		FOR BHF USE					

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. **IDPH License ID Number:** 0008490

Facility Name: Fair Oaks Nursing Home

Address: 200 Healthcare Drive (Number) Greenville (City) 62246 (Zip Code)

County: Bond

Telephone Number: 618-664-1230 **Fax #** 618-664-2855

HFS ID Number:

Date of Initial License for Current Owners: 11/01/69

Type of Ownership:

X	VOLUNTARY,NON-PROFIT
	Charitable Corp.
	Trust

IRS Exemption Code

	PROPRIETARY
	Individual
	Partnership
	Corporation
	"Sub-S" Corp.
	Limited Liability Co.
	Trust
	Other

	GOVERNMENTAL
	State
	County
	Other

In the event there are further questions about this report, please contact:
Name: Mark R Ennen Telephone Number: 618-664-1230 ext. 3058
Email Address:

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) Sherry Koehler
	(Title) Chief Financial Officer
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 10/01/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,901	10,060	1,882	22,843	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,901	10,060	1,882	22,843	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.95%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 1,882

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/01/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	207,299	17,639	33,893	258,831	(51,828)	207,003	65,009	272,012			1
2	Food Purchase		180,954		180,954		180,954		180,954			2
3	Housekeeping	93,989	26,816		120,805		120,805	19,343	140,148			3
4	Laundry	76,709	26,721		103,430		103,430	19,495	122,925			4
5	Heat and Other Utilities			185,275	185,275		185,275	9,876	195,151			5
6	Maintenance	82,401			82,401		82,401	31,135	113,536			6
7	Other (specify):*											7
8	TOTAL General Services	460,398	252,130	219,168	931,696	(51,828)	879,868	144,858	1,024,726			8
	B. Health Care and Programs											
9	Medical Director	6,000			6,000		6,000		6,000			9
10	Nursing and Medical Records	1,457,452	70,514	29,226	1,557,192		1,557,192		1,557,192			10
10a	Therapy											10a
11	Activities	41,707	4,218	1,771	47,696		47,696		47,696			11
12	Social Services	50,035	97	4,146	54,278		54,278		54,278			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,555,194	74,829	35,143	1,665,166		1,665,166		1,665,166			16
	C. General Administration											
17	Administrative	162,614	1,035	10,205	173,854		173,854		173,854			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			9,254	9,254	20,391	29,645	(20,391)	9,254			20
21	Clerical & General Office Expenses	93,614		99,258	192,872	(20,391)	172,481		172,481			21
22	Employee Benefits & Payroll Taxes			609,834	609,834	51,828	661,662	(17,439)	644,223			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,106	5,106		5,106		5,106			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			84,316	84,316		84,316		84,316			26
27	Other (specify):* Human Resources	26,841	11,098		37,939		37,939		37,939			27
28	TOTAL General Administration	283,069	12,133	817,973	1,113,175	51,828	1,165,003	(37,830)	1,127,173			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,298,661	339,092	1,072,284	3,710,037		3,710,037	107,028	3,817,065			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,756	128,756		128,756	(15,845)	112,911			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**			128,756	128,756		128,756	(15,845)	112,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,816	1,200	14,016		14,016		14,016			39
40	Barber and Beauty Shops			7,179	7,179		7,179	(7,216)	(37)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,316	120,316		120,316		120,316			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		12,816	128,695	141,511		141,511	(7,216)	134,295			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,298,661	351,908	1,329,735	3,980,304		3,980,304	83,967	4,064,271			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 Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,439)	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)	(7,216)	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	(20,391)	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)**	$ (45,046)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 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)	134,982		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 134,982		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 89,936		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fair Oaks Nursing Home

ID# 0008490

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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 Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	65,009	0	0	0	0	0	0	0	0	0	65,009	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	19,343	0	0	0	0	0	0	0	0	0	19,343	3
4	Laundry	0	19,495	0	0	0	0	0	0	0	0	0	19,495	4
5	Heat and Other Utilities	0	9,876	0	0	0	0	0	0	0	0	0	9,876	5
6	Maintenance	0	31,135	0	0	0	0	0	0	0	0	0	31,135	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	144,858	0	0	0	0	0	0	0	0	0	144,858	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	(20,391)	0	0	0	0	0	0	0	0	0	0	(20,391)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(17,439)	0	0	0	0	0	0	0	0	0	0	(17,439)	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**	(37,830)	0	0	0	0	0	0	0	0	0	0	(37,830)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,830)	144,858	0	0	0	0	0	0	0	0	0	107,028	29

