FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

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 1/1/2016 to 12/31/2016 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 Parkway, 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: 1/1/2016 Ending: 12/31/2016

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	18,666	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	18,666	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	1,940	5,830	8,035	15,805	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,940	5,830	8,035	15,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.67%

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: 1/1/2016 Ending: 12/31/2016

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	233,068	11,170	24,654	268,892		268,892		268,892			1
2	Food Purchase		158,509		158,509		158,509		158,509			2
3	Housekeeping	144,024	16,382	3,140	163,546		163,546		163,546			3
4	Laundry		4,355	4,080	8,435		8,435		8,435			4
5	Heat and Other Utilities			97,118	97,118		97,118	(8,401)	88,717			5
6	Maintenance	77,139	13,407	58,907	149,453		149,453		149,453			6
7	Other (specify):*											7
8	TOTAL General Services	454,231	203,823	187,899	845,953		845,953	(8,401)	837,552			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,858,885	62,047	60,423	1,981,355		1,981,355		1,981,355			10
10a	Therapy	530,148	495	84,226	614,869		614,869		614,869			10a
11	Activities	85,794	815	5,853	92,462		92,462		92,462			11
12	Social Services	69,807	54	864	70,725		70,725		70,725			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,544,634	63,411	161,366	2,769,411		2,769,411		2,769,411			16
	C. General Administration											
17	Administrative	163,860			163,860		163,860		163,860			17
18	Directors Fees											18
19	Professional Services			388,725	388,725		388,725	(38,781)	349,944			19
20	Dues, Fees, Subscriptions & Promotions			25,936	25,936		25,936		25,936			20
21	Clerical & General Office Expenses	181,064	12,095	93,642	286,801		286,801		286,801			21
22	Employee Benefits & Payroll Taxes			410,161	410,161		410,161		410,161			22
23	Inservice Training & Education			14,101	14,101		14,101		14,101			23
24	Travel and Seminar			22,061	22,061		22,061		22,061			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,527	46,527		46,527		46,527			26
27	Other (specify):*											27
28	TOTAL General Administration	344,924	12,095	1,001,153	1,358,172		1,358,172	(38,781)	1,319,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,343,789	279,329	1,350,418	4,973,536		4,973,536	(47,182)	4,926,354			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: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			211,717	211,717		211,717		211,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			294,635	294,635		294,635		294,635			32
33	Real Estate Taxes			75,077	75,077		75,077		75,077			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			581,429	581,429		581,429		581,429			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,886	64,945	354,831		354,831		354,831			39
40	Barber and Beauty Shops			8,692	8,692		8,692		8,692			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,029	78,029		78,029		78,029			42
43	Other (specify):*			42,610	42,610		42,610	(42,610)				43
44	**TOTAL Special Cost Centers**		289,886	194,276	484,162		484,162	(42,610)	441,552			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,343,789	569,215	2,126,123	6,039,127		6,039,127	(89,792)	5,949,335			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: 1/1/2016 Ending: 12/31/2016

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	(8,401)	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				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	(4,056)	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	(34,907)	43		24
25	Fund Raising, Advertising and Promotional	(3,647)	43		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)**	$ (51,011)		$	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))**	$ (51,011)		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

FAIR OAKS HEALTH CARE CENTER

ID# 0040915

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	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:** 1/1/2016 **Ending:** 12/31/2016

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	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	(8,401)	0	0	0	0	0	0	0	0	0	0	(8,401)	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**	(8,401)	0	0	0	0	0	0	0	0	0	0	(8,401)	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	(38,781)	0	0	0	0	0	0	0	0	0	(38,781)	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	(38,781)	0	0	0	0	0	0	0	0	0	(38,781)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,401)	(38,781)	0	0	0	0	0	0	0	0	0	(47,182)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(42,610)	0	0	0	0	0	0	0	0	0	0	(42,610)	43
44	**TOTAL Special Cost Centers**	(42,610)	0	0	0	0	0	0	0	0	0	0	(42,610)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,011)	(38,781)	0	0	0	0	0	0	0	0	0	(89,792)	45

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 56,325	WISCONSIN ILLINOIS SENIOR HOUSING	100.00%	$ 17,544	$ (38,781)	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			$ 56,325			$ 17,544	$ * (38,781)	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: 1/1/2016 Ending: 12/31/2016

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	CHARLES NASON	BOD						1
2	ANDY C. KERWIN	BOD						2
3	LORRIE DUPONT	BOD						3
4	KAREN LACKE CARRIG	BOD						4
5	KEN DEVITO	BOD						5
6	NICHOLAS LYNN	BOD						6
7	MIRIAM GEHLER	BOD						7
8	RAJEEV 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: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 2/31/2016

