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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0040915

Facility Name: FAIR OAKS HEALTH CARE CENTER

Address: 471 TERRA COTTA AVE (Number) CRYSTAL LAKE (City) 60014 (Zip Code)

County: McHENRY

Telephone Number: 815-455-0550 **Fax #** 815-455-0608

HFS ID Number:

Date of Initial License for Current Owners: 5/1/1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JOYCE SURDICK **Telephone Number:** 815-455-0550
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 1/1/2014 to 12/31/2014 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) Joyce Surdick
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) JT and Associates, LLC, 700 Pilgrim Pkwy, Suite 200 Elm Grove WI 53122
(Telephone) 262-789-9945 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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 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	51	Skilled (SNF)	51	18,615	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	51	TOTALS	51	18,615	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	1,825	6,652	7,376	15,853	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,825	6,652	7,376	15,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.16%

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)

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 [X] NO [ ]

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 05/95

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

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided _____

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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: 1/1/2014 Ending: 12/31/2014

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	210,807	5,702	23,310	239,819		239,819		239,819			1
2	Food Purchase		142,876		142,876		142,876		142,876			2
3	Housekeeping	132,063	17,188	3,449	152,700		152,700		152,700			3
4	Laundry		4,412	3,332	7,744		7,744		7,744			4
5	Heat and Other Utilities			82,905	82,905		82,905	(7,600)	75,305			5
6	Maintenance	73,332	16,427	56,179	145,938		145,938		145,938			6
7	Other (specify):*											7
8	TOTAL General Services	416,202	186,605	169,175	771,982		771,982	(7,600)	764,382			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,600,247	52,240	36,710	1,689,197		1,689,197		1,689,197			10
10a	Therapy	490,761	4,431	75,389	570,581		570,581		570,581			10a
11	Activities	70,155	2,535	5,647	78,337		78,337		78,337			11
12	Social Services	43,472		864	44,336		44,336		44,336			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,204,635	59,206	128,610	2,392,451		2,392,451		2,392,451			16
	C. General Administration											
17	Administrative	104,527			104,527		104,527		104,527			17
18	Directors Fees											18
19	Professional Services			263,514	263,514		263,514	(22,779)	240,735			19
20	Dues, Fees, Subscriptions & Promotions			31,146	31,146		31,146		31,146			20
21	Clerical & General Office Expenses	159,379	9,878	65,053	234,310		234,310		234,310			21
22	Employee Benefits & Payroll Taxes			449,950	449,950		449,950		449,950			22
23	Inservice Training & Education			2,000	2,000		2,000		2,000			23
24	Travel and Seminar			14,956	14,956		14,956		14,956			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,212	27,212		27,212		27,212			26
27	Other (specify):*											27
28	TOTAL General Administration	263,906	9,878	853,831	1,127,615		1,127,615	(22,779)	1,104,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,884,743	255,689	1,151,616	4,292,048		4,292,048	(30,379)	4,261,669			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER #0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			210,806	210,806		210,806		210,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			351,679	351,679		351,679	(872)	350,807			32
33	Real Estate Taxes			42,903	42,903		42,903		42,903			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			605,388	605,388		605,388	(872)	604,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		194,575	50,771	245,346		245,346		245,346			39
40	Barber and Beauty Shops			13,156	13,156		13,156		13,156			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,626	87,626		87,626		87,626			42
43	Other (specify):*			140,501	140,501		140,501	(140,501)				43
44	**TOTAL Special Cost Centers**		194,575	292,054	486,629		486,629	(140,501)	346,128			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,884,743	450,264	2,049,058	5,384,065		5,384,065	(171,752)	5,212,313			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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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				4
5	Telephone, TV & Radio in Resident Rooms	(7,600)	5		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	(872)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,757)	43		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	(135,744)	43		24
25	Fund Raising, Advertising and Promotional				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)**	$ (148,973)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (148,973)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIR OAKS HEALTH CARE CENTER

