

Facility Name & ID Number Fair Oaks

0008490 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 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	5,171	3,165	607	8,943	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,171	3,165	607	8,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 22.69%

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)

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 11/01/69

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 607

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/13 Fiscal Year: 12/31/13

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

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	81,270	5,907	175,112	262,289	(44,591)	217,698	136,797	354,495		1
2	Food Purchase		58,736		58,736		58,736		58,736		2
3	Housekeeping	94,792	217,140		311,932		311,932	19,856	331,788		3
4	Laundry	39,113	91,971		131,084		131,084	12,339	143,423		4
5	Heat and Other Utilities			171,042	171,042		171,042	8,288	179,330		5
6	Maintenance	53,392			53,392		53,392	20,708	74,100		6
7	Other (specify):*										7
8	TOTAL General Services	268,567	373,754	346,154	988,475	(44,591)	943,884	197,988	1,141,872		8
	B. Health Care and Programs										
9	Medical Director	6,000			6,000		6,000		6,000		9
10	Nursing and Medical Records	831,958	32,600	16,455	881,013		881,013		881,013		10
10a	Therapy										10a
11	Activities	23,896	2,629	823	27,348		27,348		27,348		11
12	Social Services	28,357		1,982	30,339		30,339		30,339		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	890,211	35,229	19,260	944,700		944,700		944,700		16
	C. General Administration										
17	Administrative	129,053	1,192	2,809	133,054		133,054		133,054		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			6,098	6,098	9,444	15,542	(9,444)	6,098		20
21	Clerical & General Office Expenses	63,417		196,778	260,195	(9,444)	250,751		250,751		21
22	Employee Benefits & Payroll Taxes			407,675	407,675	44,591	452,266	(13,589)	438,677		22
23	Inservice Training & Education										23
24	Travel and Seminar			668	668		668		668		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,758	60,758		60,758		60,758		26
27	Other (specify):* Human Resources	16,548	36,632		53,180		53,180		53,180		27
28	TOTAL General Administration	209,018	37,824	674,786	921,628	44,591	966,219	(23,033)	943,186		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,367,796	446,807	1,040,200	2,854,803		2,854,803	174,955	3,029,758		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.

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			123,684	123,684	123,684	(17,758)	105,926				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):*											36
37	TOTAL Ownership			123,684	123,684	123,684	(17,758)	105,926				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,665	500	6,165	6,165		6,165				39
40	Barber and Beauty Shops			1,767	1,767	1,767	(1,767)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,730	109,730	109,730		109,730				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,665	111,997	117,662	117,662	(1,767)	115,895				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,367,796	452,472	1,275,881	3,096,149	3,096,149	155,430	3,251,579				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: 01/01/13

Ending: 12/31/13

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	(13,589)	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)	(1,767)	40		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,444)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,800)		\$	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)	180,230		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 180,230		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 155,430		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Fair Oaks

ID# 0008490

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	136,797	0	0	0	0	0	0	0	0	0	136,797	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	19,856	0	0	0	0	0	0	0	0	0	19,856	3
4	Laundry	0	12,339	0	0	0	0	0	0	0	0	0	12,339	4
5	Heat and Other Utilities	0	8,288	0	0	0	0	0	0	0	0	0	8,288	5
6	Maintenance	0	20,708	0	0	0	0	0	0	0	0	0	20,708	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	197,988	0	197,988	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,444)	0	0	0	0	0	0	0	0	0	0	(9,444)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(13,589)	0	0	0	0	0	0	0	0	0	0	(13,589)	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	(23,033)	0	0	0	0	0	0	0	0	0	0	(23,033)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,033)	197,988	0	174,955	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	(17,758)	0	0	0	0	0	0	0	0	0	(17,758)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	(17,758)	0	(17,758)	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	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	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	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(24,800)	180,230	0	155,430	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE	\$ 177,455	Greenville Regional Hospital		\$ 198,163	\$ 20,708	1
2	V	4 LAUNDRY	24,715	Greenville Regional Hospital		37,054	12,339	2
3	V	3 HOUSEKEEPING	57,344	Greenville Regional Hospital		77,200	19,856	3
4	V	1 DIETARY	12,717	Greenville Regional Hospital		149,514	136,797	4
5	V	5 TELEPHONE SYSTEM	74,596	Greenville Regional Hospital		82,884	8,288	5
6	V	30 HOSPITAL SHARED AREA		Greenville Regional Hospital		5,171	5,171	6
7	V	30 FAIR OAKS SHARED AREA		Greenville Regional Hospital		(22,929)	(22,929)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 346,827			\$ 527,057	\$ * 180,230	14