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: 1/1/2016 Ending: 12/31/2016

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	BUILDING NEW ADDITION		8/1/2012	$ 5,820,977	$ 5,166,076			$ 290,062	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,820,977	$ 5,166,076			$ 290,062	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	$ 5,166,076			$ 290,062	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: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 76,099	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.)		$ 75,588	2
3. Under or (over) accrual (line 2 minus line 1).		$ (511)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,588	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.		$ 75,077	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	55,207	8
	2012	45,025	9
	2013	48,642	10
	2014	50,263	11
	2015	76,099	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIR OAKS HEALTH CARE CENTER COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0040915

CONTACT PERSON REGARDING THIS REPORT JOYCE SURDICK

TELEPHONE 815-455-0550 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-31-426-020	LT1	$ 75,588.00	$ 75,588.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,588.00	$ 75,588.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 1/1/2016 Ending: 12/31/2016

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).

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: 1/1/2016 Ending: 12/31/2016

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	$	$ 591,678	4
5			2001		3,671					3,671	5
6	5			2013	4,437,265	129,331		129,331		411,405	6
7											7
8											8
	Improvement Type**										
9	WOODEN FLOORS, CARPETING, 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	163		163		21,077	11
12	SPRINKLER SYSTEM			2006	72,000	2,880		2,880		31,680	12
13	UTILITY POLE, FLOORING, CELING TILE, ELECTRICL WORK			2008	26,941	1,057		1,057		8,938	13
14	WINDOW, FLOORING			2009	37,161	3,614		3,614		27,782	14
15	FLOORING, TILES			2011	7,710	1,123		1,123		7,010	15
16	PLANK FLOORING			2012	2,321	464		464		1,973	16
17	REGULATOR FOR WATER TEMPS IN RESIDENT ROOMS			2014	4,985	499		499		1,330	17
18	NEW CARPET IN MAINHALL			2014	9,790	1,958		1,958		5,384	18
19	GENERATOR UPDATES AND ADDITIONS			2014	10,020	1,002		1,002		2,672	19
20	AUTOMATIC KITCHEN DOOR			2014	3,855	385		385		931	20
21	PLUMBING - MIXING VALVES (MIGHTY OAKS)			2014	4,025	268		268		558	21
22	VINYL FLOORING, WOOD BLINDS (REMODEL OF BEDROOM)			2014	3,127	472		472		1,062	22
23	SPRINKLER SYSTEM VALVE (MIGHTY OAKS)			2014	2,850	114		114		257	23
24	FIRE DOOR			2015	4,734	237		237		375	24
25	PLUMBING-DISHWASHER			2015	1,521	76		76		133	25
26	AUTOMATIC DOOR CLOSER			2015	1,540	103		103		180	26
27	KITCHEN DOOR-REPLACE			2016	1,797	7		7		7	27
28	PLUMBING-HOT WATER HEATER			2016	2,172	9		9		9	28
29											29
30	LAND IMPROVEMENTS										30
31	REMOVE/REPLACE CONCRETE			2000	11,660	275		275		10,584	31
32	PARKING LOT			2004	15,000	750		750		9,375	32
33	LANDSCAPING (OAK TREES)			2006	3,450	230		230		2,377	33
34	LANDSCAPE/TREE REPLACEMENT			2015	2,435	244		244		487	34
35	REMOVE/REPLACE CONCRETE SIDEWALKS			2016	4,650	181		181		181	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: 1/1/2016 Ending: 12/31/2016

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)		$ 6,081,575	$ 179,514		$ 179,514	$	$ 1,196,517	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: 1/1/2016 Ending: 12/31/2016

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	$ 817,677	$ 31,143	$ 31,143	$		$ 734,087	71
72	Current Year Purchases	8,457	1,060	1,060			1,060	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 826,134	$ 32,203	$ 32,203	$		$ 735,147	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)	$ 7,107,709	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 211,717	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,717	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)	$ 1,931,664	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: 1/1/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 12/31/2016

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	13572 hrs	$ 201,916		$	$	13,572	$ 201,916	1
2	Licensed Speech and Language Development Therapist	L10A,C3	2295 hrs	58,186		30,695	495	2,295	89,376	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	21388 hrs	270,046				21,388	270,046	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			$ 530,148		$ 30,695	$ 495	37,255	$ 561,338	14