ID# 0040915

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

	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
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,600)	0	0	0	0	0	0	0	0	0	0	(7,600)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,600)	0	0	0	0	0	0	0	0	0	0	(7,600)	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	(22,779)	0	0	0	0	0	0	0	0	0	(22,779)	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	**TOTAL General Administration**	0	(22,779)	0	0	0	0	0	0	0	0	0	(22,779)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,600)	(22,779)	0	0	0	0	0	0	0	0	0	(30,379)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	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)	
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	(872)	0	0	0	0	0	0	0	0	0	0	(872)	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**	(872)	0	0	0	0	0	0	0	0	0	0	(872)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(140,501)	0	0	0	0	0	0	0	0	0	0	(140,501)	43
44	**TOTAL Special Cost Centers**	(140,501)	0	0	0	0	0	0	0	0	0	0	(140,501)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(148,973)	(22,779)	0	0	0	0	0	0	0	0	0	(171,752)	45

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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
WISCONSIN ILLINOIS SENIOR HOUSING	100	GENEVA LAKE MANOR	LAKE GENEVA, WI			
		WILD ROSE MANOR	WILD ROSE, WI			
		HOLTON MANOR	ELKHORN, WI			
		MONTELLO CARE CENTER	MONTELLO, WI			
		EAST TROY MANOR	EAST TROY, WI			
		EDGERTON CARE CENTER	EDGERTON, WI			
		INGLESIDE MANOR	MT. HOREB, WI			

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 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	19	HOME OFFICE COSTS	$ 35,520	WISCONSIN ILLINOIS SENIOR HOUSING	100.00%	$ 12,741	$ (22,779)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 35,520			$ 12,741	$ * (22,779)	14

*** 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: 1/1/2014 Ending: 12/31/2014

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	Charles Nason	BOD						2
3	Andy C. Kerwin	BOD						3
4	Jill M. Krueger	BOD						4
5	Ken DeVito	BOD						5
6	Nicholas Lynn	BOD						6
7	Miriam Gehler	BOD						7
8	Rajeef Kumar, MD FACP	BOD						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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

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

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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										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	TOTALS					$	$		$	25

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	BOND SERIES 2012		X	BUILIDNG NEW ADDITION		8/1/12	$ 5,820,977	$ 5,563,223			$ 349,675	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,820,977	$ 5,563,223			$ 349,675	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,820,977	$ 5,563,223			$ 349,675	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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 57,623	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.)		$ 50,263	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,360)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,263	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.		$ 42,903	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	55,650	8
	2010	59,443	9
	2011	55,207	10
	2012	45,025	11
	2013	48,642	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-31-426-020	LT1	$ 50,263.00	$ 50,263.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,263.00	$ 50,263.00

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 1/1/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,962 B. General Construction Type: Exterior ALUMINUM SIDING Frame WOOD 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).

NONE.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF		1995	$ 200,000	1
2					2
3	TOTALS			$ 200,000	3

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	46		1999		$ 1,328,800	$ 34,072		$ 34,072	$	$ 523,434	4
5			2001		3,671					3,671	5
6	5			2013	4,437,265	129,330		129,330		152,744	6
7											7
8											8
	Improvement Type**										
9	WOODEN FLOORS, CARPENTING, LIGHT FIXTURES			2001	39,077					39,077	9
10	FLOORING, PLUMBING, COUNTERTOPS			2003	16,324					16,324	10
11	FIRE ALARM SYSTEM, CARPET, FURNISHINGS			2005	22,694	162		162		20,751	11
12	SPRINKLER SYSTEM			2006	72,000	2,880		2,880		25,920	12
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICALWORK			2008	26,941	1,057		1,057		6,824	13
14	WINDOW, FLOORING			2009	37,161	3,699		3,699		20,554	14
15	FLOORING, TILES			2011	7,710	1,275		1,275		4,512	15
16	PLANK FLOORING			2012	2,321	465		465		1,045	16
17	REGULATOR FOR WATER TEMPS IN RESIDENT ROOMS			2014	4,985	332		332		332	17
18	NEW CARPET IN MAIN HALL			2014	9,790	1,468		1,468		1,468	18
19	GENERATOR UPDATES AND ADDITIONS			2014	10,020	668		668		668	19
20	AUTOMATIC KITCHEN DOOR			2014	3,855	161		161		161	20
21	PLUMBING - MIXING VALVES (MIGHTY OAKS)			2014	4,025	22		22		22	21
22	VINYL FLOORING AND WOOD BLINDS (REMDODEL OF BEDROO			2014	3,127	118		118		118	22
23	SPRINKLER SYSTEM VALVE (MIGHTY OAKS)			2014	2,850	29		29		29	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	LAND IMPROVEMENTS										31
32	REMOVE REPLACE CONCRETE			2000	11,660	686		686		9,692	32
33	PARKING LOT			2004	15,000	750		750		7,875	33
34	LANDSCAPING (OAK TREES)			2006	3,450	230		230		1,917	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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			$	$		$	$	$	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)		$ 6,062,726	$ 177,404		$ 177,404	$	$ 837,138	70

