

FOR BHF USE							

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**2010**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2010)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b>      <u>0040915</u></p> <p><b>Facility Name:</b>      <u>FAIR OAKS HEALTH CARE CENTER</u></p> <p><b>Address:</b>      <u>471 TERRA COTTA AVENUE</u>      <u>CRYSTAL LAKE</u>      <u>60014</u>           Number                                      City                                      Zip Code</p> <p><b>County:</b>      <u>McHENRY</u></p> <p><b>Telephone Number:</b>      <u>815-455-0550</u>      Fax # <u>815-455-0608</u></p> <p><b>HFS ID Number:</b>      _____</p> <p><b>Date of Initial License for Current Owners:</b>      <u>5/1/1995</u></p> <p><b>Type of Ownership:</b></p> <table border="0" style="width: 100%; margin-left: 20px;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b>      <u>501 C (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>JOYCE SURDICK</u>      <b>Telephone Number:</b> <u>815-455-0550</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p align="center">I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/10</u> to <u>12/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>JOYCE SURDICK</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td></td> <td colspan="2">(Firm Name &amp; Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, SUITE 200, ELM GROVE, WI 53122</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>262-789-9945</u></td> <td>Fax # <u>262-782-8766</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001      Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>JOYCE SURDICK</u>			(Title) _____			(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Print Name and Title) _____			(Firm Name & Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, SUITE 200, ELM GROVE, WI 53122</u>			(Telephone) <u>262-789-9945</u>	Fax # <u>262-782-8766</u>
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Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	46	Skilled (SNF)	46	16,790	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	46	TOTALS	46	16,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	3,006	8,154	4,059	15,219	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,006	8,154	4,059	15,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.64%

D. How many bed-hold days during this year were paid by the Department? \_\_\_\_\_ (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 05/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/95 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 40 and days of care provided 4,036

Medicare Intermediary ADMINISTAR FEDERAL / IL

IV. ACCOUNTING BASIS

ACCRAUAL  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 **FAIR OAKS HEALTH CARE CENTER** # **0040915** Report Period Beginning: **1/1/10** Ending: **12/31/10**

**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
	<b>A. General Services</b>										
1	Dietary	149,034	10,055	19,566	178,655		178,655		178,655		1
2	Food Purchase		115,513		115,513		115,513		115,513		2
3	Housekeeping	114,120	10,024	2,501	126,645		126,645		126,645		3
4	Laundry		5,356	3,582	8,938		8,938		8,938		4
5	Heat and Other Utilities			63,635	63,635		63,635	(3,201)	60,434		5
6	Maintenance	70,115	15,362	30,403	115,880		115,880		115,880		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	333,269	156,310	119,687	609,266		609,266	(3,201)	606,065		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,833	10,833		10,833		10,833		9
10	Nursing and Medical Records	1,138,713	60,533	62,160	1,261,406		1,261,406		1,261,406		10
10a	Therapy		728	403,347	404,075		404,075		404,075		10a
11	Activities	52,102	2,284	4,629	59,015		59,015		59,015		11
12	Social Services	39,366		560	39,926		39,926		39,926		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,230,181	63,545	481,529	1,775,255		1,775,255		1,775,255		16
	<b>C. General Administration</b>										
17	Administrative	100,000			100,000		100,000		100,000		17
18	Directors Fees										18
19	Professional Services			237,958	237,958		237,958	(17,506)	220,452		19
20	Dues, Fees, Subscriptions & Promotions			10,224	10,224		10,224		10,224		20
21	Clerical & General Office Expenses	67,813	9,347	53,669	130,829		130,829		130,829		21
22	Employee Benefits & Payroll Taxes			294,294	294,294		294,294		294,294		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,611	10,611		10,611		10,611		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,768	29,768		29,768		29,768		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	167,813	9,347	636,524	813,684		813,684	(17,506)	796,178		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,731,263	229,202	1,237,740	3,198,205		3,198,205	(20,707)	3,177,498		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			73,288	73,288		73,288		73,288		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			108,635	108,635		108,635		108,635		32
33	Real Estate Taxes			62,138	62,138		62,138		62,138		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			244,061	244,061		244,061		244,061		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		137,000	25,485	162,485		162,485		162,485		39
40	Barber and Beauty Shops			11,835	11,835		11,835		11,835		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			25,502	25,502		25,502		25,502		42
43	Other (specify):*			88,045	88,045		88,045	(88,045)			43
44	<b>TOTAL Special Cost Centers</b>		137,000	150,867	287,867		287,867	(88,045)	199,822		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,731,263	366,202	1,632,668	3,730,133		3,730,133	(108,752)	3,621,381		45

