FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0040915

Facility Name: FAIR OAKS HEALTH CARE CENTER

Address: 471 W TERRA COTTA (Number) CRYSTAL LAKE (City) 60014-3434 (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: NICOLE LOPEZ **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 1/1/2017 to 12/31/2017 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) NICOLE LOPEZ
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) GARY JOHNSEN, PARTNER-CPA
(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: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,825	5,124	8,161	15,110	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,825	5,124	8,161	15,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.17%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve 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: 1/1/2017 Ending: 12/31/2017

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	249,832	10,374	27,979	288,185		288,185		288,185			1
2	Food Purchase		155,442		155,442		155,442		155,442			2
3	Housekeeping	149,752	17,222	3,139	170,113		170,113		170,113			3
4	Laundry		2,078	1,975	4,053		4,053		4,053			4
5	Heat and Other Utilities			104,063	104,063		104,063	(8,754)	95,309			5
6	Maintenance	80,835	12,981	55,377	149,193		149,193		149,193			6
7	Other (specify):*											7
8	TOTAL General Services	480,419	198,097	192,533	871,049		871,049	(8,754)	862,295			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	2,018,643	60,827	35,831	2,115,301		2,115,301		2,115,301			10
10a	Therapy	611,599	2,008	42,585	656,192		656,192		656,192			10a
11	Activities	84,080	1,120	6,124	91,324		91,324		91,324			11
12	Social Services	74,470		1,152	75,622		75,622		75,622			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,788,792	63,955	95,692	2,948,439		2,948,439		2,948,439			16
	C. General Administration											
17	Administrative	208,827			208,827		208,827		208,827			17
18	Directors Fees											18
19	Professional Services			351,911	351,911		351,911	(23,420)	328,491			19
20	Dues, Fees, Subscriptions & Promotions			23,858	23,858		23,858		23,858			20
21	Clerical & General Office Expenses	188,157	10,492	81,019	279,668		279,668		279,668			21
22	Employee Benefits & Payroll Taxes			472,170	472,170		472,170		472,170			22
23	Inservice Training & Education			13,857	13,857		13,857		13,857			23
24	Travel and Seminar			14,997	14,997		14,997		14,997			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,355	28,355		28,355		28,355			26
27	Other (specify):*											27
28	TOTAL General Administration	396,984	10,492	986,167	1,393,643		1,393,643	(23,420)	1,370,223			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,666,195	272,544	1,274,392	5,213,131		5,213,131	(32,174)	5,180,957			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: 1/1/2017 Ending: 12/31/2017

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			210,231	210,231		210,231		210,231			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			286,570	286,570		286,570		286,570			32
33	Real Estate Taxes			76,990	76,990		76,990		76,990			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			573,791	573,791		573,791		573,791			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,845	82,408	379,253		379,253		379,253			39
40	Barber and Beauty Shops			6,899	6,899		6,899		6,899			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,667	74,667		74,667		74,667			42
43	Other (specify):*			111,145	111,145		111,145	(111,145)				43
44	**TOTAL Special Cost Centers**		296,845	275,119	571,964		571,964	(111,145)	460,819			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,666,195	569,389	2,123,302	6,358,886		6,358,886	(143,319)	6,215,567			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: 1/1/2017 Ending: 12/31/2017

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	(8,754)	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	(7,783)	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	(98,697)	43		24
25	Fund Raising, Advertising and Promotional	(4,665)	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)**	$ (119,899)		$	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))**	$ (119,899)		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: 1/1/2017

Ending: 12/31/2017

	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: 1/1/2017 Ending: 12/31/2017

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	(8,754)	0	0	0	0	0	0	0	0	0	0	(8,754)	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	(8,754)	0	0	0	0	0	0	0	0	0	0	(8,754)	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	(23,420)	0	0	0	0	0	0	0	0	0	(23,420)	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	(23,420)	0	0	0	0	0	0	0	0	0	(23,420)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,754)	(23,420)	0	0	0	0	0	0	0	0	0	(32,174)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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):*	(111,145)	0	0	0	0	0	0	0	0	0	0	(111,145)	43
44	**TOTAL Special Cost Centers**	(111,145)	0	0	0	0	0	0	0	0	0	0	(111,145)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(119,899)	(23,420)	0	0	0	0	0	0	0	0	0	(143,319)	45

