

Facility Name & ID Number Fair Oaks

0008490 Report Period Beginning: 01/01/08 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	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	16,411	15,110	2,514	34,035	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,411	15,110	2,514	34,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.10%

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)

Day Care - 7

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

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

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 108 and days of care provided 2,478

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	307,033	80,804	17,782	405,619	(62,014)	343,605	145,096	488,701		1
2	Food Purchase		250,025		250,025		250,025		250,025		2
3	Housekeeping	95,798			95,798		95,798	31,032	126,830		3
4	Laundry	87,180	22,662		109,842		109,842	32,731	142,573		4
5	Heat and Other Utilities			201,679	201,679		201,679		201,679		5
6	Maintenance	49,809			49,809		49,809	43,490	93,299		6
7	Other (specify):* Facilities Mgmt.	15,972	10,012		25,984		25,984		25,984		7
8	TOTAL General Services	555,792	363,503	219,461	1,138,756	(62,014)	1,076,742	252,349	1,329,091		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,635,325	98,920		1,734,245		1,734,245		1,734,245		10
10a	Therapy			3,204	3,204		3,204		3,204		10a
11	Activities	46,967	(2,381)		44,586		44,586	(2,341)	42,245		11
12	Social Services	52,350	267	2,744	55,361		55,361		55,361		12
13	CNA Training	44,131	12,251		56,382		56,382	(2,400)	53,982		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,778,773	109,057	11,948	1,899,778		1,899,778	(4,741)	1,895,037		16
	C. General Administration										
17	Administrative	175,664	17,532		193,196	(16,472)	176,724		176,724		17
18	Directors Fees										18
19	Professional Services			1,680	1,680		1,680		1,680		19
20	Dues, Fees, Subscriptions & Promotions			9,818	9,818	16,472	26,290	(16,472)	9,818		20
21	Clerical & General Office Expenses	95,494	89,803		185,297		185,297	9,393	194,690		21
22	Employee Benefits & Payroll Taxes			692,764	692,764	62,014	754,778	(3,835)	750,943		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,760	5,760		5,760		5,760		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,087	49,087		49,087		49,087		26
27	Other (specify):* PTO - HR	40,707	7,063		47,770		47,770		47,770		27
28	TOTAL General Administration	311,865	114,398	759,109	1,185,372	62,014	1,247,386	(10,914)	1,236,472		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,646,430	586,958	990,518	4,223,906		4,223,906	236,694	4,460,600		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Fair Oaks

#0008490

Report Period Beginning:

01/01/08

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			121,910	121,910	121,910	43,793	165,703				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Minor Equipment			3,628	3,628	3,628		3,628				36
37	TOTAL Ownership			125,538	125,538	125,538	43,793	169,331				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,783	1,100	9,883	9,883		9,883				39
40	Barber and Beauty Shops			9,425	9,425	9,425	(9,425)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,292	59,292	59,292		59,292				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		8,783	69,817	78,600	78,600	(9,425)	69,175				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,646,430	595,741	1,185,873	4,428,044	4,428,044	271,062	4,699,106				45

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

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/08

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	(16,445)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(9,425)	40		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,341)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,472)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees	(2,400)	13		28
29	Yellow Page Advertising				29
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,083)		\$	30

BHF USE ONLY							
48		49	50	51	52		

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

		1	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)	318,145	Page 6	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 318,145		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 271,062		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Fair Oaks

ID# 0008490

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/08

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	0	145,096	0	0	0	0	0	0	0	0	0	145,096	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	31,032	0	0	0	0	0	0	0	0	0	31,032	3
4	Laundry	0	32,731	0	0	0	0	0	0	0	0	0	32,731	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	43,490	0	0	0	0	0	0	0	0	0	43,490	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	252,349	0	0	0	0	0	0	0	0	0	252,349	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	(2,341)	0	0	0	0	0	0	0	0	0	0	(2,341)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	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	(4,741)	0	0	0	0	0	0	0	0	0	0	(4,741)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,472)	0	0	0	0	0	0	0	0	0	0	(16,472)	20
21	Clerical & General Office Expenses	0	9,393	0	0	0	0	0	0	0	0	0	9,393	21
22	Employee Benefits & Payroll Taxes	(16,445)	12,610	0	0	0	0	0	0	0	0	0	(3,835)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,917)	22,003	0	0	0	0	0	0	0	0	0	(10,914)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,658)	274,352	0	0	0	0	0	0	0	0	0	236,694	29