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



**FAIR OAKS HEALTH CARE CENTER**

ID# 0040915

Report Period Beginning: 1/1/10

Ending: 12/31/10

Sch. V Line

**NON-ALLOWABLE EXPENSES**

**Amount**

**Reference**

1	Vending	\$	(2,831)	43
2				
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49	<b>Total</b>		(2,831)	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER# 0040915

Report Period Beginning:

1/1/10

Ending:

12/31/10

## 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	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	(3,201)	0	0	0	0	0	0	0	0	0	0	(3,201)	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	<b>TOTAL General Services</b>	<b>(3,201)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,201)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(206)	(17,300)	0	0	0	0	0	0	0	0	0	(17,506)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(206)</b>	<b>(17,300)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,506)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(3,407)</b>	<b>(17,300)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,707)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER# 0040915

Report Period Beginning:

1/1/10

Ending:

12/31/10

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(88,045)	0	0	0	0	0	0	0	0	0	0	(88,045)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(88,045)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(88,045)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(91,452)	(17,300)	0	0	0	0	0	0	0	0	0	(108,752)	45



**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<b>WISCONSIN ILLINOIS SENIOR HOUSING 100</b>		<b>GENEVA LAKE MANOR</b>	<b>LAKE GENEVA, WI</b>			
		<b>WILD ROSE MANOR</b>	<b>WILDE ROSE, WI</b>			
		<b>HOLTON MANOR</b>	<b>ELKHORN, WI</b>			
		<b>SHELTERED VILLAGE</b>	<b>RIPON, WI</b>			
		<b>MONTELLO CARE CENTER</b>	<b>MONTELLO, WI</b>			
		<b>EAST TROY MANOR</b>	<b>EAST TROY, WI</b>			

**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		
	V	<b>19 HOME OFFE COSTS</b>	\$ <b>33,750</b>	<b>WISCONSIN ILLINOIS SENIOR HOUSING, INC.</b>	<b>100.00%</b>	\$ <b>16,450</b>	\$ <b>(17,300)</b>	<b>1</b>
	V							<b>2</b>
	V							<b>3</b>
	V							<b>4</b>
	V							<b>5</b>
	V							<b>6</b>
	V							<b>7</b>
	V							<b>8</b>
	V							<b>9</b>
	V							<b>10</b>
	V							<b>11</b>
	V							<b>12</b>
	V							<b>13</b>
<b>14</b>	<b>Total</b>		\$ <b>33,750</b>			\$ <b>16,450</b>	\$ <b>*</b> <b>(17,300)</b>	<b>14</b>

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

Facility Name & ID Number **FAIR OAKS HEALTH CARE CENTER** # **0040915** Report Period Beginning: **1/1/10** Ending: **12/31/10**

**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								<b>TOTAL</b>	\$		13

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

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

1/1/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

**FAIR OAKS HEALTH CARE CENTER**

# **0040915**

Report Period Beginning:

**1/1/10**

Ending:

**12/31/10**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	<b>SERIES A/B, 2010</b>		<b>X</b>	<b>PURCH. BLD &amp; EQUIP</b>	<b>\$23,018.00</b>	<b>5/12/10</b>	<b>\$ 2,657,461</b>	<b>\$ 5,055,033</b>			<b>\$ 108,635</b>	<b>1</b>								
2				<b>&amp; BUILD A NEW BUILDING</b>								<b>2</b>								
3												<b>3</b>								
4												<b>4</b>								
5												<b>5</b>								
<b>Working Capital</b>																				
6												<b>6</b>								
7												<b>7</b>								
8												<b>8</b>								
9	<b>TOTAL Facility Related</b>				<b>\$23,018.00</b>		<b>\$ 2,657,461</b>	<b>\$ 5,055,033</b>			<b>\$ 108,635</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																				
10												<b>10</b>								
11												<b>11</b>								
12												<b>12</b>								
13												<b>13</b>								
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 2,657,461</b>	<b>\$ 5,055,033</b>			<b>\$ 108,635</b>	<b>15</b>								

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2009 report.				\$	<b>55,555</b>	<b>1</b>
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.)				\$	<b>55,650</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>95</b>	<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>62,043</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>62,138</b>	<b>7</b>
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	<b>2005</b>	<b>45,410</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>		
	<b>2006</b>	<b>46,603</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009	<b>13</b>
	<b>2007</b>	<b>47,840</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	<b>14</b>
	<b>2008</b>	<b>54,423</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6	<b>15</b>
	<b>2009</b>	<b>54,423</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

# 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIR OAKS HEALTH CARE CENTER COUNTY McHENRY  
 FACILITY IDPH LICENSE NUMBER 0040915  
 CONTACT PERSON REGARDING THIS REPORT JOYCE SURDICK  
 TELEPHONE 815-455-0550 FAX #: 815-455-0608