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(15,845)	0	0	0	0	0	0	0	0	0	(15,845)	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	(15,845)	0	0	0	0	0	0	0	0	0	(15,845)	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	(7,216)	0	0	0	0	0	0	0	0	0	0	(7,216)	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**	(7,216)	0	0	0	0	0	0	0	0	0	0	(7,216)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,046)	129,013	0	0	0	0	0	0	0	0	0	83,967	45

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE	$ 158,251	Greenville Regional Hospital		$ 189,386	$ 31,135	1
2	V	4	LAUNDRY	16,473	Greenville Regional Hospital		35,968	19,495	2
3	V	3	HOUSEKEEPING	53,376	Greenville Regional Hospital		72,719	19,343	3
4	V	1	DIETARY	92,398	Greenville Regional Hospital		157,407	65,009	4
5	V	5	TELEPHONE SYSTEM	88,885	Greenville Regional Hospital		98,761	9,876	5
6	V	30	HOSPITAL SHARED AREA		Greenville Regional Hospital		8,420	8,420	6
7	V	30	FAIR OAKS SHARED AREA		Greenville Regional Hospital		(24,265)	(24,265)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 409,383			$ 538,396	$ * 129,013	14

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

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

	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.								2
3		Fair Oaks is charged all known direct costs of operation.								3
4		Fair Oaks shares cost with the hospital for certain services & therefore receives all allocations.								4
5										5
6		The following departments have costs allocated to Fair Oaks:								6
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)								13
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 Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 2010 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 2011 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:		
2006		8
2007		9
2008		10
2009		11
2010		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks Nursing Home 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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? [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		259,875	1957	$	1
2					2
3	TOTALS	259,875		$	3

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1969	1969	$ 992,165	$		$	$	$	4
5			1974	1974	367,348						5
6			1981	1981	59,093						6
7											7
8											8
	Improvement Type**										
9				1969	retired						9
10				1972	retired						10
11				1974	retired						11
12				1975	retired						12
13				1980	retired						13
14				1982	retired						14
15				1984	33,814						15
16				1985	7,721						16
17				1986	10,764						17
18				1987	30,588						18
19				1988	30,786						19
20				1989	15,099						20
21				1990	25,662						21
22				1991	26,807						22
23				1992	23,815						23
24				1997	9,666						24
25				1998	23,932						25
26				1999	76,550						26
27				2000	164,177						27
28				2001	18,150						28
29				2002	208,320						29
30				2003	6,794						30
31				2004	61,160						31
32				2005	46,786						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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,867,017	$ 91,981		$ 91,981	$	$ 2,001,395	70

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 510,805	$	$	$		$ 348,849	71
72	Current Year Purchases	8,761	32,575	32,575			32,575	72
73	Fully Depreciated Assets	(297)					(297)	73
74	ADJUSTMENTS							74
75	TOTALS	$ 519,269	$ 32,575	$ 32,575	$		$ 381,127	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	$ 31,500	76
77										77
78										78
79										79
80	TOTALS			$ 42,000	$ 4,200	$ 4,200	$		$ 31,500	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)	$ 3,428,286	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,756	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,756	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)	$ 2,414,022	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.

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

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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.

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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			1,200	12,816		14,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 1,200	$ 12,816		$ 14,016	14