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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, IL			
		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			
		INGELSIDE 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	$ 59,550	WISCONSIN ILLINOIS SENIOR HOUSING	100.00%	$ 36,130	$ (23,420)	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			$ 59,550			$ 36,130	$ * (23,420)	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: 1/1/2017 Ending: 12/31/2017

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	ANDY C. KERWIN	BOD						1
2	LORRIE DUPONT	BOD						2
3	KAREN LACKE CARRIG	BOD						3
4	NICHOLAS LYNN	BOD						4
5	MIRIAM GEHLER	BOD						5
6	RAJEEV KUMAR, MD, FACP	BOD						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 HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 2/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	$ 4,984,827			$ 281,997	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,820,977	$ 4,984,827			$ 281,997	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	$ 4,984,827			$ 281,997	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: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 75,888	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.)		$ 76,439	2
3. Under or (over) accrual (line 2 minus line 1).		$ 551	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,439	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.		$ 76,990	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	45,025	8
	2013	48,642	9
	2014	50,263	10
	2015	76,099	11
	2016	75,588	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 NICOLE LOPEZ

TELEPHONE 815-455-0550 FAX #: 815-455-0608

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-31-426-020	LT1	$ 76,438.64	$ 76,438.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,438.64	$ 76,438.64

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	$	$ 625,750	4
5			2001		3,671					3,671	5
6	5			2013	4,437,265	129,330		129,330		540,735	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		21,240	11
12	SPRINKLER SYSTEM			2006	72,000	2,880		2,880		34,560	12
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICAL WORK			2008	26,941	1,057		1,057		9,995	13
14	WINDOW, FLOORING			2009	37,161	3,614		3,614		31,396	14
15	FLOORING, TILES			2011	7,710	667		667		7,677	15
16	PLANK FLOORING			2012	2,321	348		348		2,321	16
17	REGULATOR FOR WATER TEMPS IN RESIDENT ROOMS			2014	4,985	498		498		1,828	17
18	NEW CARPET IN MAIN HALL			2014	9,790	1,958		1,958		7,342	18
19	GENERATOR UPDATES AND ADDITIONS			2014	10,020	1,002		1,002		3,674	19
20	AUTOMATIC KITCHEN DOOR			2014	3,855	386		386		1,317	20
21	PLUMBING - MIXING VALVES (MIGHTY OAKS)			2014	4,025	268		268		826	21
22	VINYL FLOORING, WOOD BLINDS (REMODEL OF BEDROOM)			2014	3,127	473		473		1,535	22
23	SPRINKLER SYSTEM VALVE (MIGHTY OAKS)			2014	2,850	114		114		371	23
24	FIRE DOOR			2015	4,734	236		236		612	24
25	PLUMBING-DISHWASHER			2015	1,521	76		76		209	25
26	AUTOMATIC DOOR CLOSER			2015	1,540	103		103		283	26
27	KITCHEN DOOR-REPLACE			2016	1,797	90		90		97	27
28	PLUMBING-HOT WATER HEATER			2016	2,172	109		109		118	28
29											29
30	LAND IMPROVEMENTS										30
31	REMOVE/REPLACE CONCRETE			2000	11,660	275		275		10,858	31
32	PARKING LOT			2004	15,000	750		750		10,125	32
33	LANDSCPATING (OAK TREES)			2006	3,450	230		230		2,607	33
34	LANDSCAPE/TREE REPLACEMENT			2015	2,435	243		243		730	34
35	REMOVE/REPLACE CONCRETE SIDEWALKS			2016	4,650	310		310		491	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: 1/1/2017 Ending: 12/31/2017

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	$ 179,252		$ 179,252	$	$ 1,375,769	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: 1/1/2017 Ending: 12/31/2017