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-31-426-020</u>	<u>LT1</u>	\$ <u>55,650.00</u>	\$ <u>55,650.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>55,650.00</u></u>	\$ <u><u>55,650.00</u></u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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 HEALTH CARE CENTER

# 0040915

Report Period Beginning:

1/1/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,629 B. General Construction Type: Exterior 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: \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	SNF		1999	\$ 200,000	1
2					2
3	TOTALS			\$ 200,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	46	1999		\$ 1,328,800	\$ 34,072		\$ 34,072		\$ 387,247	4
5		2001		3,671					3,671	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	WOODEN FLOORS, CARPENTING, LIGHT FIXTURES		2001	39,077	1,753		1,753		37,738	9
10	FLOORING, PLUMBING, COUNTERTOPS		2003	16,324	783		783		14,163	10
11	FIRE ALARM SYSTEM, CARPET, BURNISHINGS		2005	22,694	2,822		2,822		15,883	11
12	SPRINKLER SYSTEM		2006	72,000	2,880		2,880		14,400	12
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICAL WORK		2008	26,941	1,057		1,057		2,596	13
14	WINDOW, FLOORING		2009	37,161	4,796		4,796		6,872	14
15										15
16										16
17										17
18										18
19										19
20	LAND IMPROVEMENTS:									20
21	REMOVE REPLACE CONCRETE		2000	11,660	686		686		6,948	21
22	PARKING LOT		2004	15,000	750		750		4,875	22
23	LANDSCAPING (OAK TREES)		2006	3,450	230		230		997	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

\*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



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,576,778	\$ 49,829		\$ 49,829	\$	\$ 495,390	70

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 618,618	\$ 19,726	\$ 19,726	\$		\$ 553,040	71
72	Current Year Purchases	27,426	3,733	3,733			3,733	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 646,044	\$ 23,459	\$ 23,459	\$		\$ 556,773	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 2,422,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,288	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,052,163	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	<b>TOTALS</b>	\$	\$	\$	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								5
6								6
7	<b>TOTAL</b>				\$ _____			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	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$		\$ 161,850	\$		\$ 161,850	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs			63,982			63,982	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs			175,765			175,765	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): <u>RESPIRATORY THEI</u>	L10A, C3				1,750			1,750	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$ 403,347	\$		\$ 403,347	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/10**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 372,407	\$	1
2	Cash-Patient Deposits	100		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	688,814		3
4	Supply Inventory (priced at )	5,120		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,687		6
7	Other Prepaid Expenses	1,350		7
8	Accounts Receivable (owners or related parties)	4,718,250		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,816,728	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	1,552,340		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	683,205		16
17	Accumulated Depreciation (book methods)	(1,039,713)		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 (spe <b>LOAN/BOND COSTS</b> )	360,739		22
23	Other(specify): <b>NOTES RECEIVABLE</b>	107,525		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,864,096	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,680,824	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 157,002	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,672		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,279		32
33	Accrued Interest Payable	132,664		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>INTERCOMPANY LOANS</b>	35,165		36
37	<b>PROP INS, DEF REV</b>	73,590		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 659,372	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,055,033		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,055,033	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,714,405	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,966,419	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,680,824	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,735,486</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Adjustments</b>	<b>25,172</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,760,658</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>205,761</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>205,761</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,966,419</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning: 1/1/10

Ending: 12/31/10

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,984,566	1
2	Discounts and Allowances for all Levels	(185,658)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,798,908	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	815,919	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 815,919	8
<b>C. Other Operating Revenue</b>			
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	11,856	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	195,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,521	19
20	Radiology and X-Ray	8,926	20
21	Other Medical Services	75,302	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 312,302	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	265	24
25	Interest and Other Investment Income***	978	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,243	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING MACHINE &amp; EMPLOYEE MEALS</b>	7,522	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,522	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,935,894	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	609,266	31
32	Health Care	1,775,255	32
33	General Administration	813,684	33
<b>B. Capital Expense</b>			
34	Ownership	244,061	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	162,485	35
36	Provider Participation Fee	25,502	36
<b>D. Other Expenses (specify):</b>			
37	<b>BARBER &amp; BEAUTY</b>	11,835	37
38	<b>ADVERTISING &amp; ENTERTAINMENT</b>	88,045	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,730,133	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	205,761	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 205,761	43