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Greenville Regional Hospital	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	6 MAINTENANCE	\$ 164,297			\$ 207,787	\$ 43,490 1
2	V	4 LAUNDRY	20,360			53,091	32,731 2
3	V	3 HOUSEKEEPING	78,237			109,269	31,032 3
4	V	1 DIETARY	111,711			256,807	145,096 4
5	V	21 TELEPHONE SYSTEM	84,529			93,922	9,393 5
6	V	22 BENEFITS-LAB & X-RAY	107,810			112,964	5,154 6
7	V	22 BENEFITS-PHARMACY	27,821			35,277	7,456 7
8	V	30 HOSPITAL SHARED AREA				43,793	43,793 8
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 594,765			\$ 912,910	\$ * 318,145 14

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/08 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	NONE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

Facility Name & ID Number **Fair Oaks** # **0008490** Report Period Beginning: **01/01/08** Ending: **12/31/08**

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

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

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

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

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 2007 report.		\$ Non For Profit	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2003	8		
	2004	9		
	2005	10		
	2006	11		
	2007	12		
			FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2007 \$	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: 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks COUNTY Bond

FACILITY IDPH LICENSE NUMBER 0008490

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

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 Allocation:

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 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

0008490

Report Period Beginning:

01/01/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 48,896 B. General Construction Type: Exterior Brick Frame Metal Number of Stories OneC. 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/08

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1969	1969	\$ 992,165	\$		\$	\$	4
5		1974	1974	367,348					5
6		1981	1981	59,093					6
7									7
8									8
Improvement Type**									
9			1969	retired					9
10			1972	retired					10
11			1974	retired					11
12			1975	retired					12
13			1980	retired					13
14			1982	retired					14
15			1984	33,814					15
16			1985	7,721					16
17			1986	10,764					17
18			1987	30,588					18
19			1988	30,786					19
20			1989	15,099					20
21			1990	25,662					21
22			1991	26,807					22
23			1992	23,815					23
24			1997	9,666					24
25			1998	23,932					25
26			1999	76,550					26
27			2000	164,177					27
28			2001	18,150					28
29			2002	208,320					29
30			2003	6,794					30
31									31
32									32
33									33
34									34
35									35
36									36

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/08

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	HVAC Units Replaced	2004	\$ 18,230	\$		\$	\$		37
38	Dining Room Renovated	2004	42,249						38
39	Scheduling Office Renovated	2004	3,400						39
40									40
41	Fire Dampers	2005	23,173						41
42	Shower Room Renovation	2005	7,034						42
43	Roof Replacement	2005	16,579						43
44									44
45	Fan Coil Replacement	2006	10,748						45
46	Beauty Shop Renovation	2006	5,898						46
47	Room 128 Remodel	2006	4,228						47
48	Room Light Replacement (north)	2006	20,264						48
49	Shower Room Renovation	2006	3,089						49
50	Telephone Cable Upgrade	2006	5,655						50
51	Wheelchair Ramp	2006	1,925						51
52									52
53	Wheelchair Ramp-Handrail	2007	1,803						53
54	Room Light Replacement (south)	2007	18,174						54
55	Mural (south wing)	2007	1,420						55
56	Remodel 6 Resident Rooms	2007	51,221						56
57	Roof Repair	2007	19,480						57
58	Sprinkler System (east wing)	2007	77,122						58
59									59
60									60
61	Air Conditioners / FO Rooftops	2008	10,656						61
62	Windows- Resident Rooms	2008	50,293						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,523,892	\$ 84,702		\$ 84,702	\$	\$ 1,738,048	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	\$ 513,035	\$	\$	\$		\$ 312,842	71
72	Current Year Purchases	29,779	33,008	33,008			33,008	72
73	Fully Depreciated Assets	(38,381)					(37,150)	73
74								74
75	TOTALS	\$ 504,433	\$ 33,008	\$ 33,008	\$		\$ 308,700	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	Activities	Ford Bus- 2004	2004	\$ 42,000	\$ 4,200	\$ 4,200	\$	10	\$ 18,900	76
77										77
78										78
79										79
80	TOTALS			\$ 42,000	\$ 4,200	\$ 4,200	\$		\$ 18,900	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)	\$	3,070,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	121,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	121,910	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)	\$	2,065,648	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: NONE
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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.	<u> </u> /2009	\$ <u> </u>
13.	<u> </u> /2010	\$ <u> </u>
14.	<u> </u> /2011	\$ <u> </u>

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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies			12,251	12,251
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)			44,131	44,131
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$ 56,382	\$ 56,382
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.

\$ 2,400

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	19

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39	# of prescripts				1,100		8,783				9,883	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			\$		\$	1,100	\$	8,783	\$		\$	9,883	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.

