

		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: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 North Pulaski Road Chicago 60630
 Number City Zip Code

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

HFS ID Number: 36-3980966

Date of Initial License for Current Owners: 11th May 1995

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" 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: Christopher Vicere **Telephone Number:** (773) 604-4416

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-Jan-2006 to 31-Dec-2006 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.

(Signed) _____ 29th March 2007
 (Date)

Officer or Administrator of Provider
 (Type or Print Name) Christopher Vicere
 (Title) Vice President - Finance

(Signed) _____
 (Date)

Paid Preparer
 (Print Name and Title) _____
 (Firm Name & Address) _____
 (Telephone) () _____ Fax # () _____

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

Facility Name & ID Number Fairmont Care Centre# 0040493 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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>104</u>	Skilled (SNF)	<u>104</u>	<u>37,960</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>72</u>	Intermediate (ICF)	<u>72</u>	<u>26,280</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>176</u>	<u>64,240</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>14,580</u>	<u>2,227</u>	<u>5,220</u>	<u>22,027</u>	8
9	SNF/PED					9
10	ICF	<u>31,476</u>	<u>2,104</u>	<u>19</u>	<u>33,599</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,056</u>	<u>4,331</u>	<u>5,239</u>	<u>55,626</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.59%

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)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 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 11th May 1995

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

YES Date 11th May 1995 NO

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

YES NO If YES, enter number
of beds certified 104 and days of care provided 5,191Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	
	A. General Services											
1	Dietary	427,982	50,099	12,645	490,726		490,726		490,726			1
2	Food Purchase		309,281		309,281	(20,638)	288,643	(215)	288,428			2
3	Housekeeping	301,431	56,871		358,302		358,302		358,302			3
4	Laundry	83,870	31,359		115,229		115,229		115,229			4
5	Heat and Other Utilities			273,910	273,910		273,910		273,910			5
6	Maintenance	67,826	30,334	147,439	245,599		245,599	104	245,703			6
7	Other (specify):*											7
8	TOTAL General Services	881,109	477,944	433,994	1,793,047	(20,638)	1,772,409	(111)	1,772,298			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	2,794,882	259,661	237,395	3,291,938		3,291,938		3,291,938			10
10a	Therapy		5,071	4,594	9,665		9,665		9,665			10a
11	Activities	187,493	16,473		203,966		203,966		203,966			11
12	Social Services	93,671		1,537	95,208		95,208		95,208			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,076,046	281,205	282,526	3,639,777		3,639,777		3,639,777			16
	C. General Administration											
17	Administrative	89,743		280,896	370,639		370,639	(176,135)	194,504			17
18	Directors Fees											18
19	Professional Services			47,586	47,586		47,586	15,412	62,998			19
20	Dues, Fees, Subscriptions & Promotions			44,840	44,840		44,840	(27,500)	17,340			20
21	Clerical & General Office Expenses	168,775	39,358	42,379	250,512		250,512	31,035	281,547			21
22	Employee Benefits & Payroll Taxes			659,700	659,700	20,638	680,338	9,689	690,027			22
23	Inservice Training & Education			685	685		685	2,232	2,917			23
24	Travel and Seminar			2,252	2,252		2,252	3,611	5,863			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,721	10,721		10,721		10,721			26
27	Other (specify):* *Payroll Taxes (Sch VII)							19,123	19,123			27
28	TOTAL General Administration	258,518	39,358	1,089,059	1,386,935	20,638	1,407,573	(122,533)	1,285,040			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,215,673	798,507	1,805,579	6,819,759		6,819,759	(122,644)	6,697,115			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 Fairmont Care Centre

#0040493

Report Period Beginning: 1-Jan-2006 Ending:

