,662						21
22				1991	26,807						22
23				1992	23,815						23
24				1997	9,666						24
25				1998	23,932						25
26				1999	76,550						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	North Wing Renovation	2000	$ 14,734	$		$	$	$	37
38	South Wing Automatic Door Installation	2000	4,929						38
39	Activities Room Renovation	2000	8,653						39
40	Parking Lot Expansion	2000	135,861						40
41									41
42	East Wing HVAC Repair	2001	18,150						42
43									43
44	Canopy Project	2002	179,280						44
45	East Wing HVAC Repair	2002	29,040						45
46									46
47	North Wing Nurse's Station Renovated	2003	6,794						47
48									48
49	HVAC Units Replaced	2004	18,230						49
50	Dining Room Renovated	2004	42,249						50
51	Scheduling Office Renovated	2004	3,400						51
52									52
53	Fire Dampers	2005	23,173						53
54	Shower Room Renovation	2005	7,034						54
55	Roof Replacement	2005	16,579						55
56									56
57	Fan Coil Replacement	2006	10,748						57
58	Beauty Shop Renovation	2006	5,898						58
59	Room 128 Remodel	2006	4,228						59
60	Room Light Replacement (north)	2006	20,264						60
61	Shower Room Renovation	2006	3,089						61
62	Telephone Cable Upgrade	2006	5,655						62
63	Wheelchair Ramp	2006	1,925						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,293,723	$ 72,653		$ 72,653	$ (19,246)	$ 1,574,561	70

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	$ 480,213	$	$	$		$ 301,040	71
72	Current Year Purchases	34,225	34,946	34,946			34,946	72
73	Fully Depreciated Assets	(33,163)					(33,163)	73
74	ADJUSTMENTS	23,414					(145)	74
75	TOTALS	$ 504,689	$ 34,946	$ 34,946	$		$ 302,678	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	Activites	Ford Bus-2004	2004	$ 42,000	$ 4,200	$ 4,200	$	10	$ 10,500	76
77										77
78										78
79										79
80	TOTALS			$ 42,000	$ 4,200	$ 4,200	$		$ 10,500	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)	$ 2,840,412	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,799	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,799	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,391)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,887,739	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	Sprinklers	$ 10,880	92
93	Room 100	3,148	93
94			94
95		$ 14,028	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 Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

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	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 Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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

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

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies			10,688	10,688
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)			25,566	25,566
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$ 36,254	$ 36,254
10	SUM OF line 9, col. 1 and 2 (e)	$			

(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.

C. CONTRACTUAL INCOME

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

$ 35,130

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	83
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	4
TOTAL TRAINED	87

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			1,200	1,903		3,103	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	TOTAL			$		$ 1,200	$ 1,903		$ 3,103	14

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (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	$ 543,815	$ 819,442	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,000,000)	4,178,353	4,178,353	3
4	Supply Inventory (priced at)	421,405	421,405	4
5	Short-Term Investments	533,252	533,252	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	306,619	306,619	7
8	Accounts Receivable (owners or related parties)	2,417,000	2,417,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,400,444	$ 8,676,071	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			15
16	Equipment, at Historical Cost	34,999,465	37,684,125	16
17	Accumulated Depreciation (book methods)	(13,142,805)	(14,185,585)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	852,918	8,833,589	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	450,093	468,593	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 23,159,671	$ 32,800,722	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 31,560,115	$ 41,476,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,011,930	$ 1,011,930	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	533,252	533,252	29
30	Accrued Salaries Payable	786,436	786,436	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	87,382	87,382	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	340,386	377,386	36
37	Due to 3rd parties	865,000	865,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,624,386	$ 3,661,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	10,553,737	10,553,737	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Residency Fees	1,810,331	1,810,331	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,364,068	$ 12,364,068	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,988,454	$ 16,025,454	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,571,661	$ 25,451,339	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 31,560,115	$ 41,476,793	48

*(See instructions.)