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/08 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,811	\$ 273,280	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,206,000)	5,597,828	5,597,828	3
4	Supply Inventory (priced at)	455,863	455,863	4
5	Short-Term Investments	552,343	552,343	5
6	Prepaid Insurance	420,070	420,070	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	643,666	643,666	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,689,581	\$ 7,943,050	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	890,166	5,250,157	12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	39,719,387	43,437,409	16
17	Accumulated Depreciation (book methods)	(15,881,821)	(16,857,488)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	264,471	279,246	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,992,203	\$ 32,109,324	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 32,681,784	\$ 40,052,374	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,392,728	\$ 2,415,175	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	567,090	567,090	29
30	Accrued Salaries Payable	982,831	982,831	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	82,343	82,343	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)	\$ 4,024,992	\$ 4,047,439	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,434,656	9,434,656	40
41	Bonds Payable			41
42	Deferred Compensation	1,890,205	1,890,205	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,324,861	\$ 11,324,861	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,349,853	\$ 15,372,300	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,331,931	\$ 24,680,074	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 32,681,784	\$ 40,052,374	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,755,158	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,755,158	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,183,047)	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) Due from Affiliates	2,759,820	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,576,773	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)	\$ 17,331,931	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/08

Ending:

Page 19

12/31/08

VII. 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	\$ 3,692,195	1
2	Discounts and Allowances for all Levels	(408,655)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,283,540	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,400	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,425	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	2,341	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,166	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,297,706	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,138,756	31
32	Health Care	1,899,778	32
33	General Administration	1,185,372	33
B. Capital Expense			
34	Ownership	125,538	34
C. Ancillary Expense			
35	Special Cost Centers	19,308	35
36	Provider Participation Fee	59,292	36
D. Other Expenses (specify):			
37	Bad Debts	52,709	37
38	Rounding		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,480,753	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,183,047)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,183,047)	43

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

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

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

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

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/08

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			\$	\$	1
2					2
3	8,792	9,662	235,270	24.35	3
4	22,214	24,411	423,071	17.33	4
5	79,210	87,044	904,354	10.39	5
6					6
7					7
8					8
9	3,579	3,933	46,527	11.83	9
10					10
11	1,134	1,246	15,587	12.51	11
12					12
13					13
14					14
15	26,449	29,065	316,227	10.88	15
16					16
17	4,006	4,402	71,092	16.15	17
18	8,369	9,197	100,799	10.96	18
19	7,851	8,628	93,786	10.87	19
20	7,739	8,504	175,182	20.60	20
21					21
22	94	103	2,063	20.03	22
23					23
24	4,706	5,172	175,641	33.96	24
25	1,337	1,469	32,979	22.45	25
26					26
27					27
28					28
29					29
30					30
31	1,022	1,123	17,036	15.17	31
32	852	936	21,210	22.66	32
33	568	624	15,606	25.01	33
34	177,922	195,519	\$ 2,646,430 *	\$ 13.54	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		\$ 17,782	1	35
36		6,000	9	36
37				37
38				38
39		1,100	39	39
40		3,204	10a	40
41				41
42				42
43				43
44				44
45		2,744	12	45
46	Other(specify) Barber & Beauty	9,425	40	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 40,255		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53	TOTAL (lines 50 - 52)	\$ None		53

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	
Kris Albers	Administrator	0	\$ 56,232	Workers' Compensation Insurance	\$ 50,402	IDPH License Fee	\$	
Tracey Casey	Admin Asst	0	20,881	Unemployment Compensation Insurance	13,807	Advertising: Employee Recruitment		
Ryan Miffin	Marketing	0	2,024	FICA Taxes	177,200	Health Care Worker Background Check		
Debra Blankenship		0	7,972	Employee Health Insurance	304,572	(Indicate # of checks performed _____)		
Lana Rainey		0	2,006	Employee Meals	62,014	IHCA	5,663	
Brenda Poole		0	23,111	Illinois Municipal Retirement Fund (IMRF)*		E-Health Data Solutions	2,820	
Debra Hoffmann		0	45,438	Retirement Plan	113,175	IDPA License		
TOTAL (agree to Schedule V, line 17, col. 1)				Dental Plan	8,910	Other	1,336	
(List each licensed administrator separately.)			\$ 157,664	Medical Svcs. Provided to Staff		Marketing Salaries & Expense	16,472	
B. Administrative - Other				Life Insurance	4,156			
Description			Amount	EAP	16,640	Less: Public Relations Expense	()	
			\$	Other Benefits	67	Non-allowable advertising	(16,472)	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 750,943		
TOTAL (agree to Schedule V, line 17, col. 3)							TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)							\$ 9,819	
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
Verify	Criminal Check		\$ 1,680				Out-of-State Travel	\$
							In-State Travel	2,000
							Seminar Expense	3,760
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 5,760
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,680					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/08

Ending: 12/31/08

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HICA- 5,663
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,292
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 62,014 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 16,445
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? None
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BKD, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.