FOR BHF USE

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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.

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

I. IDPH License ID Number: 0050963

Facility Name: Fair Oaks Rehab & HCC

Address: 1515 Blackhawk (Number) South Beloit (City) 61080 (Zip Code)

County: Winnebago

Telephone Number: (815) 389-3911 **Fax #** (815) 389-5065

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2010

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kevin Wellen **Telephone Number:** 314-925-4446
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 1/01/2016 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 Fax # 314-925-4350

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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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 N/A

	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	78	Skilled (SNF)	78	28,548	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	78	TOTALS	78	28,548	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	14,112	3,425	7,064	24,601	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,112	3,425	7,064	24,601	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.17%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 7/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 3,661

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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		1,741	399,279	401,020		401,020		401,020			1
2	Food Purchase		12,833		12,833		12,833	(495)	12,338			2
3	Housekeeping		16,817	91,224	108,041		108,041		108,041			3
4	Laundry		6,718	55,655	62,373		62,373		62,373			4
5	Heat and Other Utilities			112,252	112,252		112,252		112,252			5
6	Maintenance	53,599	7,072	66,840	127,511		127,511	6,425	133,936			6
7	Other (specify):*											7
8	TOTAL General Services	53,599	45,181	725,250	824,030		824,030	5,930	829,960			8
	B. Health Care and Programs											
9	Medical Director					13,000	13,000		13,000			9
10	Nursing and Medical Records	1,577,305	72,660	106,591	1,756,556	(13,000)	1,743,556		1,743,556			10
10a	Therapy											10a
11	Activities	71,097	23,304	4,516	98,917		98,917		98,917			11
12	Social Services	50,200		3,472	53,672		53,672		53,672			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,698,602	95,964	114,579	1,909,145		1,909,145		1,909,145			16
	C. General Administration											
17	Administrative	89,208			89,208		89,208		89,208			17
18	Directors Fees											18
19	Professional Services			79,975	79,975		79,975	246,295	326,270			19
20	Dues, Fees, Subscriptions & Promotions			42,053	42,053		42,053	(2,458)	39,595			20
21	Clerical & General Office Expenses	113,708	22,022	541,178	676,908		676,908	(481,106)	195,802			21
22	Employee Benefits & Payroll Taxes			285,318	285,318		285,318		285,318			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,686	2,686		2,686	(264)	2,422			24
25	Other Admin. Staff Transportation			5,543	5,543		5,543	(3,905)	1,638			25
26	Insurance-Prop.Liab.Malpractice			120,953	120,953		120,953	789	121,742			26
27	Other (specify):*											27
28	TOTAL General Administration	202,916	22,022	1,077,706	1,302,644		1,302,644	(240,649)	1,061,995			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,955,117	163,167	1,917,535	4,035,819		4,035,819	(234,719)	3,801,100			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 Rehab & HCC #0050963 Report Period Beginning: 1/01/2016 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			2,244	2,244		2,244	157,196	159,440			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,792	1,792		1,792	205,138	206,930			32
33	Real Estate Taxes			88,800	88,800		88,800	5,349	94,149			33
34	Rent-Facility & Grounds			209,370	209,370		209,370	(209,370)				34
35	Rent-Equipment & Vehicles			9,691	9,691		9,691		9,691			35
36	Other (specify):* **Mortgage Ins**							79,980	79,980			36
37	**TOTAL Ownership**			311,897	311,897		311,897	238,293	550,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		168,129	747,257	915,386		915,386		915,386			39
40	Barber and Beauty Shops		18	415	433		433		433			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,108	173,108		173,108		173,108			42
43	Other (specify):* **Marketing**	51,594		23,587	75,181		75,181	(75,181)				43
44	**TOTAL Special Cost Centers**	51,594	168,147	944,367	1,164,108		1,164,108	(75,181)	1,088,927			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,006,711	331,314	3,173,799	5,511,824		5,511,824	(71,607)	5,440,217			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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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				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	(1,046)	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	(1,430)	21		18
19	Entertainment	(17,298)	21		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	(70,776)	21		24
25	Fund Raising, Advertising and Promotional	(23,587)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,591)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(59,644)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (179,372)		$	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)	107,765		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 107,765		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (71,607)		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 Rehab & HCC