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	$ 826,134	$ 29,923	$ 29,923	$		$ 764,010	71
72	Current Year Purchases	24,333	1,056	1,056			1,056	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 850,467	$ 30,979	$ 30,979	$		$ 765,066	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)	$ 7,132,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,231	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,231	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,140,835	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: 1/1/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	14130 hrs	$ 186,692		$	$	14,130	$ 186,692	1
2	Licensed Speech and Language Development Therapist	L10A,C3	1807 hrs	78,066		7,725	2,008	1,807	87,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	22471 hrs	346,841				22,471	346,841	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			$ 611,599		$ 7,725	$ 2,008	38,408	$ 621,332	14

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

STATE OF ILLINOIS

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER **#** 0040915 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 608,972	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	498,150		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,277		6
7	Other Prepaid Expenses	25,241		7
8	Accounts Receivable (owners or related parties)	1,340,306		8
9	Other(specify):	132,212		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,617,158	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			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	895,875		16
17	Accumulated Depreciation (book methods)	(2,138,047)		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):	60,913		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,077,636	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,694,794	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 223,378	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	297,714		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,502		32
33	Accrued Interest Payable	115,576		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany Loans	24,801		36
37	Deferred Revenue/Security Deposits	44,671		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 770,642	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,984,827		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)**	$ 4,984,827	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,755,469	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,939,325	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,694,794	$	48

***(See instructions.)**

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,715,856	1
2	Restatements (describe):		2
3	**Real Estate Tax Adjustment**	(14,212)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,701,644	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	237,681	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)**	$ 237,681	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)**	$ 1,939,325	24 *

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 4,088,566	1
2	Discounts and Allowances for all Levels	25,789	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,114,355	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,653,095	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,653,095	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	8,636	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	576,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,520	19
20	Radiology and X-Ray	21,532	20
21	Other Medical Services	126,952	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 812,745	23
	D. Non-Operating Revenue		
24	Contributions	1,242	24
25	Interest and Other Investment Income***	233	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,475	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Employee & Guest Meals, Fees and Rebates	14,897	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,897	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,596,567	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	871,049	31
32	Health Care	2,948,439	32
33	General Administration	1,393,643	33
	B. Capital Expense		
34	Ownership	573,791	34
	C. Ancillary Expense		
35	Special Cost Centers	497,297	35
36	Provider Participation Fee	74,667	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,358,886	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,681	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,681	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: 1/1/2017 Ending: 12/31/2017

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	1,953	2,069	$ 85,918	$ 41.53	1
2	Assistant Director of Nursing	2,004	2,080	70,968	34.12	2
3	Registered Nurses	19,383	20,934	633,138	30.24	3
4	Licensed Practical Nurses	12,643	13,457	322,251	23.95	4
5	CNAs & Orderlies	83,304	57,170	872,147	15.26	5
6	CNA Trainees					6
7	Licensed Therapist	14,920	15,472	611,599	39.53	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,981	2,101	39,316	18.71	9
10	Activity Assistants	4,069	4,101	44,764	10.92	10
11	Social Service Workers	4,009	4,400	74,470	16.93	11
12	Dietician					12
13	Food Service Supervisor	1,908	2,080	35,368	17.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,261	17,195	214,464	12.47	15
16	Dishwashers					16
17	Maintenance Workers	3,647	4,111	80,835	19.66	17
18	Housekeepers	9,543	10,203	149,752	14.68	18
19	Laundry					19
20	Administrator	2,626	2,892	147,248	50.92	20
21	Assistant Administrator	1,120	1,314	61,579	46.86	21
22	Other Administrative	7,626	8,002	133,667	16.70	22
23	Office Manager	1,941	2,137	54,490	25.50	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	1,977	2,129	34,221	16.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,915	171,847	$ 3,666,195 *	$ 21.33	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	441	$ 26,358	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	825	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	3,169	L11,C3	44
45	Social Service Consultant	20	1,152	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	520	$ 41,504		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: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOYCE SURDICK	Administrator		$ 102,496
NICOLE LOPEZ	Administrator		43,333
JOYCE SURDICK	Asst Administrator		19,534
ALLISON FRAWLEY	Asst Administrator		43,464
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 208,827