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

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 245,074	$ 549,377	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,707,027))	6,500,013	6,500,013	3
4	Supply Inventory (priced at)	446,144	446,144	4
5	Short-Term Investments			5
6	Prepaid Insurance	868,185	868,185	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)**	$ 8,059,416	$ 8,363,719	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,771,250	8,536,198	12
13	Land	1,212,192	1,640,696	13
14	Buildings, at Historical Cost	30,707,335	33,813,295	14
15	Leasehold Improvements, at Historical Cost	317,341	317,341	15
16	Equipment, at Historical Cost	9,560,209	9,849,209	16
17	Accumulated Depreciation (book methods)	(20,381,873)	(21,839,199)	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):	384,404	538,737	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,570,858	$ 32,856,277	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 32,630,274	$ 41,219,996	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,851,763	$ 3,851,763	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,625,664	1,625,664	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,683	22,683	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Maturities of Debt	527,593	527,593	36
37	Other Accrd Exp & Deferred Rev	1,051,500	1,101,400	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,079,203	$ 7,129,103	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,618,003	9,618,003	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Residency Fees	1,626,236	1,626,236	43
44	Asset Retirement Obligations	302,547	302,547	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,546,786	$ 11,546,786	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 18,625,989	$ 18,675,889	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,004,285	$ 22,544,107	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,630,274	$ 41,219,996	48

*(See instructions.)

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,392,142	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,392,142	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(661,866)	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)**	$ (661,866)	17
	B. Transfers (Itemize):		
18	Affiliated Organizations	274,009	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 274,009	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 14,004,285	24 *

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,197,600	1
2	Discounts and Allowances for all Levels	(802,411)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,395,189	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	7,216	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)**	$ 7,216	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,402,405	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,024,726	31
32	Health Care	1,665,166	32
33	General Administration	1,127,173	33
	B. Capital Expense		
34	Ownership	112,911	34
	C. Ancillary Expense		
35	Special Cost Centers	13,979	35
36	Provider Participation Fee	120,316	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,064,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	(661,866)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (661,866)	43

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

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

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

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

Facility Name & ID Number Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,908	2,120	$ 56,618	$ 26.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,283	6,981	156,863	22.47	3
4	Licensed Practical Nurses	21,635	24,039	445,560	18.53	4
5	CNAs & Orderlies	56,098	62,331	758,302	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,425	3,805	47,763	12.55	8
9	Activity Director					9
10	Activity Assistants	3,398	3,776	41,707	11.05	10
11	Social Service Workers	3,499	3,888	50,035	12.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,704	18,560	207,299	11.17	15
16	Dishwashers					16
17	Maintenance Workers	3,345	3,717	82,401	22.17	17
18	Housekeepers	7,724	8,582	93,989	10.95	18
19	Laundry	6,391	7,101	76,709	10.80	19
20	Administrator	1,908	2,120	72,815	34.35	20
21	Assistant Administrator					21
22	Other Administrative	191	212	4,495	21.20	22
23	Office Manager					23
24	Clerical	8,241	9,157	180,049	19.66	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	972	1,080	18,056	16.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,722	157,469	$ 2,298,661 *	$ 14.60	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		$ 12,003	1 & 3	35
36	Medical Director				36
37	Medical Records Consultant		2,747	17 & 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,200	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		2,800	12 & 3	45
46	Other(specify) Beauty Shop		7,179	40 & 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,929		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

Facility Name & ID Number: Fair Oaks Nursing Home # 0008490 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kris Albers	Administrator		$ 72,815
Dawn Welch	DON		56,618
Tracy Casey	Adm Assistant		31,939
Melanie Bone	Billing		1,242
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 162,614

B. Administrative - Other

Description	Amount
Medical Records Consultant	$ 2,747
Flowers for Residents/Family	1,397
Public Transportation for residents	644
Others	5,417
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,205

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,699
Unemployment Compensation Insurance	5,398
FICA Taxes	123,378
Employee Health Insurance	354,128
Employee Meals	34,389
Illinois Municipal Retirement Fund (IMRF)*	
Dental Plan	9,859
Retirement Plan	21,689
Life & Disability	7,811
Vision Plan	696
Medical Svcs for Staff	37,747
Others	9,429
TOTAL (agree to Schedule V, line 22, col.8)	$ 644,223

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,391
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
IHCA	5,664
e-Health Data Solutions	2,820
Life Services Network	500
INHAA	100
Others	170
Less: Public Relations Expense	( )
Non-allowable advertising	(20,391)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,311
Seminar Expense	2,795
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,106

**See instructions.

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
					Amount of Expense Amortized Per Year								
	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		$		$	$	$	$	$	$	$	$	$

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 - $5,664**

(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? **3.4 yrs**

(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. $ **120,316**
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. $ **51,828** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **17,439**

(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 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.