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 759,872	$ 32,117	$ 32,117	$		$ 670,823	71
72	Current Year Purchases	14,471	1,285	1,285			1,285	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 774,343	$ 33,402	$ 33,402	$		$ 672,108	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,037,069	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,806	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,806	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)	$ 1,509,246	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	L10A,C3	14380 hrs	$ 183,418		$	$	14,380	$ 183,418	1
2	Licensed Speech and Language Development Therapist	L10A,C3	2287 hrs	63,514		3,030	1,193	2,287	67,737	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	20227 hrs	243,829			3,238	20,227	247,067	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$ 490,761		$ 3,030	$ 4,431	36,894	$ 498,222	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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 356,402	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	525,157		3
4	Supply Inventory (priced at)	21,122		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,528		6
7	Other Prepaid Expenses	3,582		7
8	Accounts Receivable (owners or related parties)	1,821,612		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,755,403	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	9,361		11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	6,040,046		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	817,949		16
17	Accumulated Depreciation (book methods)	(1,505,667)		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 LOAN/BOND COSTS	74,613		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,636,302	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,391,705	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,773	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,447		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,360		32
33	Accrued Interest Payable	144,148		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY LOANS	17,366		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 525,094	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,563,223		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,563,223	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,088,317	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,303,388	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,391,705	$	48

*(See instructions.)

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,974,155	1	
2	Restatements (describe):		2	
3	**DEPRECIATION ADJ**	(273)	3	
4	**REAL ESTATE ADJ**	14,903	4	
5	**ROUNDING**	1	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,988,786	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	314,602	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)**	$ 314,602	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,303,388	24	*

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,867,496	1
2	Discounts and Allowances for all Levels	(71,175)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,796,321	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,304,507	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,304,507	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	11,389	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	409,342	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,865	19
20	Radiology and X-Ray	15,358	20
21	Other Medical Services	83,606	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 575,560	23
	D. Non-Operating Revenue		
24	Contributions	9,574	24
25	Interest and Other Investment Income***	872	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,446	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	EMPLOYEE & GUEST MEALS, FEES	11,833	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,833	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,698,667	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	771,982	31
32	Health Care	2,392,451	32
33	General Administration	1,127,615	33
	B. Capital Expense		
34	Ownership	605,388	34
	C. Ancillary Expense		
35	Special Cost Centers	399,003	35
36	Provider Participation Fee	87,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,384,065	40
41	**Income before Income Taxes (line 30 minus line 40)****	314,602	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 314,602	43

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 1/1/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 72,874	$ 35.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,900	13,689	420,968	30.75	3
4	Licensed Practical Nurses	14,297	15,184	339,908	22.39	4
5	CNAs & Orderlies	53,933	57,187	740,020	12.94	5
6	CNA Trainees					6
7	Licensed Therapist	12,568	12,568	490,761	39.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	32,306	15.53	9
10	Activity Assistants	4,319	4,163	37,849	9.09	10
11	Social Service Workers	1,890	2,090	43,472	20.80	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	31,548	15.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,767	16,745	179,259	10.71	15
16	Dishwashers					16
17	Maintenance Workers	3,720	4,104	73,332	17.87	17
18	Housekeepers	12,960	13,771	132,063	9.59	18
19	Laundry					19
20	Administrator	2,000	2,080	104,527	50.25	20
21	Assistant Administrator					21
22	Other Administrative	3,879	4,224	77,960	18.46	22
23	Office Manager	5,959	6,333	81,419	12.86	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	2,063	2,201	26,477	12.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,255	160,579	$ 2,884,743 *	$ 17.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	251	$ 14,301	L1, C3	35
36	Medical Director	12	10,000	L9, C3	36
37	Medical Records Consultant	15	840	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	13	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	45	3,337	L11, C3	44
45	Social Service Consultant	12	864	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	$ 30,092		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOYCE SURDICK			$ 104,527
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,527