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

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

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

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



Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	1,562	1,578	\$ 49,293	\$ 31.24	1
2	Assistant Director of Nursing	1,920	2,080	42,464	20.42	2
3	Registered Nurses	11,027	11,744	281,849	24.00	3
4	Licensed Practical Nurses	10,051	11,045	234,721	21.25	4
5	CNAs & Orderlies	36,317	39,008	507,495	13.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	27,809	13.37	9
10	Activity Assistants	2,639	2,815	24,293	8.63	10
11	Social Service Workers	2,129	2,345	39,366	16.79	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	29,822	14.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,202	11,518	119,212	10.35	15
16	Dishwashers					16
17	Maintenance Workers	3,751	4,048	70,115	17.32	17
18	Housekeepers	10,920	11,708	114,120	9.75	18
19	Laundry					19
20	Administrator	2,000	2,080	100,000	48.08	20
21	Assistant Administrator					21
22	Other Administrative	1,816	2,153	48,641	22.59	22
23	Office Manager	2,144	2,155	19,172	8.90	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,502	1,762	22,891	12.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,980	110,199	\$ 1,731,263 *	\$ 15.71	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	171	\$ 10,867	L1, C3	35
36	Medical Director	36	10,833	L9, C3	36
37	Medical Records Consultant	16	1,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	16	750	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,454	L11, C3	44
45	Social Service Consultant	8	560	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	295	\$ 27,464		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Amount			Description	Amount	Description	Amount		
JOYCE SURDICK					Workers' Compensation Insurance	\$ 48,447	IDPH License Fee	\$		
					Unemployment Compensation Insurance	18,690	Advertising: Employee Recruitment			
					FICA Taxes	126,809	Health Care Worker Background Check (Indicate # of checks performed _____)			
					Employee Health Insurance	89,275	Patient Background Checks			
					Employee Meals		ALL OTHER		10,224	
					Illinois Municipal Retirement Fund (IMRF)*					
					EMPLOYEE LIFE INSURANCE	3,818				
					PENSION & RETIREMENT	7,255				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 100,000						
B. Administrative - Other										
Description				Amount						
				\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$						
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			
	GENERAL DATA PROCES	\$ 30,135			\$	Out-of-State Travel	\$			
	MANAGEMENT FEES	136,500								
	LEGAL FEES	14,368				In-State Travel				
	ACCOUNTING FEES	21,028								
	HOME OFFICE MGMT	33,750				Seminar Expense	6,128			
	OTHER	2,177				GENERAL BUSINESS TRAVEL	2,982			
						BUSINESS MEALS	1,501			
						Entertainment Expense	( )			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 237,958						
						TOTAL (agree to Sch. V, line 24, col. 8)	\$ 10,611			

\* 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? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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. \$ 25,502  
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. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ 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? N/A
  - d. Have vehicle usage logs been maintained? N/A
  - 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?
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: ANDERSON, ZURMUEHLEN & CO PC
- (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.

**FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE**  
**ID NUMBER: 0040915**  
**Seminar 2010**

<b>Attendee</b>	<b>Title</b>	<b>Date of Seminar</b>	<b>Location</b>	<b>Title of Seminar</b>	<b>Sponsor of Seminar</b>	<b>Cost</b>
Surdick, Joyce	Administrator	03/24-03/26	Navy pier Chicago	LSN Mtg & Expo	LSN	\$450.00
Surdick, Joyce	Administrator	Spring 2010	Webinar	CHC Meeting	E.D. of Wish Corp.	\$261.00
Surdick, Joyce	Administrator	03/2,3/9,316	Webinar	Access to Nature	Pioneer Network	\$274.00
Surdick, Joyce	Administrator	2/8/2011	Webinar	Interdisciplinary Team	AMDA	\$140.00
Surdick, Joyce	Administrator	2/8/2011	Webinar	Model MD Agreement	AMDA	\$26.00
Surdick, Joyce	Administrator	5/3/2011	Webinar	Prep Interdisciplinary Team	Telespan	\$250.00
Surdick, Joyce	Administrator	Sping 2010	New York	Spring Seminar	CHC	\$1,175.00
Surdick, Joyce	Administrator	Fall 2010	Philadelphia	Fall Seminar	CHC	\$860.00
Surdick, Joyce	Administrator	Nov 2010	Springfield IL	INHA	LSN	\$289.00
Lori Tapaninen	Business Office Man.	Fall 2010	Philadelphia	Fall Seminar	CHC	\$860.00
Patti Rygh	ADON	12/29	Westmont, IL	ICD-9 Coding	Pathway Health Serv.	\$169.00
Sharon Froney	Dietary Mgr	05/4-12/31 Ongoing	On Site	Dietary Mgr Training	University of FL	\$586.00
Sharon Froney	Dietary Mgr	5/3/2011	Webinar	Prep Interdisciplinary Team	Telspan	\$250.00
Jim Surdick	Soc Ser.	05/03	Webinar	Pre Interdisciplinary Team	Telespan	\$250.00
Surdick, Jim	Social Service Directc	Nov 2010	Springfield IL	INHA	LSN	\$288.00
						\$6,128.00
						<b>Cost</b>
No single travel item greater than \$250.						\$4,483.00
						\$10,611.00