

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418 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	<u>131</u>	Skilled (SNF)	<u>131</u>	<u>47,946</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>131</u>	TOTALS	<u>131</u>	<u>47,946</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>1,500</u>	<u>500</u>	<u>2,686</u>	<u>4,686</u>	8
9	SNF/PED					9
10	ICF	<u>13,986</u>	<u>4,552</u>		<u>18,538</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,486</u>	<u>5,052</u>	<u>2,686</u>	<u>23,224</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.44%

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)

None

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

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

YES NO

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 07/01/95

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

YES Date 07/01/95 NO

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

YES NO If YES, enter number of beds certified 30 and days of care provided 2,686

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Oak Grove Rehab & Skilled Care # 0041418 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	139,676	8,852	6,159	154,687		154,687	154,687			1
2	Food Purchase		107,398		107,398	(4,000)	103,398	103,398			2
3	Housekeeping	134,479	22,231	15,957	172,667		172,667	172,667			3
4	Laundry	30,267	6,682		36,949		36,949	36,949			4
5	Heat and Other Utilities			132,149	132,149		132,149	132,149			5
6	Maintenance	52,241		16,718	68,959		68,959	68,959			6
7	Other (specify):*										7
8	TOTAL General Services	356,663	145,163	170,983	672,809	(4,000)	668,809	668,809			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	669,405	71,253	21,595	762,253		762,253	762,253			10
10a	Therapy										10a
11	Activities	35,024	4,963		39,987		39,987	39,987			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	704,429	76,216	33,595	814,240		814,240	814,240			16
	C. General Administration										
17	Administrative	31,353			31,353		31,353	63,673	95,026		17
18	Directors Fees										18
19	Professional Services			25,203	25,203		25,203	(9,986)	15,217		19
20	Dues, Fees, Subscriptions & Promotions			11,337	11,337		11,337	(4,011)	7,326		20
21	Clerical & General Office Expenses	54,655	25,080	34,693	114,428		114,428	130,270	244,698		21
22	Employee Benefits & Payroll Taxes			182,193	182,193	4,000	186,193		186,193		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,282	2,282		2,282		2,282		24
25	Other Admin. Staff Transportation			22,624	22,624		22,624		22,624		25
26	Insurance-Prop.Liab.Malpractice			130,386	130,386		130,386		130,386		26
27	Other (specify):* ALLOCATED BENEFITS							26,090	26,090		27
28	TOTAL General Administration	86,008	25,080	408,718	519,806	4,000	523,806	206,036	729,842		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,147,100	246,459	613,296	2,006,855		2,006,855	206,036	2,212,891		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 Oak Grove Rehab & Skilled Care

#0041418

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			35,708	35,708	35,708	87,228	122,936				30
31	Amortization of Pre-Op. & Org.						1,048	1,048				31
32	Interest			37,486	37,486	37,486	328,618	366,104				32
33	Real Estate Taxes						35,133	35,133				33
34	Rent-Facility & Grounds			471,303	471,303	471,303	(459,538)	11,765				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			544,497	544,497	544,497	(7,511)	536,986				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,920	71,920	71,920		71,920				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			71,920	71,920	71,920		71,920				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,147,100	246,459	1,229,713	2,623,272	2,623,272	198,525	2,821,797				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 Oak Grove Rehab & Skilled Care

0041418

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				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	(23,028)	30		9
10	Interest and Other Investment Income	(194)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,946)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,752)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,011)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(563)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,494)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,287		34
35	Other- Attach Schedule Allocate Indirect Costs	236,732		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 241,019		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 198,525		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

Oak Grove Rehab & Skilled Care

ID# 0041418

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 Oak Grove Rehab & Skilled Care

0041418

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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	(10,752)	0	0	0	0	0	0	0	0	0	0	(10,752)	19
20	Fees, Subscriptions & Promotions	(4,011)	0	0	0	0	0	0	0	0	0	0	(4,011)	20
21	Clerical & General Office Expenses	(4,509)	341	0	0	0	0	0	0	0	0	0	(4,168)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(19,272)	341	0	0	0	0	0	0	0	0	0	(18,931)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,272)	341	0	0	0	0	0	0	0	0	0	(18,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418

