		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0050963

Facility Name: Fair Oaks Rehabilitation & Helath Care Center

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, CPA **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 1/1/2018 to 12/31/2018 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) 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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	78	Skilled (SNF)	78	28,470	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	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,482	6,557	7,466	24,505	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,482	6,557	7,466	24,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.07%

D. How many bed reserve days during this year were paid by the Department?
None (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)
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 4,392

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Cent # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		3,617	403,933	407,550		407,550	507	408,057			1
2	Food Purchase		6,210		6,210		6,210	(1,663)	4,547			2
3	Housekeeping		15,669	90,019	105,688		105,688		105,688			3
4	Laundry		8,807	59,763	68,570		68,570		68,570			4
5	Heat and Other Utilities			131,541	131,541		131,541		131,541			5
6	Maintenance	60,721	5,558	58,593	124,872		124,872	4,834	129,706			6
7	Other (specify):*											7
8	**TOTAL General Services**	60,721	39,861	743,849	844,431		844,431	3,678	848,109			8
	B. Health Care and Programs											
9	Medical Director					13,500	13,500		13,500			9
10	Nursing and Medical Records	1,581,987	83,786	224,785	1,890,558	(13,500)	1,877,058	2,751	1,879,809			10
10a	Therapy											10a
11	Activities	20,620	13,368	60,828	94,816		94,816		94,816			11
12	Social Services	62,443		2,340	64,783		64,783		64,783			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,665,050	97,154	287,953	2,050,157		2,050,157	2,751	2,052,908			16
	C. General Administration											
17	Administrative	102,034			102,034		102,034		102,034			17
18	Directors Fees											18
19	Professional Services			97,510	97,510		97,510	312,609	410,119			19
20	Dues, Fees, Subscriptions & Promotions			12,899	12,899		12,899	(1,668)	11,231			20
21	Clerical & General Office Expenses	135,160	15,680	598,330	749,170		749,170	(539,119)	210,051			21
22	Employee Benefits & Payroll Taxes			308,738	308,738		308,738		308,738			22
23	Inservice Training & Education			1,280	1,280		1,280		1,280			23
24	Travel and Seminar			10,198	10,198		10,198		10,198			24
25	Other Admin. Staff Transportation			3,961	3,961		3,961		3,961			25
26	Insurance-Prop.Liab.Malpractice			180,489	180,489		180,489	(159)	180,330			26
27	Other (specify):*											27
28	**TOTAL General Administration**	237,194	15,680	1,213,405	1,466,279		1,466,279	(228,337)	1,237,942			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,962,965	152,695	2,245,207	4,360,867		4,360,867	(221,908)	4,138,959			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 Rehabilitation & Helath Care Center #0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			1,257	1,257		1,257	104,663	105,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,286	1,286		1,286	51,691	52,977			32
33	Real Estate Taxes			98,026	98,026		98,026	1,466	99,492			33
34	Rent-Facility & Grounds			191,615	191,615		191,615	(191,615)				34
35	Rent-Equipment & Vehicles			9,868	9,868		9,868		9,868			35
36	Other (specify):* **Mortgage Ins**							10,738	10,738			36
37	**TOTAL Ownership**			302,052	302,052		302,052	(23,057)	278,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,605	753,109	888,714		888,714		888,714			39
40	Barber and Beauty Shops			3,482	3,482		3,482		3,482			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,624	166,624		166,624		166,624			42
43	Other (specify):* **Marketing**	65,295		21,550	86,845		86,845	(86,845)				43
44	**TOTAL Special Cost Centers**	65,295	135,605	944,765	1,145,665		1,145,665	(86,845)	1,058,820			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,028,260	288,300	3,492,024	5,808,584		5,808,584	(331,810)	5,476,774			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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(1,118)	2		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	1,876	30		9
10	Interest and Other Investment Income	(8,816)	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	(4,732)	21		18
19	Entertainment	(10,046)	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	(224,823)	21		24
25	Fund Raising, Advertising and Promotional	(21,550)	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	(68,321)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (337,530)		$	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)	5,720		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,720		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (331,810)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Fair Oaks Rehabilitation & Helath Care Center