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER **#** 0040915 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 283,627	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	606,788		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,348		6
7	Other Prepaid Expenses	11,644		7
8	Accounts Receivable (owners or related parties)	1,338,141		8
9	Other(specify):	46,066		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,300,614	$	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	6,058,895		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	871,968		16
17	Accumulated Depreciation (book methods)	(1,927,815)		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):	65,486		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,277,895	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,578,509	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,889	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	269,369		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,740		32
33	Accrued Interest Payable	118,885		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany Loans	33,694		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 696,577	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,166,076		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)**	$ 5,166,076	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,862,653	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,715,856	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,578,509	$	48

***(See instructions.)**

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,643,282	1
2	Restatements (describe):		2
3	**Real Estate Tax Adjustment**	(4,290)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,638,992	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	76,864	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)**	$ 76,864	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)**	$ 1,715,856	24 *

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 4,134,030	1
2	Discounts and Allowances for all Levels	(215,060)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,918,970	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,388,013	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,388,013	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	10,683	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	575,434	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	68,866	19
20	Radiology and X-Ray	18,532	20
21	Other Medical Services	95,549	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 769,064	23
	D. Non-Operating Revenue		
24	Contributions	28,415	24
25	Interest and Other Investment Income***	13	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,428	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Employee & Guest Measl, Fees and Rebates	11,516	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,516	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,115,991	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	845,953	31
32	Health Care	2,769,411	32
33	General Administration	1,358,172	33
	B. Capital Expense		
34	Ownership	581,429	34
	C. Ancillary Expense		
35	Special Cost Centers	406,133	35
36	Provider Participation Fee	78,029	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,039,127	40
41	**Income before Income Taxes (line 30 minus line 40)****	76,864	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 76,864	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: 1/1/2016 Ending: 12/31/2016

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	1,902	2,080	$ 80,149	$ 38.53	1
2	Assistant Director of Nursing	1,208	1,288	34,953	27.14	2
3	Registered Nurses	20,505	21,709	706,238	32.53	3
4	Licensed Practical Nurses	8,760	9,584	262,589	27.40	4
5	CNAs & Orderlies	53,084	56,424	742,768	13.16	5
6	CNA Trainees					6
7	Licensed Therapist	13,016	13,016	530,148	40.73	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,363	2,521	37,499	14.87	9
10	Activity Assistants	5,124	5,324	48,295	9.07	10
11	Social Service Workers	3,794	4,074	69,807	17.13	11
12	Dietician					12
13	Food Service Supervisor	1,874	2,032	33,762	16.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,088	16,959	199,306	11.75	15
16	Dishwashers					16
17	Maintenance Workers	3,688	4,094	77,139	18.84	17
18	Housekeepers	13,483	14,539	144,024	9.91	18
19	Laundry					19
20	Administrator	1,948	2,168	117,091	54.01	20
21	Assistant Administrator	1,042	1,082	46,769	43.22	21
22	Other Administrative	7,824	8,137	128,252	15.76	22
23	Office Manager	1,956	2,156	52,812	24.50	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	2,217	2,329	32,188	13.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,876	169,516	$ 3,343,789 *	$ 19.73	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	401	$ 22,732	L1,C3	35
36	Medical Director	12	10,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	750		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	3,303		44
45	Social Service Consultant	16	864		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	486	$ 37,649		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: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOYCE SURDICK	Administrator		$ 117,091
ALLISON FRAWLEY	Asst Administrator		46,769
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 163,860

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
See Professional Services Schedule	Data Processing	$ 17,986
Carriage Healthcare, Inc.	Management Fees	227,880
See Legal Supplemental Schedule	Legal Fees	62,945
See Professional Services Schedule	Accounting Fees	15,347
Wisconsin Illinois Senior Housing	Home Office Mgmt	56,325
See Professional Services Schedule	Other	8,242
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 388,725

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,576
Unemployment Compensation Insurance	21,715
FICA Taxes	248,188
Employee Health Insurance	79,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	2,483
Pension & Retirement	11,051
TOTAL (agree to Schedule V, line 22, col.8)	$ 410,161

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,204
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	16,732
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,936

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,433
General Business Travel	10,255
Business Meals	1,373
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,061

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. $ **78,029**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Anderson, Zurmuehlen & Co PC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Travel and Seminar 2016