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 Profesional Service Schedule	Data Processing	$ 20,522
Carriage Healthcare, Inc.	Management Fees	238,200
See Legal Supplementatl Schedule	Legal Fees	2,552
See Profesional Service Schedule	Accounting Fees	23,072
Wisconsin Illinois Senior Housing	Home Office Mgmt	59,550
See Profesional Service Schedule	Other	8,015
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 351,911

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,707
Unemployment Compensation Insurance	11,544
FICA Taxes	271,996
Employee Health Insurance	74,961
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	7,730
Pension & Retirement	12,232
TOTAL (agree to Schedule V, line 22, col.8)	$ 472,170

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	10,599
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	13,259
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,499
General Business Travel	3,784
Business Meals	1,714
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,997

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER # 0040915 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. $ **74,667**
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

PROFESSIONAL SERVICES - 2017

Vendor	Account#/Description	Amount	
Ascentis Payroll	General Data Processing Fees	$20,522	
Total General Data Processing Fees		**$20,522**	
Carriage Healthcare Companines	Management Fees	$238,200	
Total Management Fees		**$238,200**	
The Waggoner Law Firm PC	Legal Fees	$2,552	
Total Legal Fees		**$2,552**	
PDR Certified Public Accountants	Professional Accounting Fees	$8,777	
JT & Associates, LLC	Professional Accounting Fees	$1,975	
Wisconsin Illinois Senior Housing	Professional Accounting Fees	$12,320	
Total Professoinal Accounting Fees		**$23,072**	
Wisconsin Illinois Senior Housing	Home Office (Owner Fees)	$59,550	
Total Home Office (Owner Fees)		**$59,550**	
Employee Health Consultants	Professional Services	$1,400	Employee Assistance Program
Applied Computer Technologies	Professional Services	$5,467	IT for Computers
Wisconsin Illinois Senior Housing	Professional Services	$1,147	Services provided and retained by WISH and billed to facility
Total Professional Services		**$8,015**	
	Grand Total:	**$351,911**	

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE

ID NUMBER: 0040915

LEGAL INVOICE SUMMARY - 2017

INVOICE DATE	FIRM	ALLOWABLE	NON ALLOWABLE	DESCRIPTION OF SERVCES
1/5/2017	The Waggoner Law Firm	$138		Lien against insurance company for a resident in-house with auto insurance primary payer
2/2/2017	The Waggoner Law Firm	$432		Lien against insurance company for a resident in-house with auto insurance primary payer
2/2/2017	The Waggoner Law Firm	$1,128		Appear in court with Joyce Surdick regarding Bulthuis
5/3/2017	The Waggoner Law Firm	$72		Review title for resident in house to place lien
6/5/2017	The Waggoner Law Firm	$784		Appear in court with Joyce Surdick regarding affidavit and judgement for Bulthuis
	Total Allowable Invoices:	**$2,552**		

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Inservice Training and Education - 2017

Attendee	Title	Location	Reason	Time Frame	Cost
C. Smith	C N A	Rasmussen College, Bloomington, MN	Registered Nurse Degree	Summer Quarter 2017 (7/5/17-9/17/17)	$5,850
C. Smith	C N A	Rasmussen College, Bloomington, MN	Registered Nurse Degree	Fall Quarter 2017 (10/3/17-12/17/17)	$5,621
C Ison	DON	Willimington Delaware	Spring Conference	May 08/17	$1,800
Joyce/Cari/Nicole	Admin/DON	Crystal Lake to Airport	Limo Service	May 08/17	$117
A-Tec Ambulance		Crystal Lake Fair Oaks	CPR classes provided by ATEC	June 20/21	$270
A. Johnson	PT	Rolling Meadows, IL	Vestibular Rehabilitation class	February 2017	$199
				Inservice Training & Education	**$13,857**