ID# 0050963

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (1,418)	20	1
2	Marketing Salaries	(65,295)	43	2
3				3
4	Misc Income	(813)	21	4
5	Vending Machine Income	(545)	2	5
6	Stateline Chamber of Commerce Dues	(250)	20	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**	(68,321)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center **#** 0050963 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

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	507	0	0	0	0	0	0	0	0	0	507	1
2	Food Purchase	(1,663)	0	0	0	0	0	0	0	0	0	0	(1,663)	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	0	4,834	0	0	0	0	0	0	0	0	0	4,834	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,663)	5,341	0	0	0	0	0	0	0	0	0	3,678	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	2,751	0	0	0	0	0	0	0	0	0	2,751	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	2,751	0	0	0	0	0	0	0	0	0	2,751	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	10,734	301,875	0	0	0	0	0	0	0	0	312,609	19
20	Fees, Subscriptions & Promotions	(1,668)	0	0	0	0	0	0	0	0	0	0	(1,668)	20
21	Clerical & General Office Expenses	(240,414)	8,153	(306,858)	0	0	0	0	0	0	0	0	(539,119)	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	(159)	0	0	0	0	0	0	0	0	0	(159)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(242,082)	18,728	(4,983)	0	0	0	0	0	0	0	0	(228,337)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(243,745)	26,820	(4,983)	0	0	0	0	0	0	0	0	(221,908)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

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	1,876	96,136	6,651	0	0	0	0	0	0	0	0	104,663	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,816)	61,793	(1,286)	0	0	0	0	0	0	0	0	51,691	32
33	Real Estate Taxes	0	1,466	0	0	0	0	0	0	0	0	0	1,466	33
34	Rent-Facility & Grounds	0	(191,615)	0	0	0	0	0	0	0	0	0	(191,615)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	10,738	0	0	0	0	0	0	0	0	0	10,738	36
37	**TOTAL Ownership**	(6,940)	(21,482)	5,365	0	0	0	0	0	0	0	0	(23,057)	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):*	(86,845)	0	0	0	0	0	0	0	0	0	0	(86,845)	43
44	**TOTAL Special Cost Centers**	(86,845)	0	0	0	0	0	0	0	0	0	0	(86,845)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(337,530)	5,338	382	0	0	0	0	0	0	0	0	(331,810)	45

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 PG6-Supp		See PG6-Supp		See PG6-Supp		

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	$ 191,615	TI - South Beloit	100.00%	$	$ (191,615)	1
2	V	32	Interest		TI - South Beloit	100.00%	61,793	61,793	2
3	V	19	Legal & Accounting		TI - South Beloit	100.00%	10,734	10,734	3
4	V	36	Mortgage Insurance		TI - South Beloit	100.00%	10,738	10,738	4
5	V	30	Depreciation		TI - South Beloit	100.00%	96,136	96,136	5
6	V	06	Maintenance		TI - South Beloit	100.00%	4,834	4,834	6
7	V	33	Real Estate Taxes	98,026	TI - South Beloit	100.00%	99,492	1,466	7
8	V	26	Insurance	11,111	TI - South Beloit	100.00%	10,952	(159)	8
9	V	1	Dietary Small Equip		TI - South Beloit	100.00%	507	507	9
10	V	10	Nursing Small Equip		TI - South Beloit	100.00%	2,751	2,751	10
11	V	21	Furniture & Small Equip		TI - South Beloit	100.00%	8,153	8,153	11
12	V								12
13	V								13
14	Total			$ 300,752			$ 306,090	$ * 5,338	14