ID# 0050963

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (888)	21	1
2	Vending Machine Revenues	(495)	2	2
3	Marketing Salary	(51,594)	43	3
4	Marketing Transportation	(3,905)	25	4
5	Marketing Seminars	(264)	24	5
6	Marketing Vechile Expense	(40)	6	6
7	PAC Dues & Lobbying Portion of Dues	(2,033)	20	7
8	Chamber of Commerce	(425)	20	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**	(59,644)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks Rehab & HCC **#** 0050963 **Report Period Beginning:** 1/01/2016 **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	(495)	0	0	0	0	0	0	0	0	0	0	(495)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(40)	6,465	0	0	0	0	0	0	0	0	0	6,425	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(535)	6,465	0	0	0	0	0	0	0	0	0	5,930	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	8,647	237,648	0	0	0	0	0	0	0	0	246,295	19
20	Fees, Subscriptions & Promotions	(2,458)	0	0	0	0	0	0	0	0	0	0	(2,458)	20
21	Clerical & General Office Expenses	(95,983)	0	(385,123)	0	0	0	0	0	0	0	0	(481,106)	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	(264)	0	0	0	0	0	0	0	0	0	0	(264)	24
25	Other Admin. Staff Transportation	(3,905)	0	0	0	0	0	0	0	0	0	0	(3,905)	25
26	Insurance-Prop.Liab.Malpractice	0	789	0	0	0	0	0	0	0	0	0	789	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(102,610)	9,436	(147,475)	0	0	0	0	0	0	0	0	(240,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(103,145)	15,901	(147,475)	0	0	0	0	0	0	0	0	(234,719)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 **Report Period Beginning:** 1/01/2016 **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	147,711	9,485	0	0	0	0	0	0	0	0	157,196	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,046)	206,184	0	0	0	0	0	0	0	0	0	205,138	32
33	Real Estate Taxes	0	5,349	0	0	0	0	0	0	0	0	0	5,349	33
34	Rent-Facility & Grounds	0	(209,370)	0	0	0	0	0	0	0	0	0	(209,370)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	79,980	0	0	0	0	0	0	0	0	0	79,980	36
37	**TOTAL Ownership**	(1,046)	229,854	9,485	0	0	0	0	0	0	0	0	238,293	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):*	(75,181)	0	0	0	0	0	0	0	0	0	0	(75,181)	43
44	**TOTAL Special Cost Centers**	(75,181)	0	0	0	0	0	0	0	0	0	0	(75,181)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(179,372)	245,755	(137,990)	0	0	0	0	0	0	0	0	(71,607)	45

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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
See Board Listing at PG6-Supp		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 209,370	TI- South Beloit	100.00%	$	$ (209,370)	1
2	V	32	Interest		TI- South Beloit	100.00%	206,184	206,184	2
3	V	19	Legal		TI- South Beloit	100.00%	450	450	3
4	V	19	Accounting		TI- South Beloit	100.00%	8,197	8,197	4
5	V	36	Mortgage Interest Premium		TI- South Beloit	100.00%	11,336	11,336	5
6	V	30	Depreciation		TI- South Beloit	100.00%	147,711	147,711	6
7	V	36	Amortization		TI- South Beloit	100.00%	68,644	68,644	7
8	V	6	Maintenance		TI- South Beloit	100.00%	6,465	6,465	8
9	V	33	Real Estate Taxes	88,800	TI- South Beloit	100.00%	94,149	5,349	9
10	V	26	Insurance	9,000	TI- South Beloit	100.00%	9,789	789	10
11	V								11
12	V								12
13	V								13
14	Total			$ 307,170			$ 552,925	$ * 245,755	14