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Travel and Seminars - 2017

Attendee	Title	Date of Seminar	Location	Title of Seminar	Sponsor of Seminar	Cost	
J. Surdick	Administrator	November	Stout Island, WI	Fall Conference	CHC	$1,250	
L. Tapaninen	BOM	November	Stout Island, WI	Fall Conference	CHC	$1,250	
N. Lopez	Admin In Training	November	Stout Island, WI	Fall Conference	CHC	$1,250	
P. Juarez	HR	November	Stout Island, WI	Fall Conference	CHC	$1,250	
J. Surdick	Administrator	April	Wilmington DE	Spring Conference	CHC	$1,800	
N. Lopez	Admin In Training	April	Wilmington DE	Spring Conference	CHC	$1,800	
Surdick/Fetko/Occonnor	Admin/MDS/MDS	April	Inhouse	Coding ICD10	The Coding Institute	$207	
Surdick/Fetko/Occonnor	Admin/MDS/MDS	December	Inhouse Webinar	ICD10-CM Coding Tips	Polaris Group	$116	
Erick Palomino	Dietary Sanitation	November	MCC	Crystal Lake	MCC	$175	
Greenhouse Group	Medical Cannabis	April	Barrington		Greenhouse Group	$105	
C. Ison	Admin In Training	April	Willimington DE	Spring Conference	CHC	$270	
H Dougla	C N A	Dec	East Troy WI	C N A retention	CHC	$47	
M Bush	C N A	Dec	East Troy WI	C N A retention	CHC	$47	
M Schnulle	C N A	Dec	East Troy WI	C N A retention	CHC	$47	
J. Surdick	Administrator	April	Delaware	CHC Spring Conference	CHC	$270	Air Fare
N. Lopez	Admin In Training	April	Delaware	CHC Spring Conference	CHC	$270	Air Fare
Surdick/Lopez/Ison	Administration	April	Delaware	CHC Spring Conference	CHC	$770	Limo/Baggage
L. Tapaninen	Business Office Manager	June	Holton WI	AR training	CHC	$37	
D Adams	Maintenance	June	Cary Illinois	N/A	N/A	$32	Gas
A. Frawley	Assit Admin	April	New Orlean LA	VPCI Convention	Remedy Partners	$886	
J Surdick	Administrator	July	Naperville IL	Wound Care Seminar	Forum Pharmacy	$247	Lodging
Surdick/Lopez/Tapaninnen/Jaurez	Administration	October	Stout Island WI	Spring Seminar	CHC	$408	Car Rental /Gas
C Blair	Admissions	November	Various Hospitals	Marketing	N/A	$151	
J Surdick	Administrator	November	Denver CO	CHC Meeting	CHC	$277	Ohare Parking/Baggage
J Surdick	Administrator	February	Ohare	Meals	CHC	$14	
A Frawley	Assit Admin	April	New Orleans	Meals	Remedy Partners	$66	
Surdick/Lopez/Ison	Admin/DON	April	Chicago/Delawar	Meals	CHC	$141	
Surdick/Ison	Admin/DOn	July	Naperville Il	Meals	Forum, Pharmacy	$85	
Surdick/Lopez/Tapaninen/Juarez	Administration	October	Wisconsin	Meals	CHC	$187	
Staff	Nrsing Training	October	Inhouse	Meals	Fair Oaks	$143	
Staff	Nursing Training	November	Inhouse	Meals	Fair Oaks	$109	
N Lopez	QA meeting	December	Inhouse	Meals	Fair Oaks	$28	
Ortho of Illinois	Marketing	December	Crystal Lake	Meals	Fair Oaks	$246	
Staff	Dietary	June	Inhouse	Meals	Fair Oaks	$157	
L. Tapaninen	BOM	October	Wisconsin	Meals	CHC	$22	
J Surdick	Admininistrator	May	Wisconsin	Meals	CHC	$44	
Staff	All Staff Meeting	May	Inhouse	Meals	Fair Oaks	$103	

	Cost
No single travel item greater than $250.	$690

Travel and Seminars: $14,997