

Facility Name & ID Number Fair Oaks Rehab & HCC# 0043422 Report Period Beginning: 1/1/08 Ending: 12/31/08

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>78</u>	Skilled (SNF)	<u>78</u>	<u>28,548</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>78</u>	TOTALS	<u>78</u>	<u>28,548</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>17,432</u>	<u>4,373</u>	<u>4,231</u>	<u>26,036</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,432</u>	<u>4,373</u>	<u>4,231</u>	<u>26,036</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.20%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. 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

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 / /

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

YES Date / / NO

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

YES NO If YES, enter number of beds certified 78 and days of care provided 4,231Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 1/1/08 Fiscal Year: 12/31/08

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

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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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	145,914	7,690	9,908	163,512		163,512	(1,151)	162,361			1
2	Food Purchase		143,500		143,500		143,500	(1,421)	142,079			2
3	Housekeeping		11,443	74,255	85,698		85,698		85,698			3
4	Laundry		10,800	49,503	60,303		60,303		60,303			4
5	Heat and Other Utilities			107,909	107,909		107,909		107,909			5
6	Maintenance	50,749	6,527	44,428	101,704		101,704		101,704			6
7	Other (specify):* Trash Removal			5,296	5,296		5,296		5,296			7
8	TOTAL General Services	196,663	179,960	291,299	667,922		667,922	(2,572)	665,350			8
	B. Health Care and Programs											
9	Medical Director			34,290	34,290		34,290		34,290			9
10	Nursing and Medical Records	1,399,064	69,582	5,952	1,474,598		1,474,598		1,474,598			10
10a	Therapy		241	359,408	359,649		359,649		359,649			10a
11	Activities	56,444	337	5,077	61,858		61,858		61,858			11
12	Social Services	96,753	616	2,958	100,327		100,327		100,327			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,552,261	70,776	407,685	2,030,722		2,030,722		2,030,722			16
	C. General Administration											
17	Administrative	67,721	(766)		66,955		66,955		66,955			17
18	Directors Fees											18
19	Professional Services			345,136	345,136		345,136	(12,000)	333,136			19
20	Dues, Fees, Subscriptions & Promotions			51,898	51,898		51,898	(12,876)	39,022			20
21	Clerical & General Office Expenses	103,653	29,757	90,480	223,890		223,890	(47,321)	176,569			21
22	Employee Benefits & Payroll Taxes			270,509	270,509		270,509		270,509			22
23	Inservice Training & Education			1,796	1,796		1,796		1,796			23
24	Travel and Seminar			4,500	4,500		4,500		4,500			24
25	Other Admin. Staff Transportation			2,749	2,749		2,749	(2,749)				25
26	Insurance-Prop.Liab.Malpractice			100,664	100,664		100,664		100,664			26
27	Other (specify):*											27
28	TOTAL General Administration	171,374	28,991	867,732	1,068,097		1,068,097	(74,946)	993,151			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,920,298	279,727	1,566,716	3,766,741		3,766,741	(77,518)	3,689,223			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 Rehab & HCC #0043422 Report Period Beginning: 1/1/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			153,766	153,766		153,766		153,766		30
31	Amortization of Pre-Op. & Org.			2,007	2,007		2,007	(2,007)			31
32	Interest			153,759	153,759		153,759	(3,978)	149,781		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			1,396	1,396		1,396		1,396		35
36	Other (specify):*										36
37	TOTAL Ownership			310,928	310,928		310,928	(5,985)	304,943		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		200,277	34,726	235,003		235,003		235,003		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			42,997	42,997		42,997		42,997		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		200,277	77,723	278,000		278,000		278,000		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,920,298	480,004	1,955,367	4,355,669		4,355,669	(83,503)	4,272,166		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 Rehab & HCC

0043422

Report Period Beginning: 1/1/08

Ending: 12/31/08

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,151)	1		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	(3,978)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,421)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,749)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,650)	21		24
25	Fund Raising, Advertising and Promotional	(12,876)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(564)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,389)		\$	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	(2,007)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,107)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (25,114)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (83,503)		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						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