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

	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	(23,028)	110,256	0	0	0	0	0	0	0	0	0	87,228	30
31	Amortization of Pre-Op. & Org.	0	1,048	0	0	0	0	0	0	0	0	0	1,048	31
32	Interest	(194)	328,812	0	0	0	0	0	0	0	0	0	328,618	32
33	Real Estate Taxes	0	35,133	0	0	0	0	0	0	0	0	0	35,133	33
34	Rent-Facility & Grounds	0	(471,303)	0	0	0	0	0	0	0	0	0	(471,303)	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	(23,222)	3,946	0	(19,276)	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)	(42,494)	4,287	0	(38,207)	45								

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418

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01/01/08

Ending:

12/31/08

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
See Schedule Attached		See Schedule Attached		Abbey, LLC	Carbondale	Bldg Rental
				ABS Management	Chicago	Management

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	34 Rent	\$ 471,303	Abbey of Carbondale, LLC	100.00%	\$	\$ (471,303)	1
2	V	32 Interest		Abbey of Carbondale, LLC		328,812	328,812	2
3	V	33 Real Estate Tax		Abbey of Carbondale, LLC		35,133	35,133	3
4	V	21 Office		Abbey of Carbondale, LLC		341	341	4
5	V	30 Depreciation		Abbey of Carbondale, LLC		110,256	110,256	5
6	V	31 Amortization		Abbey of Carbondale, LLC		1,048	1,048	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 471,303			\$ 475,590	\$ * 4,287	14

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

Facility Name & ID Number Oak Grove Rehab & Skilled Care # 0041418 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	David Abell		Administrative	9.50	93,265	9	18.00	ABS Salary	\$ 26,735	17-7	1
2	Tamar Abell		Administrative	9.50	31,088	6.5	13.25	ABS Salary	8,912	17-7	2
3	Joseph Brandman		Administrative	19.00	97,772	7.5	15.00	ABS Salary	28,026	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,673		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 Oak Grove Rehab & Skilled Care

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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

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

Name of Related Organization ABS Management
 Street Address 2711 W. Howard
 City / State / Zip Code Chicago, IL 60645
 Phone Number (773-338-4400
 Fax Number)

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	David Abell	588		\$ 120,000	\$ 120,000	131	\$ 26,735	1
2	17	Tamar Abell	588		40,000	40,000	131	8,912	2
3	17	Joseph Brandman	588		125,798	125,798	131	28,026	3
4	21	Clerical	588		411,237	411,237	131	91,619	4
5	34	Rent	588		52,809		131	11,765	5
6	27	Payroll Taxes	588		47,774		131	10,644	6
7	27	Health & Welfare	588		69,332		131	15,446	7
8	19	Professional Fees	588		3,440		131	766	8
9	21	Office	588		192,195		131	42,819	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				\$ 1,062,585	\$ 697,035		\$ 236,732	25

Facility Name & ID Number Oak Grove Rehab & Skilled Care # 0041418 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	Chase		X	Mortgage	\$42,574.16	09/01/97	\$ 5,550,000	\$ 0		7.5000	\$ 273,502	1
2	First Bank		X	Mortgage	\$24,242.53	10/10/08	3,430,000	3,419,855	10/9/13	7.0000	55,310	2
3	Wolfe,Brandman,Shabat	X		Working Capital		08/11/95	260,000	260,000		9.0000	22,500	3
4	S Hakkian & G Mandelbaum	X		Working Capital		08/11/95	260,000	260,000		9.0000	1,875	4
5	Schneider Children & Solomon	X		Working Capital		08/11/95	260,000	260,000		9.0000		5
Working Capital												
6	MB Financial		X	Working Capital			200,000	0		8.0000	11,324	6
7	First Bank		X	Working Capital			183,410	183,410		7.0000	1,787	7
8												8
9	TOTAL Facility Related				\$66,816.69		\$ 10,143,410	\$ 4,383,265			\$ 366,298	9
B. Non-Facility Related*												
10	Interest Income										(194)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			(194)	14
15	TOTALS (line 9+line14)						\$ 10,143,410	\$ 4,383,265			\$ 366,104	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.	\$	35,969	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.)	\$	35,199	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(770)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	35,903	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.	\$	35,133	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	31,045	8
	2004	32,478	9
	2005	33,844	10
	2006	35,264	11
	2007	35,199	12

Line 4:35199 x 1.02

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.