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

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 48,408	Tutera Health Care Services	100.00%	$ 350,283	$ 301,875	15
16	V	30	Management - Depreciation		Tutera Health Care Services	100.00%	6,651	6,651	16
17	V	21	Management Fee	298,870	Tutera Health Care Services	100.00%		(298,870)	17
18	V	21	A&G - Purchased Services	30	Bethany Health Care and Rehab		30		18
19	V	25	Mileage Reimbursement	645	Crystal Pines Rehab and Helathcare		645		19
20	V	10	Nursing Agency	28,318	Crystal Pines Rehab and Helathcare		28,318		20
21	V	25	Mileage Reimbursement	335	Dixon Healthcare and Rehabilitation		335		21
22	V	10	Nursing Purchased Svs	1,956	Dixon Healthcare and Rehabilitation		1,956		22
23	V	19	Data Processing/Legal	243	Walnut Creek Management		243		23
24	V	20	Employee Want Ads	3,451	Walnut Creek Management		3,451		24
25	V	21	Postage/Small Equip/Entertainment	4,925	Walnut Creek Management		4,925		25
26	V	24	Travel & Seminar	12,341	Walnut Creek Management		12,341		26
27	V	10	Nursing Supplies	126	Walnut Creek Management		126		27
28	V	21	RP Asset Management Fees	7,988	JCT Capital, Inc			(7,988)	28
29	V	32	Interest	1,286	JCT Capital, Inc			(1,286)	29
30	V	22	Insurance	2,498	CarePlus, Inc		2,498		30
31	V	26	Insurance	166,771	LTC Plus Insurance, Inc		166,771		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 578,191			$ 578,573	$ * 382	39

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

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Tutera Investments, LLC	99%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT INV LLC	1%	Windsor Rehab & Health Care Center	Terrell, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3			Bethany Rehab & Health Care Center	DeKalb IL	Continua Home Healtl	Kansas City MO	Home Health	3
4			Carlinville Rehab & Health Care Center	Carlinville, IL	Country Gardens Assi	Muskogee, OK	AL	4
5			Coulterville Rehab & Health Care Center	Coulterville, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Oakley Court ssisted L	Freeport, IL	AL	6
7			Dixon Rehab & Health Care Center	Dixon, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Cente	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assited I	Boiling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Assisted	Laurinburg, NC	AL	11
12			Mattoon Rehab & Health Care Center	Mattoon, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Paradise Prk Assisted	Fox Lake, IL	AL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL	TI South Beloit	South Beloit, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LLC	Kansas City MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Cente	Raytown, MO	Walnut Creek Mgmt C	Kansas City MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New En	Kansas City MO	Mgmt Company	19
20			Holly Hill Rehab & Health Care Center	Sulphur, LA	Tutera Investments In	Kansas City MO	Mgmt Company	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	JCT Capital Inc	Kansas City MO	Mgmt Company	21
22			St. Paul's Senior Community	Belleville, IL	Tutera Group Inc	Kansas City MO	Mgmt Company	22
23			Greenfield Manor	Greenfield, IA	LTC Plus Insurance In	Kansas City MO	Insurance Company	23
24			Griswold Care Center	Griswold, IA	Residence at Pleasonto	Pleasontan	Al/IL	24
25			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Mt Ayr	Mt.Ayr, IA	AL/IL	25
26			Stratford Rehab & Health Care Center	Overland Park, KS	Missiona Chateua Seni	Prairie Village, KS	AL/IL	26
27			Carnegie Village Rehab & Health Care Center	Belton, MO				27
28			Tiffany Springs Rehab & Health Care Center	Kansas City, MO				28
29			Northland Rehab & Health Care Center	Kansas City, MO				29
30			Westview of Derby	Derby, KS				30

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Cer # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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, MO 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	193,500,518	48	$ 12,214,787	$ 8,837,460	5,549,101	$ 350,289	1
2	30	Management Fee - Depreciation	Direct Costs	193,500,518	48	231,947		5,549,101	6,652	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					$ 12,446,734	$ 8,837,460		$ 356,941	25