Attendee	Title	Date of Seminar	Location	Title of Seminar	Sponsor of Seminar	Cost
J. Surdick/A. Frawley	Administrator	4/6/2016	Orlando FL	BCPI	Remedy Partners	$148
R. Burns	Activity Director	6/24/2016	DeKalb, IL	Northern Illinois Activity Professionals	DeKalb County Rehab and Nursing Center	$40
S. Froney	Dietary Department	June-December 2016	online	DSB Food Handlers certification	DSB	$140
S. Froney	Dietary Manager	7/21/2016			Association of Nutrition & Food Service professional	$155
C. Ison	DON	Apr-16	Puerta Vallarta	Spring Conference	CHC	$2,061
C. Ison	DON	9/28/2016	Baltimore MD	Aligning for the Future of Post -Acute Care	AANC	$175
D. Reising	Care Plan Coordinator	9/28/2016	Baltimore MD	Aligning for the Future of Post -Acute Care	AANC	$175
C. Ison	DON	9/28/2016	Baltimore MD	Aligning for the Future of Post -Acute Care		$663
J. Surdick/A. Frawley	Administrator	4/6/2016	Orlando FL	BCPI	Remedy Partners	$306
C. Blair	Admissions/Marketing	March	various	Marketing		$71
J. Surdick	Administrator	March	Elkhorn WI	Meals		$54
J. Surdick	Administrator	4/16/2016	Puerta Vallarta	Spring Conference	CHC	$2,061
J. Surdick/A Frawley	Administrator	4/6/2017	Orlando FL	BCPI	Remedy Partners	$1,072
J. Surdick/A Frawley/L Tapaninen	Admin/Admin Assist./Business Office Mgr	4/1/2016	Pewaukee, MI	Boot Camp	CHC	$439
A. Frawley	Assist. Admin	5/4/2016	Wisconsin Dells	Annual Business Meeting	Leading Age	$384
J. Surdick/ A Frawley/Ltapaninen/P Juarez	Admin/Assist/Admin/BOM/HR	11/1/2016	Scottsdale AZ	Fall Conference	CHC	$1,213
J. Surdick/ A Frawley/Ltapaninen/P Juarez	Admin/Assist/Admin/BOM/HR	11/1/2016	Scottsdale AZ	Fall Conference	CHC	$515
A. Frawley	Assist. Admin	11/1/2016	Philadelphia, PA	BCPI	Remedy Partners	$835
A. Lohr	Rehab Mgr	12/1/2016	Edgerton, WI	Update on Treatment Codes	Progressive Beginnings	$83
J. Surdick	Administrator	3/1/2016	Richmond Illinois	Meals		$49
J. Surdick/ A Frawley/Ltapaninen	Adminis/Assist Admin/BOM	4/1/2016	Pewaukee, MI	Boot Camp/Meals	CHC	$604
J. Surdick	Administrator	5/1/2016		Error		$36
C Ison/D Reising	DOB/Care Plan Coordinator	9/28/2016	Baltimore MD	Aligning for the Future of Post -Acute Care		$99
J. Surdick/ A Frawley/Ltapaninen/P Juarez		10/1/2016	Scottsdale AZ	Fall Conference	CHC	$466
A. Frawley	Assistant Administrator	11/1/2016	Philadelphia, PA	BCPI	Remedy Partners	$120
Staff		2016		CE Solutions employee online courses		$2,117
A. Frawley	Assistant Administrator	5/4/2016	Wisconsin Dells	Leading Age		$285
P Juarez	HR	8/5/2016	Online	Business Management Daily		$197
Staff		2016		CE Solutions employee online courses		$299
J. Surdick/ A Frawley/Ltapaninen/P Juarez	Admin/Assist/Admin/BOM/HR	11/012016	Scottsdale AZ	Fall Conference		$7,200
					Travel and Seminars:	**$22,061**

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Inservice Training and Education 2016

Attendee	Title	Location	Reason	Time Frame	Cost
C. Smith		Rasmussen College, Bloomington, MN	Registered Nurse Degree	Summer Quarter 2016 (7/5/16-9/17/16)	$5,505
C. Smith		Rasmussen College, Bloomington, MN	Registered Nurse Degree	Fall Quarter 2016 (10/3/16-12/17/16)	$5,525
M Nickett	Wound Care Education	Wound Care Eduction Institute, Glenview, IL	Wound Care	March	$60
C. Ison	Wound Care Education	Wound Care Eduction Institute, Glenview, IL	Wound Care	March	$60
Nursing Staff	Atec	Fair Oaks, Crystal Lakes, IL	CPR Certification	August	$180
Nursing Staff	LeadingAge	Illinois	1 Year Membership	2016-2017	$393
D. Reising	AANAC	Baltimore, MD	Nursing Assessment Cordinator	September	$650
C. Ison	AANAC	Baltimore, MD	Nursing Assessment Cordinator	September	$649
C. Ison	AADNS	Denver CO	1 Year Membership	September 2016-2017	$199
I Doyle		Galena, IL	Modality Training	January 22, 2016	$213
R Jugueta	MPS Advanced Circuit	Hoffman Estates	Intro Needless Acupunture for Pain	February 1, 2016	$110
A. Johnson	Rehab Connections	Homer Glen , IL	Core Trunk Strengthening	September 23, 2016	$119
R Jugueta	MPS Advanced Circuit	Hoffman Estates	Advanced Needless Acupunture for Pain	October 8 and 8 2016	$299
A Fleischmann	Northern Speech Services	On line	Dysphagia Assessments	January-2016	$139
				Inservice Training & Education	**$14,101**