Fair Oaks Rehab & HCC

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Misc. Income	\$ (564)	21	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	(564)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	(1,151)	0	0	0	0	0	0	0	0	0	0	(1,151)	1
2	Food Purchase	(1,421)	0	0	0	0	0	0	0	0	0	0	(1,421)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,572)	0	0	0	0	0	0	0	0	0	0	(2,572)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	19
20	Fees, Subscriptions & Promotions	(12,876)	0	0	0	0	0	0	0	0	0	0	(12,876)	20
21	Clerical & General Office Expenses	(24,214)	(23,107)	0	0	0	0	0	0	0	0	0	(47,321)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,749)	0	0	0	0	0	0	0	0	0	0	(2,749)	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	(51,839)	(23,107)	0	(74,946)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,411)	(23,107)	0	(77,518)	29								

STATE OF ILLINOIS

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1/1/08

Ending:

Summary B

12/31/08

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(2,007)	0	0	0	0	0	0	0	0	0	0	(2,007)	31
32	Interest	(3,978)	0	0	0	0	0	0	0	0	0	0	(3,978)	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	(5,985)	0	0	0	0	0	0	0	0	0	0	(5,985)	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)	(60,396)	(23,107)	0	(83,503)	45								

Facility Name & ID Number Fair Oaks Rehab & HCC

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1/1/08

Ending:

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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
Midwest Care Centers, Inc.	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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Clerical & Other General Office	\$ 44,992	Midwest Care Centers	100.00%	\$ 21,885	\$ (23,107)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 44,992			\$ 21,885	\$ * (23,107)	14

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

Facility Name & ID Number

Fair Oaks Rehab & HCC

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1/1/08

Ending:

12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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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

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

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

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	21	Clerical & Other General Office	Direct Cost	16,109,679	3	\$ 80,944	\$ 4,355,669	\$ 21,885	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 80,944	\$	\$ 21,885	25

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	Enterprise Bank		x	Mortgage	Various	12/1/2004	\$ 2,100,765	\$ 1,168,763		0.7000	\$ 153,759	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 2,100,765	\$ 1,168,763			\$ 153,759	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,100,765	\$ 1,168,763			\$ 153,759	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks Rehab & HCC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0043422

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, MGMT, Co.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 Rehab & HCC

0043422 Report Period Beginning:

1/1/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,393 B. General Construction Type: Exterior Brick and Block Frame _____ Number of Stories _____

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

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

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

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

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

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

1. Total Amount Incurred: 50,833 2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: _____ 4. Dates Incurred: Various

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>14,393</u>		<u>\$ 150,000</u>	1
2					2
3	TOTALS	14,393		\$ 150,000	3

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning:

1/1/08

Ending:

12/31/08

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			1985	1972	\$ 1,738,000	\$ 57,933	30	\$ 57,933	\$	\$ 728,994	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Fence around dumpster		1999	2,231		8			2,231	9
10		Repair Sidewalk		2001	595	40	15	40		301	10
11		Landscaping		2001	1,680	168	10	168		1,302	11
12		Installation of New Blacktop		2002	4,992	624	8	624		3,796	12
13		Underground Wiring for Facility Sign		2003	1,275	128	10	128		765	13
14		Sealcoat and stripe parking lot		2003	600		2			600	14
15		Pave back parking lot		2003	11,817	1,477	8	1,477		7,878	15
16		Parking Lot extension		2007	3,850	770	5	770		1,283	16
17		Buildings & Improvements		1998	2,396	80	30	80		852	17
18		Windows-30 Vision 2000 White		1999	14,819	494	30	494		4,812	18
19		119 Gal Hot water heater		1999	3,036	202	15	202		2,026	19
20		Hand Rail		1999	1,554	155	10	155		1,502	20
21		Capital Construction Costs		1999	108,000	4,000	27	4,000		38,000	21
22		Remodel Halls 1 & 3		1999	6,665	444	15	444		3,999	22
23		Heat units for new addition		1999	1,580	158	10	158		1,422	23
24		Handrails		2000	2,106	140	15	140		1,269	24
25		Wallpaper Border		2000	1,218	122	10	122		1,086	25
26		Wallpaper 623 rolls		2000	5,031	503	10	503		4,486	26
27		Water Heater 119 gal		2000	2,564	256	10	256		2,243	27
28		48 inch oak fluorescent		2000	105		7			105	28
29		Concrete Walkways, pads		2000	4,850	323	15	323		2,748	29
30		Gazebo		2000	2,380	149	8	149		2,380	30
31		Window treatments		2000	3,211	321	10	321		2,676	31
32		Digital Communicator		2000	510	34	15	34		281	32
33		Air Duct		2000	2,150	108	20	108		878	33
34		Door Alarm System		2000	1,225	82	15	82		653	34
35		Door alarm syste - keypads & wiring		2001	2,490	166	15	166		1,314	35
36		Corridor Dining Room remodel		2001	101,279	3,376	30	3,376		25,601	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 Rehab & HCC