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Cen # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 2,118,477			$ 62,307	1
2	Interest Income Offset										(514)	2
3												3
4												4
5												5
	Working Capital											
6	JCT Capital	X		Note Payabe			114,000	346,042		0.0100	1,286	6
7	Interest Income Offset										(8,816)	7
8	Related Party Offset										(1,286)	8
9	TOTAL Facility Related						$ 114,000	$ 2,464,519			$ 52,977	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 114,000	$ 2,464,519			$ 52,977	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,110 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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	94,638	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.)	$	96,104	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,466	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	98,026	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.	$	99,492	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	93,608	8
	2014	94,535	9
	2015	94,149	10
	2016	94,638	11
	2017	96,104	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks Rehabilitation & Helath Care Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0050963

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-07-258-002	Long-Term Care	$ 96,103.84	$ 96,103.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 96,103.84	$ 96,103.84

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,393 B. General Construction Type: Exterior Brick Frame Block 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. [X] (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	Long-Term Care	14,393	2010	$ 233,678	1
2					2
3	TOTALS	14,393		$ 233,678	3

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,249,148	$ 81,787	27	$ 81,787	$	$ 695,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP HVAC			2013	6,946	762	7	762		5,804	9
10	CEILING INSULATION			2013	6,625	766	7	766		5,475	10
11											11
12	HOME OFFICE DEPRECIATION					6,651		6,651			12
13											13
14	WATER HEATER (TI - SOUTH BELOIT)			2012	2,886	841	7	841		5,746	14
15	FIRE SPRINKLER SYSTEM (TI - SOUTH BELOIT)			2013	6,071	405	15	405		2,057	15
16	WATER HEATER (TI - SOUTH BELOIT)			2014	5,243	54	10	54		2,534	16
17	REPLACE EXTERIOR DOORS/FRAMES w/ ALUMINUM DOORS (TI			2017	5,010	334	15	334		640	17
18	VINYL FLOORING (All Hallways) (TI - SB)			2017	20,009	1,334	15	1,334		2,557	18
19	SHOWER REPAIR - Vinyl shower walls in all three locations (TI-SB)			2017	8,200	820	10	820		1,572	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

*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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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)		$ 2,310,138	$ 93,754		$ 93,754	$	$ 721,576	70

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

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 78,595	$ 11,184	$ 11,184	$	Various	$ 30,060	71
72	Current Year Purchases	7,502	982	982		7	982	72
73	Fully Depreciated Assets	478,995				Various	478,995	73
74								74
75	TOTALS	$ 565,092	$ 12,166	$ 12,166	$		$ 510,037	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	2012	$ 57,910	$	$	$	5	$ 57,910	76
77										77
78										78
79										79
80	TOTALS			$ 57,910	$	$	$		$ 57,910	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)	$ 3,166,818	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,920	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 105,920	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)	$ 1,289,523	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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 9,868 Description: Dishwasher, Washer 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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-3	hrs	$	4,116	$ 294,095	$ 11	4,116	$ 294,106	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		820	60,780	74	820	60,854	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		5,108	351,698	85	5,108	351,783	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				91,650		91,650	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB					46,536	43,785		90,321	13
14	TOTAL			$	10,044	$ 753,109	$ 135,605	10,044	$ 888,714	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 Rehabilitation & Helath Care Center # 0050963 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 326,257	$ 333,790	1
2	Cash-Patient Deposits	14,972	14,972	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	880,659	880,659	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,284	132,602	6
7	Other Prepaid Expenses	369,966	376,981	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	11,864	134,526	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,731,002	$ 1,873,530	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			14
15	Leasehold Improvements, at Historical Cost	13,571	2,313,138	15
16	Equipment, at Historical Cost	18,266	620,002	16
17	Accumulated Depreciation (book methods)	(19,352)	(1,289,523)	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): WIP & PP&E Tax Ajd	76,238	(549,117)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 88,723	$ 1,328,178	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,819,725	$ 3,201,708	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 567,602	$ 567,602	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,972	14,972	28
29	Short-Term Notes Payable	346,042	346,042	29
30	Accrued Salaries Payable	129,824	129,824	30
31	Accrued Taxes Payable (excluding real estate taxes)	66,621	164,647	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		5,120	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fee Payabe	576	576	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,125,637	$ 1,228,783	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,118,477	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)**	$	$ 2,118,477	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,125,637	$ 3,347,260	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 694,088	$ (145,552)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,819,725	$ 3,201,708	48