31-Dec-2006

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	
	D. Ownership											
30	Depreciation			61,137	61,137		61,137	413,533	474,670			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,090	37,090		37,090	764,052	801,142			32
33	Real Estate Taxes			181,283	181,283		181,283		181,283			33
34	Rent-Facility & Grounds			1,920,000	1,920,000		1,920,000	(1,920,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,199,510	2,199,510		2,199,510	(742,415)	1,457,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		243,429	348,457	591,886		591,886		591,886			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		243,429	444,817	688,246		688,246		688,246			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,215,673	1,041,936	4,449,906	9,707,515		9,707,515	(865,059)	8,842,456			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 Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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	259,689	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(215)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	(4,609)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,118)	24		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,419)	21		24
25	Fund Raising, Advertising and Promotional	(56,096)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,087)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(864)	20		28
29	Other-Attach Schedule ** Page 5A attached **	104	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 163,135		\$	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)	(1,028,194)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,028,194)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (865,059)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance Cost (incurred in 2006)	\$ (4,767)	6 1
2	Deferred Maintenance Cost (allocated for 2006)	4,871	6 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	104	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(215)	0	0	0	0	0	0	0	0	0	0	(215)	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	104	0	0	0	0	0	0	0	0	0	0	104	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(111)	0	0	0	0	0	0	0	0	0	0	(111)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(176,135)	0	0	0	0	0	0	0	0	0	(176,135)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,452	960	0	0	0	0	0	0	0	0	15,412	19
20	Fees, Subscriptions & Promotions	(57,210)	29,710	0	0	0	0	0	0	0	0	0	(27,500)	20
21	Clerical & General Office Expenses	(33,506)	61,454	3,087	0	0	0	0	0	0	0	0	31,035	21
22	Employee Benefits & Payroll Taxes	0	9,689	0	0	0	0	0	0	0	0	0	9,689	22
23	Inservice Training & Education	0	2,232	0	0	0	0	0	0	0	0	0	2,232	23
24	Travel and Seminar	(1,118)	4,729	0	0	0	0	0	0	0	0	0	3,611	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	19,123	0	0	0	0	0	0	0	0	0	19,123	27
28	TOTAL General Administration	(91,834)	(34,746)	4,047	0	(122,533)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,945)	(34,746)	4,047	0	(122,644)	29							

STATE OF ILLINOIS

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006 Ending:

Summary B

31-Dec-2006

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	255,080	685	157,768	0	0	0	0	0	0	0	0	413,533	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	53,013	711,039	0	0	0	0	0	0	0	0	764,052	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,920,000)	0	0	0	0	0	0	0	0	(1,920,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	255,080	53,698	(1,051,193)	0	(742,415)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	163,135	18,952	(1,047,146)	0	(865,059)	45							

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

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee Income	\$ 280,896	Lancaster, Ltd.	100.00%	\$	\$ (280,896)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	36,999	36,999	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	14,452	14,452	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	61,454	61,454	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	9,689	9,689	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	4,729	4,729	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	67,762	67,762	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	29,081	29,081	8
9	V	32 Interest		Lancaster, Ltd.	100.00%	53,013	53,013	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	685	685	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	629	629	11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	19,123	19,123	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	2,232	2,232	13
14	Total		\$ 280,896			\$ 299,848	\$ * 18,952	14

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

VII. RELATED PARTIES (continued)

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	\$ 1,920,000				\$ (1,920,000)	15
16	V	32	Interest	88,961			800,000	711,039	16
17	V	30	Depreciation				157,768	157,768	17
18	V	21	State Replacement Tax				3,087	3,087	18
19	V	19	Professional Fees				960	960	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,008,961			\$ 961,815	\$ * (1,047,146)	39

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

Facility Name & ID Number

Fairmont Care Centre

#

0040493

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 18,521	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	18,478	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,999		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 Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006

Ending: -Dec-2006

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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road,
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 478-1192

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	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	5	\$ 18,521	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,454		5	985	2
3	17	Cheryl Morris	Hours Worked	48	7	177,385	177,385	5	18,478	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,436		5	983	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		280,896	14,452	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	280,896	61,454	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		280,896	9,689	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		280,896	4,729	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	280,896	67,762	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	280,896	29,081	18
19	32	Interest	Management Fees	2,146,620	7	8,729		280,896	1,142	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		280,896	685	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		280,896	629	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		280,896	17,155	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		280,896	2,232	23
24	32	*Direct Interest*							51,871	24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 299,848	25

Facility Name & ID Number

Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Harston Investments		X	Long Term Loan			\$	\$			\$ 800,000						
2																	
3																	
4																	
5																	
Working Capital																	
6	JP Morgan Chase Bank		X	Working Capital							1,142						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 801,142						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 801,142						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

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.	\$	183,500	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.)	\$	181,283	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,217)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	183,500	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.	\$	181,283	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	185,366	8
	2002	187,445	9
	2003	176,350	10
	2004	179,455	11
	2005	181,283	12

**** Accrual is based on 2005 Taxes, adjusted for inflation****

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 Fairmont Care Centre, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604 - 4416 FAX #: (773) 478 - 1192

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)	(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>13-11-300-009-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>181,282.55</u>	\$ <u>181,282.55</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>181,282.55</u>	\$ <u>181,282.55</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 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 Fairmont Care Centre

0040493 Report Period Beginning:

1-Jan-2006 Ending:

31-Dec-2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick 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).