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

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: 91,994 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 1,048 4. Dates Incurred: 07/01/95

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>Facility</u>		<u>1995</u>	<u>\$ 500,000</u>	1
2					2
3	TOTALS			\$ 500,000	3

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418

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 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	131		1995		\$ 3,500,000	\$ 110,256	39	\$ 89,744	\$ (20,512)	\$ 1,153,851	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Engineering & Evaluation & Study		1996	44,451	1,140	39	1,140		13,680	9
10		Painting & Decorating		1996	53,121	1,362	39	1,362		16,344	10
11		Roofwork		1996	52,008	1,334	39	1,334		16,008	11
12		Plumbing Repair		1996	55,427	1,421	39	1,421		17,052	12
13		Hot Water Heater		1996	5,847	150	39	150		1,800	13
14		HVAC System & Room Unit		1996	77,612	1,990	39	1,990		23,880	14
15		Electrical Work		1996	62,356	1,599	39	1,599		19,188	15
16		Nurses Call System		1996	34,894	895	39	895		10,740	16
17		Security System, Sign & Telephone System		1996	8,788	225	39	225		2,700	17
18		Built- in Cabinets		1996	28,280	725	39	725		8,700	18
19		Flooring		1996	33,593	861	39	861		10,332	19
20		Hand Rails		1996	12,770	327	39	327		3,924	20
21		Ceiling System		1996	36,565	938	39	938		11,256	21
22		Landscaping		1996	8,768	225	39	225		2,700	22
23		Paving		1996	11,490	295	39	295		3,540	23
24		Tuckpointing		1996	16,600	426	39	426		5,112	24
25		Windows & Glazing		1996	27,958	717	39	717		8,604	25
26		Wallpaper & PVL Covering		1996	24,423	626	39	626		7,512	26
27		Window Treatment		1996	7,529	193	39	193		2,316	27
28		Elevator Repair		1996	2,960	76	39	76		912	28
29		New Walls/Repair Existing Walls		1996	49,733	1,275	39	1,275		15,300	29
30		Sprinkler		1996	30,000	769	39	769		9,228	30
31		Hardware		1996	7,299	187	39	187		2,244	31
32		Supervision & General		1996	120,993	3,102	39	3,102		37,224	32
33		Redecorating		1996	291,706	7,821	39	7,821		93,511	33
34		Windows		1999	7,331	188	39	188		1,856	34
35		Roof Repair		2000	22,000	565	39	565		4,942	35
36		New Roof		2002	44,237	1,134	39	1,134		7,796	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 Oak Grove Rehab & Skilled Care

0041418

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	Air Conditioning	2002	\$ 4,392	\$ 113	39	\$ 113	\$	\$ 748	37
38	Hall Remodeling	2003	17,932	460	39	460		2,530	38
39	Roof Repair	2004	12,750	850	15	850		4,038	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,713,813	\$ 142,245		\$ 121,733	\$ (20,512)	\$ 1,519,568	70

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

Facility Name & ID Number Oak Grove Rehab & Skilled Care # 0041418 Report Period Beginning: 01/01/08 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	\$ 533,598	\$ 3,719	\$ 1,203	\$ (2,516)	10	\$ 523,978	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 533,598	\$ 3,719	\$ 1,203	\$ (2,516)		\$ 523,978	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)	\$ 5,747,411	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,964	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,936	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,028)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,043,546	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:				\$ _____			3
4	Additions				_____			4
5	Allocated From Abs Management				11,765			5
6					_____			6
7	TOTAL				\$ 11,765			7