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Management - Operating	$ 43,645	Tutera Health Care Services	100.00%	$ 281,293	$ 237,648	15
16	V	30	Management - Depreciation		Tutera Health Care Services	100.00%	9,485	9,485	16
17	V	21	Management Fee	289,273	Tutera Health Care Services	100.00%		(289,273)	17
18	V	10	Nursing Admin - Purchased Svs	2,310	Walnut Creek Management Company LLC		2,310		18
19	V	21	Postage & Small Equipment	18,680	Walnut Creek Management Company LLC		18,680		19
20	V	10	Nursing Purchased Services	2,025	Crystal Pines Rehab & Healthcare		2,025		20
21	V	24	Seminar Expenses	375	Walnut Creek Management Company LLC		375		21
22	V	21	Asset Management Fee	95,850	JCT Capital LLC			(95,850)	22
23	V	26	Insurance	109,906	LTC Plus Insurance Inc.		109,906		23
24	V	20	Dues	500	Walnut Creek Management Company LLC		500		24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 562,564			$ 424,574	$ * (137,990)	39

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	Joseph Tutera	100%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI - Metropolis	Metropolis, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Manage	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Se	Kansas City, MO	Management Co	3
4			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Cen	Crystal Lake, IL	Walnut Creek New En	Kansas City, MO	Management Co	5
6			Dixon Rehabilitation & Health Care Center	Dixon, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	6
7			Hamilton Memorial Rehabilitation & Health Ca	McLeansboro, IL	The Atriums Senior Li	Overland Park, KS	Independent/Assiste	7
8			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Carnegie Village Senio	Belton, MO	Independent/Assiste	8
9			Highland Rehabilitation & Health Care Center	Kansas City, MO	Continua Home Healt	Kansas City, MO	Home Health	9
10			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Hospice KS	Kansas	Hospice	10
11			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice MO	Missouri	Assisted Living	11
12			Mattoon Rehabilitation & Health Care Center	Matoon, IL	Country Gardens Assi	Muskogee, OK	Assisted Living	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens Senic	Statesboro, GA	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care C	Independence, MO	Lamar Court Assisted	Overland Park, KS	Assisted Living	14
15			Montgomery Chilren's Specialty Center	Montgomery, AL	Oakley Courts Assiste	Freeport, IL	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Center	Moweaqua, IL	Rose Estates Assisted I	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons M	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, KS	Independent/Assiste	18
19			Charlton Place Rehabilitation & Health Care Ce	Deatsville, AL	Wesley Court Assisted	Boiling Springs, SC	Assisted Living	19
20			Startford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place Assisted	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Car	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Cent	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Center	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood Nurisng Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rehabilitation & Health Care Cente	Coulterville, IL				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Close to Home	Matthews, MO				30

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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			Holly Ridge	Dexter, MO				1
2			Ramsey Creek	Scott City, MO				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	N/A								$		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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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 [X] NO [ ]

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

Name of Related Organization: Tutera Health Care Services
Street Address: 7611 State Line Road
City / State / Zip Code: Kansas City, Missouri 64114
Phone Number: (816-444-0900
Fax Number: (816-822-0081

	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	19	Management Fee - Operating	Direct Costs	186,997,591	47	$ 10,144,719	$ 7,332,933	5,185,059	$ 281,292	1
2	30	Management Fee - Capital	Direct Costs	186,997,591	47	342,075		5,185,059	9,485	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					$ 10,486,794	$ 7,332,933		$ 290,777	25

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	Tutera Investments		X	Note Payable			$	$ 816,591			$ 1,792	1
2	TI - South Beloit		X	Mortgage Payable HUD Loan				2,246,949			206,184	2
3	Interest Income										(1,046)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,063,540			$ 206,930	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 3,063,540			$ 206,930	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,336 Line # 36

*** 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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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.**	$	94,535	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.)	$	94,149	2
3. Under or (over) accrual (line 2 minus line 1).	$	(386)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	94,535	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.	$	94,149	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	86,673	8
	2012	91,681	9
	2013	93,608	10
	2014	94,535	11
	2015	94,149	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 Rehab & HCC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0050963