*** None ***

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: N/A 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	<u>Nursing Care Facility</u>	<u>218,869</u>	<u>1995</u>	<u>\$ 685,000</u>	1
2					2
3	TOTALS	218,869		\$ 685,000	3

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-2006

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	176		1995		\$ 2,240,980	\$ 57,462	20	\$ 57,462	\$	\$ 1,099,345	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Canopy and Awning	1995		3,300	85	20	85		1,605	9
10		Intercom System	1995		1,844	47	20	47		866	10
11		Roof Exhausters	1996		2,136	55	20	55		896	11
12		Permanent Signage	1997		16,625	982	15	982		12,518	12
13		Fire Alarm	1997		68,600	1,759	20	1,759		25,044	13
14		Parking Lot Excavation	1997		45,000	2,657	15	2,657		34,253	14
15		Parking Lot Asphalt	1997		68,000	4,015	15	4,015		33,910	15
16		Concrete Curbs	1997		18,000	1,063	15	1,063		8,977	16
17		Phase I Expansion-Landscaping	1997		41,000	2,421	15	2,421		20,447	17
18		Site Sewer	1997		28,500	1,683	15	1,683		14,213	18
19		Phase I Expansion-Building	1997		1,218,394	27,835	20	108,562	80,727	801,720	19
20		Ceramic Tiled Hallway	1998		10,603	272	15	272		3,561	20
21		Electrical Enhancements	1998		6,210	159	15	159		2,085	21
22		Phase II-Landscape	1999		15,000	886	15	886		8,358	22
23		Site Sewer	1999		40,376	2,384	15	2,384		22,495	23
24		Fire Protection	1999		43,440	1,114	20	1,114		8,123	24
25		Excavation	1999		49,650	2,932	15	2,932		27,664	25
26		Phase II Expansion	1999		2,281,933	55,008	20	214,541	159,533	1,209,231	26
27		Electrical-Courtyard	2001		6,520	167	15	167		995	27
28		Building Roofing	2001		21,919	562	20	562		2,927	28
29		Garage Roofing	2001		7,500	192	20	192		1,000	29
30		Heating System	2001		17,965	461	15	461		2,401	30
31		Addition to Heating System	2002		8,561	998	20	856	(142)	3,638	31
32		Improvement to Heating System	2002		11,688	1,363	20	1,169	(194)	4,870	32
33		Parking Lot Expansion	2002		31,500	1,528	20	3,150	1,622	13,125	33
34		Garden Pond	2003		5,000	193	20	333	140	1,166	34
35		Installation of Boiler & Heating Pipes	2003		54,886	1,407	20	4,573	3,166	14,863	35
36		Fire Rated Wooden Door	2006		1,440	8	15	36	28	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 Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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		\$	\$		\$	\$	\$	37
38								38
39								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)	\$ 6,366,570	\$ 169,698		\$ 414,578	\$ 244,880	\$ 3,380,332	70

**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	\$ 625,422	\$ 33,839	\$ 52,237	\$ 18,398	7	\$ 202,310	71
72	Current Year Purchases	23,671	4,736	3,009	(1,727)	7	3,009	72
73	Fully Depreciated Assets	1,042,650	6,023	4,161	(1,862)	7	1,042,650	73
74			685	685		7	6,396	74
75	TOTALS	\$ 1,691,743	\$ 45,283	\$ 60,092	\$ 14,809		\$ 1,254,365	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)		\$ 8,743,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 214,981	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 474,670	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 259,689	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,634,697	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	Rental Property	\$ 179,744	\$ 4,608	\$ 53,518	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 179,744	\$ 4,608	\$ 53,518	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: *** Fairmont Property, LLC (a related entity)***

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

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	\$ _____

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	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.

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>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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 127,366	\$		\$ 127,366	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			50,724			50,724	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			170,367			170,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs							8
9	Pharmacy	39-2	# of prescripts				175,378		175,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **Medical Supplies**	39-2					22,128		22,128	
	Speciality Beds	39-2					45,923		45,923	13
14	TOTAL			\$		\$ 348,457	\$ 243,429		\$ 591,886	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 Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2006

Ending:

31-Dec-2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2006 (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	\$ 2,253	\$ 2,253	1
2	Cash-Patient Deposits	71,364	71,364	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,007,646	2,007,646	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,326	54,326	6
7	Other Prepaid Expenses	1,944	1,944	7
8	Accounts Receivable (owners or related parties)	2,925	1,291,003	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,140,458	\$ 3,428,536	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	570,377	3,856,289	15
16	Equipment, at Historical Cost	1,300,732	1,428,918	16
17	Accumulated Depreciation (book methods)	(1,526,105)	(2,767,896)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**		90,728	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 345,004	\$ 5,713,763	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,485,462	\$ 9,142,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 258,394	\$ 258,394	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,364	71,364	28
29	Short-Term Notes Payable	985,453	192,893	29
30	Accrued Salaries Payable	537,943	537,943	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,627	16,627	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,500	183,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,053,281	\$ 1,260,721	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,053,281	\$ 9,260,721	46
47	TOTAL EQUITY(page 18, line 24)	\$ 432,181	\$ (118,422)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,485,462	\$ 9,142,299	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 700,047	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 700,047	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(267,866)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (267,866)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 432,181	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (897,702)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (897,702)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	779,280	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 779,280	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (118,422)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,394,533	1
2	Discounts and Allowances for all Levels	(1,291,527)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,103,006	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	874,626	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 874,626	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	158,944	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,713	19
20	Radiology and X-Ray	6,660	20
21	Other Medical Services	52,126	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 222,443	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	Net Rental Income (Refer page 23A)	239,574	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 239,574	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,439,649	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,793,047	31
32	Health Care	3,639,777	32
33	General Administration	1,386,935	33
B. Capital Expense			
34	Ownership	2,199,510	34
C. Ancillary Expense			
35	Special Cost Centers	591,886	35
36	Provider Participation Fee	96,360	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,707,515	40
41	Income before Income Taxes (line 30 minus line 40)**	(267,866)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (267,866)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpayer

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

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

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	1,957	2,086	\$ 76,841	\$ 36.84	1
2	Assistant Director of Nursing	5,286	5,736	170,040	29.64	2
3	Registered Nurses	40,630	42,609	1,164,468	27.33	3
4	Licensed Practical Nurses	2,687	2,748	62,560	22.77	4
5	CNAs & Orderlies	111,916	120,804	1,278,085	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,221	1,401	20,993	14.98	9
10	Activity Assistants	13,561	14,689	166,500	11.34	10
11	Social Service Workers	5,732	6,435	93,671	14.56	11
12	Dietician					12
13	Food Service Supervisor	2,069	2,135	37,532	17.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,665	35,500	390,450	11.00	15
16	Dishwashers					16
17	Maintenance Workers	3,858	4,155	67,826	16.32	17
18	Housekeepers	26,489	29,042	301,431	10.38	18
19	Laundry	8,181	8,698	83,870	9.64	19
20	Administrator	1,821	2,086	89,743	43.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,183	10,662	168,775	15.83	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	1,949	2,086	42,888	20.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	270,205	290,872	\$ 4,215,673 *	\$ 14.49	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	333	\$ 12,645	1-3	35
36	Medical Director	1,218	39,000	9-3	36
37	Medical Records Consultant	117	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	20	482	10-3	39
40	Physical Therapy Consultant	60	1,640	10a-3	40
41	Occupational Therapy Consultant	13	430	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	75	2,524	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	43	1,537	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,879	\$ 62,482		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,173	\$ 218,758	10-3	50
51	Licensed Practical Nurses	382	13,931	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,555	\$ 232,689		53

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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting and Decorating	Jan-00	\$ 4,221	3	\$ 704								
2	Painting and Decorating	Feb-00	10,169	3	1,695								
3	Painting and Decorating	Mar-00	606	3	101								
4	Painting and Decorating	Apr-00	2,192	3	366								
5	Painting and Decorating	Jul-00	241	3	41								
6	Painting and Decorating	Aug-00	592	3	98								
7	Painting and Decorating	Sep-00	2,588	3	431								
8	Painting and Decorating	Oct-00	8,123	3	1,355								
9	Painting and Decorating	Jul-02	4,909	3	1,636	1,636	818						
10	Painting and Decorating	Feb-04	2,742	3		457	914	914	457				
11	Painting and Decorating	Sep-04	1,973	3		329	657	657	330				
12	Painting and Decorating	May-05	3,784	3			631	1,261	1,261	631			
13	Painting and Decorating	Aug-05	3,735	3			622	1,245	1,245	623			
14	Painting and Decorating	Oct-06	4,767	3				794	1,589	1,589	795		
15													
16													
17													
18													
19													
20	TOTALS		\$ 50,642		\$ 6,427	\$ 2,422	\$ 3,642	\$ 4,871	\$ 4,882	\$ 2,843	\$ 795	\$	\$

FAIRMONT CARE CENTRE, INC

Provider # 0040493

Report Period : January 1st., 2005 through December 31st. 2006.

Fairmont Care Centre, Inc. has rental property. Management was very strict in the accounting of this rental property. Maintenance workers have maintained detailed logs as to the exact hours that they have spent doing work at the rental property. The following represents a detail of the \$ 198,418 of rental income as listed on page 19, line # 28 of the 2006 cost report :

Rental Income received	\$268,200
Less : Maintenance Salary & Employee Benefits	(8,323)
Utilities	(6,618)
Maintenance Supplies and Expense	(8,196)
Furnishings and Improvements	(3,118)
Insurance	(2,371)
NET RENTAL INCOME	<u>\$239,574</u>

* This agrees with Page 19, Line 28.