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

Vendor/Payee	Type	Amount
	GENERAL DATA PROC	$ 15,146
	MANAGEMENT FEES	165,581
	LEGAL FEES	16,730
	ACOUNTING FEES	21,517
	HOME OFFICE MGMT	35,520
	OTHER	9,020
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 263,514

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,412
Unemployment Compensation Insurance	33,199
FICA Taxes	218,934
Employee Health Insurance	107,369
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
GROUP LIFE INSURANCE	5,690
PENSION & RETIREMENT	6,346
TOTAL (agree to Schedule V, line 22, col.8)	$ 449,950

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
ALL OTHER	31,146
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,146

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,148
GENERAL BUSINESS TRAVEL	12,088
BUSINESS MEALS	1,720
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,956

**See instructions.

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Seminar 2014

Attendee	Title	Date of Seminar	Location	Title of Seminar	Sponsor of Seminar	Cost
J. Surdick	Administrator	February	Webinar	Managed Care 101	IHCA	$50.00
A. Lohr	Rehab Manager	April	Schaumburg	Kinesiology Taping	Summit	$179.00
J. Surdick	Administrator	August	Webinar	Disaster Preparedness	IHCA	$125.00
J. Surdick	Administrator	September	Webinar	Once Excel Training	Robus IT	$19.00
L. Kozar	HR	October	Webinar	Onboarding in the 1st 10 d	Business 21 Publishing	$207.00
J. Surdick	Administrator	October	Olympia Resort	Quality Improvement	CHC	$41.00
C. Ison	DON	April	Annapolis, MD	Spring Conference	CHC	$2,115.00
C. Ison/Michell Nicke	DON/MDS Cord	October	Olympia Resort	Quality Improvement	CHC	$242.00
J. Surdick	Administrator	April	Annapolis, MD	Spring Conference	CHC	$2,115.00
Surdick, Tapaninen, I	Admin, Bus. Mnd, HF	October	Indianapolis, IN	Fall Conference	CHC	$6,900.00
S. Szabelski	Dietary	October		Recertification	IDPH	$118.00
S. Froney	Dietary	September		Food Serv. Sanitation	MCC	$175.00
S. Froney	Dietary	November		II Food Service Cert.	IDPH	$35.00
B. Goodrich	Activities	May			Northern IL Act. Prof	$40.00
B. Goodrich/M. Rozn	Activies	August		Activy Asst Training	Health Pro	$158.00
						$12,519.00

	Destination	Reason	Mileage	Rates	Time Frame	Cost
L. Kozar	Rosemont	Sales & Property T	94.00	.55 per mile	April	$65.00
J Surdick & L Tapanil	Madison, WI	AR Bootcamp			April	$227.00
L. Kozar	Lake Geneva, WI	Paryoll Demo	57.00	.55 per mile	August	$31.00
J. Durdick	Olympia Resort	Quality Improvement			October	$121.00
P. Botts	Various	Marketing			Sept- April	$183.00
						$627.00

	Cost
No single travel item greater than $250.	$1,810.00
	$14,956.00

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE

ID NUMBER: 0040915

LEGAL INVOICE SUMMARY

INVOICE DATE	FIRM	ALLOWABLE	NON ALLOWABLE	DECRIPTION OF SERVCES
1/2/2014	Waggoner Law Firm	$ 200		Facility agreement, Collection Issues
2/3/2014	Waggoner Law Firm	632		Facility agreement, Collection Issues
11/4/2014	Waggoner Law Firm	2241		Collection Issues
11/4/2014	Waggoner Law Firm	1625		Collection Issues
2/7/2014	Duane Morris	932		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
2/7/2014	Duane Morris	2126		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
3/11/2014	Duane Morris	1220		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
4/10/2014	Duane Morris	4459		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
7/10/2014	Duane Morris	709		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
10/13/2014	Duane Morris	510		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
11/10/2014	Duane Morris	1468		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
11/10/2014	Duane Morris	608		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
	Total Allowablae Invoices	$ 16,730		

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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?
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. $ **87,626**
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.