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

TELEPHONE 314-925-4446 FAX #: 314-925-4350

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.	04-07-258-002	Long Term Care Facility	$ 94,148.62	$ 94,148.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 94,148.62	$ 94,148.62

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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,393 B. General Construction Type: Exterior Brick and Block Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	14,393	2010	$ 233,678	1
2					2
3	TOTALS	14,393		$ 233,678	3

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	78		2010	1975	$ 2,249,147	$ 81,787	39	$ 81,787	$	$ 531,617	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater (TI-South Beliot)			2012	5,886	841	7	841		4,064	9
10	Fire Sprinkler System (TI-South Beloit)			2013	6,071	405	15	405		1,248	10
11	Water Heater (TI-South Beliot)			2014	5,243	524	10	524		1,486	11
12	Rooftop HVAC			2013	6,946	239	15	239		4,794	12
13	Ceiling Insulation			2013	6,626	1,073	7	1,073		3,941	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	Home Office and Allocated Depreciation					9,485		9,485			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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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)		$ 2,279,919	$ 94,354		$ 94,354	$	$ 547,150	70

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	$ 507,665	$ 52,762	$ 52,762	$	10	$ 473,296	71
72	Current Year Purchases	6,361	742	742		5	742	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 514,026	$ 53,504	$ 53,504	$		$ 474,038	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		Van	6/1/2012	$ 57,910	$ 11,582	$ 11,582	$	5	$ 53,084	76
77										77
78										78
79										79
80	TOTALS			$ 57,910	$ 11,582	$ 11,582	$		$ 53,084	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,085,533	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 159,440	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 159,440	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)	$ 1,074,272	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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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 [X] 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 [X] NO

16. Rental Amount for movable equipment: $ 9,691 Description: Dietary, Laundry, and Copier (see WTB)
(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 Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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 Rehab & HCC

STATE OF ILLINOIS
0050963 Report Period Beginning: 1/01/2016 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	V39-3	hrs	$	15,113	$ 244,834	$	15,113	$ 244,834	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		3,710	60,096		3,710	60,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		19,704	319,202	283	19,704	319,485	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				127,934		127,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					123,125	39,912		163,037	13
14	TOTAL			$	38,527	$ 747,257	$ 168,129	38,527	$ 915,386	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 Rehab & HCC **#** 0050963 **Report Period Beginning:** 1/01/2016 **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	$ 172,709	$ 191,799	1
2	Cash-Patient Deposits	15,944	15,944	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,246,949	1,246,949	3
4	Supply Inventory (priced at)	11,481	11,481	4
5	Short-Term Investments			5
6	Prepaid Insurance	113,240	118,447	6
7	Other Prepaid Expenses	97,083	104,532	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	25,692	140,951	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,683,098	$ 1,830,103	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		233,678	13
14	Buildings, at Historical Cost		2,266,348	14
15	Leasehold Improvements, at Historical Cost	13,571	13,571	15
16	Equipment, at Historical Cost	12,276	571,936	16
17	Accumulated Depreciation (book methods)	(14,183)	(1,074,272)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Long-Term Assets	34,948	64,575	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 46,612	$ 2,075,836	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,729,710	$ 3,905,939	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 401,230	$ 401,230	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,944	15,944	28
29	Short-Term Notes Payable	816,591	816,591	29
30	Accrued Salaries Payable	122,713	122,713	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,472	69,472	31
32	Accrued Real Estate Taxes(Sch.IX-B)		94,535	32
33	Accrued Interest Payable		13,076	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	(3,910)	(3,910)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,422,040	$ 1,529,651	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,246,949	39
40	Mortgage Payable			40
41	Bonds Payable			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)**	$	$ 2,246,949	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,422,040	$ 3,776,600	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 307,670	$ 129,339	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,729,710	$ 3,905,939	48

***(See instructions.)**

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 149,310	1
2	Restatements (describe):		2
3	**Prior year adjustments**	54,763	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 204,073	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	271,097	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	(167,500)	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)**	$ 103,597	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)**	$ 307,670	24 *