0043422

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	Connection to fire alarm system on 2 basement door holders	2001	\$ 700	\$ 70	10	\$ 70	\$	\$ 496	37
38	Audit Adjustment	1996	(45,222)	(1,507)	30	(1,507)		(18,968)	38
39	Lithonia light fixtures	2002	936	94	10	94		608	39
40	Dining Room materials	2002	1,047		5			1,047	40
41	Dining Rm Remodel	2003	97,363	6,491	15	6,491		38,945	41
42	Aviary	2003	3,287	219	15	219		1,223	42
43	Heat Detectors - kitchen door	2003	972	97	10	97		535	43
44	Install Steel Fire Door	2003	556	28	20	28		153	44
45	Edwards Fire alarm system	2003	3,000	300	10	300		1,575	45
46	Entry doors	2003	8,125	406	20	406		2,099	46
47	Facility Sign	2004	1,230	123	10	123		574	47
48	Duct Work	2004	11,255	563	20	563		2,392	48
49	Frames for washing machines in laundry room	2006	3,665	244	15	244		733	49
50	Telephone System	2006	7,500	750	10	750		2,125	50
51	Wallpaper	2006	2,499	500	5	500		1,370	51
52	Concrete for garage, generator, sidewalk, dumpster, curb	2006	10,246	683	15	683		1,878	52
53	New garage	2006	6,100	407	15	407		983	53
54	Wing addition	2006	636,900	31,845	20	31,845		76,863	54
55	Used breaker box	2007	9,000	600	15	600		1,150	55
56	Heat System replaced in halls 1,2,3	2007	16,655	1,110	15	1,110		2,036	56
57	Tempering valves to control water temperature	2007	1,727	345	5	345		662	57
58	Siding	2007	32,000	1,600	20	1,600		2,000	58
59	Wing addition - 1 vr. Walk thru related to fas #137	2007	2,632	132	20	132		197	59
60	Install Dry Well	2008	1,500	94	20	94		94	60
61	Nurse Call and Fire Alarm Conduit System	2008	3,045	254	12	254		254	61
62	Monument Signs	2008	4,435	296	10	296		296	62
63	Countertops	2008	595	45	10	45		45	63
64	Sprinkler Head	2008	1,775	232	7	232		232	64
65	Shower Door Rooms	2008	1,240	103	5	103		103	65
66	Wallpaper Remodeling	2008	4,810	481	5	481		481	66
67	Wallpaper Remodeling	2008	2,387	199	5	199		199	67
68	Wallpaper	2008	4,241	1,484	5	1,484		1,484	68
69	Wallpaper	2008	15,628	2,344	5	2,344		2,344	69
70	TOTAL (lines 4 thru 69)		\$ 2,884,038	\$ 122,885		\$ 122,885	\$	\$ 971,691	70

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

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	
1	Totals from Page 12A, Carried Forward		\$ 2,884,038	\$ 122,885		\$ 122,885	\$	\$ 971,691	1
2	Carpet	2008	1,216	61	10	61		61	2
3	Outpatient Therapy Sign	2008	1,285	21	10	21		21	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	TOTAL (lines 1 thru 33)		\$ 2,886,539	\$ 122,967		\$ 122,967	\$	\$ 971,773	34

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0043422 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	\$ 453,112	\$ 29,694	\$ 29,694	\$	Various	\$ 313,438	71
72	Current Year Purchases	22,538	1,104	1,104		Various	1,104	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 475,650	\$ 30,799	\$ 30,799	\$		\$ 314,543	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)	\$ 3,512,189	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 153,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 153,766	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,286,315	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 1,396 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	10a, 3	hrs	\$	1,545	\$ 132,385	\$	1,545	\$ 132,385	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		71	37,198		71	37,198	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,792	189,825		1,792	189,825	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,409	\$ 359,408	\$	3,409	\$ 359,408	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 Rehab & HCC