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,538,450	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,538,450	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,260,075)	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) **Hospital-Net Income**	3,923,883	15
16	Other (describe) **Emerald Pointe-Net Income**	3,948	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,667,756	17
	B. Transfers (Itemize):		
18	**Depreciation for BHU & WL**	(43,224)	18
19	**Due to Affiliateed Organizations**	(591,321)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (634,545)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 15,571,661	24 *

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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	$ 3,621,471	1
2	Discounts and Allowances for all Levels	(546,893)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,074,578	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	35,130	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,297	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	778	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 43,205	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 3,117,783	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,105,532	31
32	Health Care	2,050,688	32
33	General Administration	1,017,469	33
	B. Capital Expense		
34	Ownership	113,966	34
	C. Ancillary Expense		
35	Special Cost Centers	10,399	35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37	Bad Debts	20,661	37
38	Rounding	13	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,377,858	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,260,075)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,260,075)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

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

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

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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	5,844	6,422	$ 136,722	$ 21.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,375	11,401	256,959	22.54	3
4	Licensed Practical Nurses	18,521	20,353	369,949	18.18	4
5	CNAs & Orderlies	76,513	84,080	972,690	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,583	3,937	44,147	11.21	9
10	Activity Assistants					10
11	Social Service Workers	3,591	3,946	49,249	12.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,802	22,859	258,804	11.32	15
16	Dishwashers					16
17	Maintenance Workers	4,582	5,035	89,361	17.75	17
18	Housekeepers	8,278	9,097	90,489	9.95	18
19	Laundry	7,461	8,199	84,524	10.31	19
20	Administrator	3,749	4,120	168,682	40.94	20
21	Assistant Administrator					21
22	Other Administrative	184	202	3,125	15.47	22
23	Office Manager					23
24	Clerical	3,866	4,248	63,852	15.03	24
25	Vocational Instruction	2,831	3,111	71,410	22.95	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	339	373	8,700	23.32	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,084	1,191	16,499	13.85	31
32	Other Health Ca PTO & HR	759	834	18,539	22.23	32
33	Other(specify) Support Svcs	1,460	1,604	40,316	25.13	33
34	TOTAL (lines 1 - 33)	173,822	191,012	$ 2,744,017 *	$ 14.37	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		$ 15,268	1	35
36	Medical Director		2,500	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,200	39	39
40	Physical Therapy Consultant		3,418	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,060	12	45
46	Other(specify) Beauty Shop		7,296	40	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,742		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)		$ None		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alan Harnetiaux	Administrator	0	$ 150,308
Mary Compton	Admin Assistant	0	18,374
Ryan Mifflin	Marketing	0	3,125
Lisa Beck	Quality Mgmt	0	8,700
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 180,507

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
Verify	Criminal Check	$ 2,320
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,320

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,116
Unemployment Compensation Insurance	5,654
FICA Taxes	142,503
Employee Health Insurance	308,344
Employee Meals	52,471
Illinois Municipal Retirement Fund (IMRF)*	
Retirment Plan	86,602
Dental Plan	5,005
Life Insurance	2,010
EAP/Wellness Program	4,434
Medical Svcs Provided to Staff-page 6	14,464
Other Benefits	8,567
TOTAL (agree to Schedule V, line 22, col.8)	$ 678,170

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA	5,664
Center for Medicare & Medicaid	3,380
E-Health Data Solutions	2,820
Other	1,670
Marketing Salaries/Expenses	16,460
Less: Public Relations Expense	( )
Non-allowable advertising	(16,460)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,056
Seminar Expense	3,881
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,937

**See instructions.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 1/01/06 Ending: 12/31/06

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Fair Oaks** **# 0008490** **Report Period Beginning: 1/01/06 Ending: 12/31/06**

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 - $5,664**

(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? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,130**
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. $ **74,927** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **22,456**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **None**
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? **None**
d. Have vehicle usage logs been maintained? **Yes**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** 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 $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.