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE

ID NUMBER: 0040915

LEGAL INVOICE SUMMARY

INVOICE DATE	FIRM	ALLOWABLE	NON ALLOWABLE	DESCRIPTION OF SERVCES
1/4/2016	The Waggoner Law Firm	$200		Employee Issues and Collections
1/25/2016	Duane Morris LLP	$680		Regulatory and Compliance
1/25/2016	Duane Morris LLP	$5,760		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
2/9/2016	Duane Morris LLP	$9,449		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
2/9/2016	Duane Morris LLP	$278		Regulatory and Compliance
3/8/2016	Duane Morris LLP	$6,606		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
4/20/2016	Duane Morris LLP	$16,304		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
5/1/2016	The Waggoner Law Firm	$550		Lawsuit against Bulthuis for funds owed to facility
5/2/2016	The Waggoner Law Firm	$719		Lawsuit against Bulthuis for funds owed to facility
5/11/2016	Duane Morris LLP	$1,684		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
6/20/2016	Duane Morris LLP	$1,033		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
7/5/2016	The Waggoner Law Firm	$138		Lawsuit against Bulthuis for funds owed to facility
7/25/2016	Duane Morris LLP	$11,976		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
8/4/2016	The Waggoner Law Firm	$138		Lawsuit against Bulthuis for funds owed to facility
8/11/2016	The Waggoner Law Firm	$344		Lawsuit against Bulthuis for funds owed to facility
8/18/2016	Duane Morris LLP	$2,662		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
9/1/2016	The Waggoner Law Firm	$316		Lawsuit against Bulthuis for funds owed to facility
9/20/2016	Duane Morris LLP	$278		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
10/3/2016	The Waggoner Law Firm	$660		Lawsuit against Bulthuis for funds owed to facility
10/24/2016	Duane Morris LLP	$1,712		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
11/1/2016	The Waggoner Law Firm	$206		Lawsuit against Bulthuis for funds owed to facility
11/14/2016	Duane Morris LLP	$348		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
12/2/2016	The Waggoner Law Firm	$421		Lawsuit against Bulthuis for funds owed to facility
12/2/2016	The Waggoner Law Firm	$138		Employee Issues
12/19/2016	Duane Morris LLP	$348		Lawsuit regarding Certificate of Need Decision by Health Facilities and Services Review Board
	Total Allowable Invoices:	$62,945		
	Duane Morris	**$59,117**		
	The Waggoner Law Firm	**$3,828**		
		$62,945		

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE

ID NUMBER: 0040915

PROFESSIONAL SERVICES - 2016

Vendor	Account#/Description	Amount	
Ascentis Payroll	General Data Processing Fees	$17,986	
Total General Data Processing Fees		**$17,986**	
Carriage Healthcare Companines	Management Fees	$227,880	
Total Management Fees		**$227,880**	
Duane Morris LLP	Legal Fees	$59,117	
The Waggoner Law Firm PC	Legal Fees	$3,828	
Total Legal Fees		**$62,945**	
PDR Certified Public Accountants	Professional Accounting Fees	$3,400	
JT & Associates, LLC	Professional Accounting Fees	$1,925	
Wisconsin Illinois Senior Housing	Professional Accounting Fees	$10,022	
Total Professoinal Accounting Fees		**$15,347**	
Wisconsin Illinois Senior Housing	Home Office (Owner Fees)	$56,325	
Total Home Office (Owner Fees)		**$56,325**	
Employee Health Consultants	Professional Services	$1,400	Employee Assistance Program
Applied Computer Technologies	Professional Services	$4,484	IT for Computers
Wisconsin Illinois Senior Housing	Professional Services	$2,358	Services provided and retained by WISH and billed to facility
Total Professional Services		**$8,242**	
	Grand Total:	**$388,725**	