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

Facility Name & ID Number

Fair Oaks

0008490

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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Report Period Beginning:

01/01/13

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Greenville Regional Hospital
 Street Address 200 Healthcare Drive
 City / State / Zip Code Greenville, IL 62246
 Phone Number (618-664-1230
 Fax Number (618-664-2855

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	Note:	Greenville Regional Hospital, Inc. operates Greenville Regional Hospital & Fair Oaks.							
3		Fair Oaks is charged all known direct costs of operation.							
4		Fair Oaks shares cost with the hospital for certain services & therefore receives all allocations.							
5									5
6		The following departments have costs allocated to Fair Oaks:							
7									7
8		Maintenance of Plant							8
9		Laundry							9
10		Housekeeping							10
11		Dietary							11
12		Utilities & Telephone							12
13		Depreciation (Only of those departments that share services)							
14		Administration and General							14
15		Financial Services							15
16		HR & Staff Benefits.							16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Fair Oaks

0008490

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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 2012 report.		\$		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).		\$		3		
4. Real Estate Tax accrual used for 2013 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.		\$		7		
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks COUNTY Bond

FACILITY IDPH LICENSE NUMBER 0008490

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,896 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1

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: _____ 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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$		\$	\$	\$
5		1974	1974	367,348					
6		1981	1981	59,093					
7									
8									
Improvement Type**									
9			1969	retired					
10			1972	retired					
11			1974	retired					
12			1975	retired					
13			1980	retired					
14			1982	retired					
15			1984	33,814					
16			1985	7,721					
17			1986	10,764					
18			1987	30,588					
19			1988	30,786					
20			1989	15,099					
21			1990	25,662					
22			1991	26,807					
23			1992	23,815					
24			1997	9,666					
25			1998	23,932					
26			1999	76,550					
27			2000	164,177					
28			2001	18,150					
29			2002	208,320					
30			2003	6,794					
31			2004	61,160					
32			2005	46,786					
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Fan Coil Replacement	2006	\$ 10,748	\$		\$	\$	\$	37
38	Beauty Shop Renovation	2006	5,898						38
39	Room 128 Remodel	2006	4,228						39
40	Room Light Replacement (north)	2006	20,264						40
41	Shower Room Renovation	2006	3,089						41
42	Telephone Cable Upgrade	2006	5,655						42
43	Wheelchair Ramp	2006	1,925						43
44									44
45	Wheelchair Ramp-Handrail	2007	1,803						45
46	Room Light Replacement (south)	2007	18,174						46
47	Mural (south wing)	2007	1,420						47
48	Remodel 6 Resident Rooms	2007	51,221						48
49	Roof Repair	2007	19,480						49
50	Sprinkler System (east wing)	2007	77,122						50
51									51
52	Air Conditioners/FO Rooftops	2008	10,656						52
53	Windows-Resident Rooms	2008	50,293						53
54									54
55	Fire Detection System Upgrade	2009	9,106						55
56	Security System Upgrade	2009	63,194						56
57	Sprinkler System- Phase I	2009	66,407						57
58									58
59	Sprinkler System-Phase II	2010	98,337						59
60									60
61	Sprinkler System-Phase III	2011	108,800						61
62									62
63	Electrical Work-Emergency Power Upgrade	2012	8,181						63
64	Shower Room Floor Replacement	2012	5,165						64
65	Roof Replacement Admin Offices	2012	5,990						65
66									66
67	Dining Room Door Replacement	2013	2,658						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,889,011	\$ 91,057		\$ 91,057	\$	\$ 2,185,224	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 504,060	\$ 28,427	\$ 28,427	\$		\$ 435,939	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 504,060	\$ 28,427	\$ 28,427	\$		\$ 435,939	75