***(See instructions.)**

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 514,484	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 514,484	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	179,604	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)**	$ 179,604	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)**	$ 694,088	24 *

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

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 5,426,635	1
2	Discounts and Allowances for all Levels	(3,909,314)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,517,321	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,196,588	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,196,588	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	545	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	168,980	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,489	19
20	Radiology and X-Ray		20
21	Other Medical Services	69,586	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 264,600	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,866	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,866	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	813	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 813	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,988,188	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	844,431	31
32	Health Care	2,050,157	32
33	General Administration	1,466,279	33
	B. Capital Expense		
34	Ownership	302,052	34
	C. Ancillary Expense		
35	Special Cost Centers	979,041	35
36	Provider Participation Fee	166,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,808,584	40
41	**Income before Income Taxes (line 30 minus line 40)****	179,604	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 179,604	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,791,968	44
45	Private Pay - Net Inpatient Revenue	1,109,915	45
46	Medicare - Net Inpatient Revenue	(1,126,047)	46
47	Other-(specify) Managed Care	(258,515)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,517,321	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 Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,123	1,200	$ 52,199	$ 43.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,728	19,195	609,171	31.74	3
4	Licensed Practical Nurses	10,811	11,838	329,096	27.80	4
5	CNAs & Orderlies	41,673	43,373	568,971	13.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	601	617	8,970	14.54	9
10	Activity Assistants	1,043	1,043	11,650	11.17	10
11	Social Service Workers	3,351	3,779	62,443	16.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,230	2,466	60,721	24.62	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,036	2,279	102,034	44.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,517	8,085	135,160	16.72	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	1,192	1,447	22,550	15.58	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,861	2,175	65,295	30.02	33
34	TOTAL (lines 1 - 33)	91,166	97,497	$ 2,028,260 *	$ 20.80	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	$ 403,933	V01-3	35
36	Medical Director	Monthly	13,500	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,147	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	55,328	V11-3	44
45	Social Service Consultant	Monthly	2,340	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 482,248		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	675	$ 49,733	V10-3	50
51	Licensed Practical Nurses	64	6,688	V10-3	51
52	Certified Nurse Assistants/Aides	1,290	54,310	V10-3	52
53	TOTAL (lines 50 - 52)	2,029	$ 110,731		53

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Boomgarden	Administrator	0	$ 77,826
Matthew Miller	Administrator	0	24,208
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,034

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Officers	Legal	$ 840
Heyl Royster Voelker & Allen	Legal	4,958
Lathrop & Gage LLP	Legal	41
CliftonLarsonAllen LLP	Accounting/Cost Reporting	13,177
Walnut Creek Mgmt Co LLC	Data Processing	53,122
PointClickCare Technologies Inc	Data Processing	21,741
Allscripts Healthcare LLC	Professional Services	2,280
Pinnacle Quality Insight	Professional Services	1,251
Property Valuation Services	Professional Services	100
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 97,510

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,571
Unemployment Compensation Insurance	
FICA Taxes	192,540
Employee Health Insurance	48,709
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	19,918
TOTAL (agree to Schedule V, line 22, col.8)	$ 308,738

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,521
Health Care Worker Background Check	
(Indicate # of checks performed 144)	1,440
Patient Background Checks	
IL Health Care Association	3,301
IL Secretary of State	150
Other Licenses	150
Other Dues & Subscriptions	2,347
Less: Public Relations Expense	(1,668)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,231

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,198
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,198

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Oaks Rehabilitation & Helath Care Center # 0050963 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Health Care Association, $4,719**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,358** 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. $ **166,624**
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? **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? **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? **N/A**
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. $ **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