0043422

Report Period Beginning: 1/1/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 208,734	\$	1
2	Cash-Patient Deposits	21,294		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,090,959		3
4	Supply Inventory (priced at)	15,743		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,166		6
7	Other Prepaid Expenses	1,105		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,364,001	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,000		13
14	Buildings, at Historical Cost	2,858,000		14
15	Leasehold Improvements, at Historical Cost	28,540		15
16	Equipment, at Historical Cost	475,650		16
17	Accumulated Depreciation (book methods)	(1,286,319)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	61,099		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(53,090)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,233,880	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,597,881	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 524,992	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,294		28
29	Short-Term Notes Payable	1,624,628		29
30	Accrued Salaries Payable	128,062		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,729		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,026		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued</u>	42,393		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,380,124	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,168,763		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)	\$ 1,168,763	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,548,887	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 48,994	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,597,881	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (88,856)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (88,856)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	137,850	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)	\$ 137,850	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)	\$ 48,994	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning: 1/1/08

Ending: 12/31/08

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	\$ 4,369,875	1
2	Discounts and Allowances for all Levels	(861,018)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,508,857	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	620,340	6
7	Oxygen	(28)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 620,312	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	1,151	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	309,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,759	19
20	Radiology and X-Ray		20
21	Other Medical Services	27,365	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 359,807	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,978	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc.	565	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 565	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,493,519	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	667,922	31
32	Health Care	2,030,722	32
33	General Administration	1,068,097	33
B. Capital Expense			
34	Ownership	310,928	34
C. Ancillary Expense			
35	Special Cost Centers	235,003	35
36	Provider Participation Fee	42,997	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,355,669	40
41	Income before Income Taxes (line 30 minus line 40)**	137,850	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 137,850	43

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

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

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

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

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	7,257	7,331	\$ 213,544	\$ 29.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,754	5,810	214,072	36.85	3
4	Licensed Practical Nurses	11,898	12,018	278,859	23.20	4
5	CNAs & Orderlies	45,836	46,066	539,449	11.71	5
6	CNA Trainees	3,989	4,089	51,614	12.62	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,660	4,946	56,445	11.41	10
11	Social Service Workers	5,040	5,308	96,753	18.23	11
12	Dietician	13,407	13,523	145,914	10.79	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,972	2,109	50,749	24.06	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,968	2,008	73,210	36.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	6,127	6,236	97,399	15.62	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	955	1,002	10,207	10.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,863	110,446	\$ 1,828,215 *	\$ 16.55	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	215	\$ 9,908	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	64	2,160	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,942	11, 3	44
45	Social Service Consultant	45	2,958	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	369	\$ 17,968		49

C. CONTRACT NURSES

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

Facility Name & ID Number Fair Oaks Rehab & HCC

0043422

Report Period Beginning: 1/1/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Georgette Parnet	Administrator	100	\$ 67,721	Workers' Compensation Insurance	\$ 69,894	IDPH License Fee	\$ 13,180	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	138,955	Health Care Worker Background Check		
				Employee Health Insurance	56,556	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*	5,104	Dues and Subscriptions	6,438	
						Advertising and PR	18,312	
						License	1,092	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 67,721					
(List each licensed administrator separately.)								
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								4,500
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)								\$ 4,500
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Management Fees	Mgmt Fee	\$ 269,954			\$			
WCMC Shared Employees	Purchased Svcs	20,444						
Cobraguard	Purchased Svcs	1,016						
Creek Mgmt.	Purchased Svcs	1,359						
Michael F. Flanagan LLC	Legal Fees	12,000						
Misc. Vendors	Legal Fees	3,252						
E-Health Data Solutions	Data Processing Fees	3,172						
Galaxy Hosted Software	Data Processing Fees	13,240						
Pinnacle Consulting	Professional Services	495						
Emdeon Business Services	Data Processing Fees	402						
Wisconsin Physician Services	Data Processing Fees	107						
Misc.	See attached	19,697						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 345,136	TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