D. Vehicle Costs. (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	\$ 39,900	76
77										77
78										78
79										79
80	TOTALS			\$ 42,000	\$ 4,200	\$ 4,200	\$		\$ 39,900	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)	\$ 3,435,071	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,684	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,684	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)	\$ 2,661,063	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		\$ NONE	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/13

Ending: 12/31/13

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					_____			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	39	# of prescrpts			500	5,665		6,165	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			\$		\$ 500	\$ 5,665		\$ 6,165	14	

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

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(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	\$ 1,404,133	\$ 1,743,041	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (6,838,332))	4,859,858	4,859,858	3
4	Supply Inventory (priced at)	484,611	484,611	4
5	Short-Term Investments			5
6	Prepaid Insurance	747,857	747,857	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,496,459	\$ 7,835,367	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,506,611	6,560,095	12
13	Land	1,197,527	1,626,032	13
14	Buildings, at Historical Cost	30,925,486	34,027,176	14
15	Leasehold Improvements, at Historical Cost	40,170	40,170	15
16	Equipment, at Historical Cost	9,938,796	10,260,244	16
17	Accumulated Depreciation (book methods)	(23,233,948)	(25,043,130)	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):	439,502	479,894	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,814,144	\$ 27,950,481	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 29,310,603	\$ 35,785,848	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,738,932	\$ 2,738,933	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,438,635	1,438,635	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,304	22,304	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Current Maturities of Debt</u>	524,996	524,996	36
37	<u>Other Accrd Exp & Deferred Rev</u>	512,420	562,520	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,237,287	\$ 5,287,388	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,536,313	8,536,313	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Life Residency Fees</u>	1,589,310	1,589,310	43
44	<u>Asset Retirement Obligations</u>	331,971	331,971	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,457,594	\$ 10,457,594	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,694,881	\$ 15,744,982	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,771,151	\$ 20,040,866	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 29,466,032	\$ 35,785,848	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,789,156	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,789,156	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,444,169)	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)	\$ (1,444,169)	17
B. Transfers (Itemize):			
18	Affiliated Organizations	426,164	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 426,164	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,771,151	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,605,862	1
2	Discounts and Allowances for all Levels	(378,282)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,227,580	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	1,852	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)	\$ 1,852	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	Alden Network	422,548	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 422,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,651,980	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	988,475	31
32	Health Care	944,700	32
33	General Administration	921,628	33
B. Capital Expense			
34	Ownership	123,684	34
C. Ancillary Expense			
35	Special Cost Centers	7,932	35
36	Provider Participation Fee	109,730	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,096,149	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,444,169)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,444,169)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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:

01/01/13

Ending:

12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,653	1,837	\$ 48,933	\$ 26.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,464	4,960	118,217	23.83	3
4	Licensed Practical Nurses	11,331	12,590	242,244	19.24	4
5	CNAs & Orderlies	35,934	39,927	427,608	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,775	1,972	25,341	12.85	8
9	Activity Director					9
10	Activity Assistants	2,534	2,816	23,896	8.49	10
11	Social Service Workers	1,679	1,865	28,358	15.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,273	6,970	81,270	11.66	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,233	53,392	23.91	17
18	Housekeepers	7,264	8,071	94,790	11.74	18
19	Laundry	3,119	3,466	39,112	11.28	19
20	Administrator	1,282	1,424	49,547	34.79	20
21	Assistant Administrator					21
22	Other Administrative	46	51	937	18.37	22
23	Office Manager					23
24	Clerical	5,982	6,647	128,151	19.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director			6,000		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)	85,346	94,829	\$ 1,367,796 *	\$ 14.42	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	\$ 2,912	1 & 3	35
36	Medical Director			36
37	Medical Records Consultant	552	17 & 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	500	39 & 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	1,742	12 & 3	45
46	Other(specify) <u>Beauty Shop</u>	1,767	40 & 3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,473		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ NONE		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/13

Ending:

12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$5,899
- (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. \$ 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. \$ 109,730
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. \$ 44,591 Has any meal income been offset against related costs? YES Indicate the amount. \$ 13,589
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.