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

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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	$ 5,199,255	1
2	Discounts and Allowances for all Levels	(2,843,813)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,355,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,945,101	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,945,101	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	495	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(940)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	267,677	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,975	19
20	Radiology and X-Ray		20
21	Other Medical Services	164,237	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 480,444	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,046	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,046	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	888	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 888	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,782,921	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	824,030	31
32	Health Care	1,909,145	32
33	General Administration	1,302,644	33
	B. Capital Expense		
34	Ownership	311,897	34
	C. Ancillary Expense		
35	Special Cost Centers	991,000	35
36	Provider Participation Fee	173,108	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,511,824	40
41	**Income before Income Taxes (line 30 minus line 40)****	271,097	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 271,097	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,441,832	44
45	Private Pay - Net Inpatient Revenue	648,346	45
46	Medicare - Net Inpatient Revenue	(494,364)	46
47	Other-(specify) Insurance	(240,372)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,355,442	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

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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	4,138	4,638	$ 159,825	$ 34.46	1
2	Assistant Director of Nursing	0	0			2
3	Registered Nurses	11,590	12,441	402,252	32.33	3
4	Licensed Practical Nurses	12,991	13,412	364,719	27.19	4
5	CNAs & Orderlies	47,807	50,562	635,212	12.56	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	0	0			9
10	Activity Assistants	5,856	6,194	71,097	11.48	10
11	Social Service Workers	2,577	2,926	50,200	17.16	11
12	Dietician	0	0			12
13	Food Service Supervisor	0	0			13
14	Head Cook	0	0			14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0			16
17	Maintenance Workers	2,005	2,217	53,599	24.18	17
18	Housekeepers	0	0			18
19	Laundry	0	0			19
20	Administrator	1,680	1,988	89,208	44.87	20
21	Assistant Administrator	0	0			21
22	Other Administrative	0	0			22
23	Office Manager	0	0			23
24	Clerical	5,020	5,833	113,708	19.49	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	379	403	15,297	37.98	31
32	Other Health Care(specify)	0	0			32
33	Other(specify) Marketing	1,832	1,992	51,594	25.90	33
34	TOTAL (lines 1 - 33)	95,875	102,605	$ 2,006,711 *	$ 19.56	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	Monthly	$ 399,279	V01-3	35
36	Medical Director	Monthly	13,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,184	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,516	V11-3	44
45	Social Service Consultant	Monthly	3,472	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 428,451		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 45,348	V10-3	50
51	Licensed Practical Nurses		32,307	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 77,655		53

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Storey, Shelia	Admin	0	$ 89,208
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,208

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
Danile Maher Law Offices	Legal Fees	$ 200
Tutera Health Care Services	Data Processing	7,396
Various	Data Processing	41,412
Marcum, LLP	Accounting	8,585
Property Valuation Services	Compliance	100
Accrued Prof Services	Unnamed	138
Allscripts	General Prof Svcs	1,710
Pinnacle Quality Insight	Customer Satisfaction Survey	1,524
PointClickCare	Data Processing	16,589
Lathrop Gage	Legal Fees	117
Heyl Royster Voelker & Allen	Legal Fees	2,204
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 79,975

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,511
Unemployment Compensation Insurance	0
FICA Taxes	181,055
Employee Health Insurance	43,765
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	11,987
TOTAL (agree to Schedule V, line 22, col.8)	$ 285,318

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	$ 1,990
Advertising: Employee Recruitment	28,949
Health Care Worker Background Check	
(Indicate # of checks performed 189)	1,899
IL Healthcare Association	5,148
Dues & Subscriptions	4,067
Less: Public Relations Expense	(2,458)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,595

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,422
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,422

**See instructions.

Facility Name & ID Number Fair Oaks Rehab & HCC # 0050963 Report Period Beginning: 1/01/2016 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? **Yes**
If YES, give association name and amount. **IL Healthcare Association $5,148**

(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? **N/A**

(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? **N/A**

(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? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,284** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **173,108**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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