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

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

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

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

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	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oak Grove Rehab & Skilled Care # 0041418 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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		# 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			\$		\$	\$		\$	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 Oak Grove Rehab & Skilled Care# 0041418Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (127,346)	\$ (106,003)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,027,418	1,027,418	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,468	122,468	6
7	Other Prepaid Expenses	35,000	35,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Others</u>	25,000	46,899	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,082,540	\$ 1,125,782	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,500,000	14
15	Leasehold Improvements, at Historical Cost	1,213,813	1,213,813	15
16	Equipment, at Historical Cost	33,599	533,599	16
17	Accumulated Depreciation (book methods)	(378,191)	(2,354,299)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	76,280	91,994	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(76,053)	(82,341)	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)	\$ 869,448	\$ 3,402,766	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,951,988	\$ 4,528,548	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,084	\$ 231,084	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,806	23,806	28
29	Short-Term Notes Payable	183,410	183,410	29
30	Accrued Salaries Payable	59,470	59,470	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,492	6,492	31
32	Accrued Real Estate Taxes(Sch.IX-B)		35,903	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to LLC</u>	2,415,686		36
37	<u>Due to Others</u>	1,160,588	2,889,187	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,080,536	\$ 3,429,352	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,419,855	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)	\$	\$ 3,419,855	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,080,536	\$ 6,849,207	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,128,548)	\$ (2,320,659)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,951,988	\$ 4,528,548	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,315,893)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,315,893)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	187,345	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)	\$ 187,345	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)	\$ (2,128,548)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oak Grove Rehab & Skilled Care

0041418

Report Period Beginning: 01/01/08

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	\$ 2,810,423	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,810,423	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		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	194	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 194	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)	\$ 2,810,617	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	672,809	31
32	Health Care	814,240	32
33	General Administration	519,806	33
B. Capital Expense			
34	Ownership	544,497	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	71,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,623,272	40
41	Income before Income Taxes (line 30 minus line 40)**	187,345	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 187,345	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 Oak Grove Rehab & Skilled Care

0041418

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	Director of Nursing	2,051	2,145	\$ 46,991	\$ 21.91	1
2	Assistant Director of Nursing	480	480	9,423	19.63	2
3	Registered Nurses	3,580	3,965	69,452	17.52	3
4	Licensed Practical Nurses	11,368	12,056	168,355	13.96	4
5	CNAs & Orderlies	39,469	39,803	345,458	8.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	404	411	3,616	8.80	9
10	Activity Assistants	3,699	3,784	31,408	8.30	10
11	Social Service Workers	2,080	2,673	29,726	11.12	11
12	Dietician					12
13	Food Service Supervisor	2,124	2,163	22,096	10.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,882	15,127	117,580	7.77	15
16	Dishwashers					16
17	Maintenance Workers	6,223	6,335	52,241	8.25	17
18	Housekeepers	17,199	17,330	134,479	7.76	18
19	Laundry	3,855	3,880	30,267	7.80	19
20	Administrator	1,120	1,160	31,353	27.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,044	6,316	54,655	8.65	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,578	117,628	\$ 1,147,100 *	\$ 9.75	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	124	\$ 6,159	1-3	35
36	Medical Director	96	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	250	19,840		38
39	Pharmacist Consultant	42	1,755	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	512	\$ 39,754		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 Oak Grove Rehab & Skilled Care

0041418

Report Period Beginning: 01/01/08

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	
Janice Franklin	Administrator		\$ 10,385	Workers' Compensation Insurance	\$ 60,843	IDPH License Fee	\$ 1,900	
Amarra Lifter	Administrator		303	Unemployment Compensation Insurance	27,108	Advertising: Employee Recruitment	4,926	
Gayle Yates	Administrator		20,665	FICA Taxes	87,753	Health Care Worker Background Check (Indicate # of checks performed <u>50</u>)	500	
				Employee Health Insurance	6,489	Patient Background Checks		
				Employee Meals	4,000	Advertising	4,011	
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 31,353			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(4,011)	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 186,193	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,326	
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
Mendel Schneider	Accounting		\$ 4,800				Out-of-State Travel	\$
Richard Peelo	Accounting		4,200					
Personnel Planners	UC Tax Consultant		2,122				In-State Travel	
Meyer Magence	Legal		1,863					
Reed Smith	Legal		1,466				Seminar Expense	
Rebecca Whittington	Legal-Adjusted Out		10,752				ICLTC	1,751
							Holistic Aromatics	381
							Hinds Enviromental	150
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,203	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,282

* Attach copy of IMRF notifications

**See instructions.

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,250 Line 10
- (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. \$ 71,920
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,000 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
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? 0
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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.