

		FOR BHF USE					

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**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0040915</u></p> <p><b>Facility Name:</b> <u>FAIR OAKS HEALTH CARE CENTER</u></p> <p><b>Address:</b> <u>471 TERRA COTTA AVE</u> <u>CRYSTAL LAKE</u> <u>60014</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>MCHENRY</u></p> <p><b>Telephone Number:</b> <u>(815) 455-0550</u> <b>Fax #</b> <u>(815) 455-0608</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>501C(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>NICOLE LOPEZ</u> <b>Telephone Number:</b> <u>(815) 455-0550</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from _____ to _____ 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: 1px solid black; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">           (Signed) _____ (Date) _____            (Type or Print Name) <u>NICOLE LOPEZ</u>            (Title) <u>ADMINISTRATOR</u> </td> </tr> <tr> <td style="border: 1px solid black; vertical-align: top;">Paid Preparer</td> <td style="border: none;">           (Signed) _____ (Date) _____            (Print Name and Title) <u>GARY JOHNSEN</u>  <u>PARTNER, CPA</u>            (Firm Name &amp; Address) <u>JT AND ASSOCIATES, LLC</u>  <u>700 PILGRIM PKWY, #200, ELM GROVE, WI 53122</u>            (Telephone) <u>(262) 789-9945</u> Fax # <u>(262) 782-8766</u> </td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>NICOLE LOPEZ</u> (Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>GARY JOHNSEN</u> <u>PARTNER, CPA</u> (Firm Name & Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, #200, ELM GROVE, WI 53122</u> (Telephone) <u>(262) 789-9945</u> Fax # <u>(262) 782-8766</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>NICOLE LOPEZ</u> (Title) <u>ADMINISTRATOR</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>GARY JOHNSEN</u> <u>PARTNER, CPA</u> (Firm Name & Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, #200, ELM GROVE, WI 53122</u> (Telephone) <u>(262) 789-9945</u> Fax # <u>(262) 782-8766</u>							

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

**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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,666	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,666	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,420	5,498	5,921	12,839	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,420	5,498	5,921	12,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.78%

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  NO

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

I. On what date did you start providing long term care at this location?  
Date started 5/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 5/95 NO

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

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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: \_\_\_\_\_ Ending: \_\_\_\_\_

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	297,989	11,099	19,781	328,869		328,869		328,869		1
2	Food Purchase		147,917		147,917		147,917		147,917		2
3	Housekeeping	160,366	22,700	1,674	184,740		184,740		184,740		3
4	Laundry		295		295		295		295		4
5	Heat and Other Utilities			120,629	120,629		120,629	(11,163)	109,466		5
6	Maintenance	68,401	24,604	53,378	146,383		146,383		146,383		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>526,756</b>	<b>206,615</b>	<b>195,462</b>	<b>928,833</b>		<b>928,833</b>	<b>(11,163)</b>	<b>917,670</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,833	10,833		10,833		10,833		9
10	Nursing and Medical Records	2,208,741	168,276	188,662	2,565,679		2,565,679		2,565,679		10
10a	Therapy	508,016	4,330	36,240	548,586		548,586		548,586		10a
11	Activities	92,779	4,283	3,664	100,726		100,726		100,726		11
12	Social Services	71,104		864	71,968		71,968		71,968		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,880,640</b>	<b>176,889</b>	<b>240,263</b>	<b>3,297,792</b>		<b>3,297,792</b>		<b>3,297,792</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	104,785			104,785		104,785		104,785		17
18	Directors Fees										18
19	Professional Services			399,911	399,911		399,911	5,805	405,716		19
20	Dues, Fees, Subscriptions & Promotions			50,275	50,275		50,275		50,275		20
21	Clerical & General Office Expenses	222,493	11,522	66,121	300,136		300,136		300,136		21
22	Employee Benefits & Payroll Taxes			540,930	540,930		540,930		540,930		22
23	Inservice Training & Education			10,279	10,279		10,279		10,279		23
24	Travel and Seminar			713	713		713		713		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,934	41,934		41,934		41,934		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>327,278</b>	<b>11,522</b>	<b>1,110,163</b>	<b>1,448,963</b>		<b>1,448,963</b>	<b>5,805</b>	<b>1,454,768</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,734,674</b>	<b>395,026</b>	<b>1,545,888</b>	<b>5,675,588</b>		<b>5,675,588</b>	<b>(5,358)</b>	<b>5,670,230</b>		<b>29</b>

\*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:

Ending:

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			179,703	179,703		179,703		179,703		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			241,676	241,676		241,676		241,676		32
33	Real Estate Taxes			82,380	82,380		82,380		82,380		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>Amortization</b>			1,481	1,481		1,481		1,481		36
37	<b>TOTAL Ownership</b>			505,240	505,240		505,240		505,240		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		262,617		262,617		262,617		262,617		39
40	Barber and Beauty Shops			1,101	1,101		1,101		1,101		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			76,254	76,254		76,254		76,254		42
43	Other (specify):*			337,410	337,410		337,410	(337,410)			43
44	<b>TOTAL Special Cost Centers</b>		262,617	414,765	677,382		677,382	(337,410)	339,972		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,734,674	657,643	2,465,893	6,858,210		6,858,210	(342,768)	6,515,442		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:

Ending:

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(11,163)	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	(150,000)	43		18
19	Entertainment	(16,212)	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	(163,110)	43		24
25	Fund Raising, Advertising and Promotional	(8,088)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (348,573)		\$	30

<b>BHF USE ONLY</b>							
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	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (348,573)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0040915

Report Period Beginning: \_\_\_\_\_

Ending: \_\_\_\_\_

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
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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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER# 0040915 Report Period Beginning:

Ending:

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
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	(11,163)	0	0	0	0	0	0	0	0	0	0	(11,163)	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	<b>TOTAL General Services</b>	<b>(11,163)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,163)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	5,805	0	0	0	0	0	0	0	0	0	5,805	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	<b>TOTAL General Administration</b>	<b>0</b>	<b>5,805</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,805</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,163)</b>	<b>5,805</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,358)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER# 0040915

Report Period Beginning:

Ending:

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(337,410)	0	0	0	0	0	0	0	0	0	0	(337,410)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(337,410)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(337,410)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(348,573)	5,805	0	0	0	0	0	0	0	0	0	(342,768)	45



Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

**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 ILLINIOS SENIOR HOUSING 100		GENEVA LAKE MANOR	LAKE GENEVA, WI			
		HOLTON MANOR	ELKHORN, WI			
		MONTELLO CARE CENTER	MONTELLO, WI			
		EAST TROY MANOR	EAST TROY, WI			
		EDGERTON CARE CENTER	EDGERTON, WI			
		INGLESIDE MANOR	MT. HOREB, WI			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 HOME OFFICE COST	\$ 63,240	WISCONSIN ILLINOIS SENIOR HOUSING	100.00%	\$ 69,045	\$ 5,805	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		\$ 63,240			\$ 69,045	\$ * 5,805	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:

Ending:

**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	NICOLAS LYNN	BOD						4
5	MIRIAM GEHLER	BOD						5
6	RAJEEV KUMAR, MD, FACP	BOD						6
7	KERI GERLACH	BOD						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: Ending:

**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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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:

Ending:

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

Ending:

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	BOND SERIES		X	BUILDING NEW ADDITIONS		8/1/12	\$ 5,820,977	\$ 5,339,452		\$ 231,779	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$ 5,820,977	\$ 5,339,452		\$ 231,779	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 5,820,977	\$ 5,339,452		\$ 231,779	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:

Ending:

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 report.	\$ 75,678	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.)	\$ 79,029	2
3. Under or (over) accrual (line 2 minus line 1).	\$ 3,351	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$ 79,029	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$ 82,380	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2015	76,099	8
2016	75,588	9
2017	76,439	10
2018	75,678	11
2019	79,029	12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

**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.**

**2019 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 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-31-426-020</u>	<u>LT1</u>	\$ <u>79,029.00</u>	\$ <u>79,029.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>79,029.00</u></u>	\$ <u><u>79,029.00</u></u>

**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        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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**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:

Ending:

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).

Blank lines for listing other business entities.

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: SNF, 1995, \$200,000. Row 2: (blank). Row 3: TOTALS, \$200,000.



Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	46	1999		\$ 1,328,800	\$ 34,072		\$ 34,072	\$	\$ 727,966	4
5		2001		3,671					3,671	5
6	5		2013	4,437,265	111,815		111,815		893,493	6
7										7
8										8
<b>Improvement Type**</b>										
9	WOODEN FLOORS, CARPETING, LIGHT FIXTURES		2001	39,077					39,077	9
10	FLOORING, PLUMBING, COUNTERTOPS		2003	16,324					16,327	10
11	FIRE ALARM SYSTEM, CARPET FURNISHINGS		2005	22,694	163		163		21,729	11
12	SPRINKLER SYSTEM		2006	72,000	2,880		2,880		43,200	12
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICAL WORK		2008	26,941	1,057		1,057		13,163	13
14	WINDOW, FLOORING		2009	37,161					37,161	14
15	FLOORING, TILES		2011	7,710					7,710	15
16	PLANK FLOORING		2012	2,321					2,321	16
17	REGULATOR FOR WATER TEMPS IN RESIDENT ROOMS		2014	4,985	498		498		3,323	17
18	NEW CARPET IN MAIN HALL		2014	9,790					9,790	18
19	GENERATOR UPDATES AND ADDITIONS		2014	10,020	1,002		1,002		6,680	19
20	AUTOMATIC KITCHEN DOOR		2014	3,855	386		386		2,474	20
21	PLUMBING-MIXING VALVES (MIGHTY OAKS)		2014	4,025	268		268		1,631	21
22	VINYL FLOORING, WOOD BLINDS (REMODEL OF BEDROOM)		2014	3,127	153		153		2,552	22
23	SPRINKLER SYSTEM VALAVE (MIGHTY OAKS)		2014	2,850	114		114		713	23
24	FIRE DOOR		2015	4,734	237		237		1,322	24
25	PLUMBING-DISHWASHER		2015	1,521	76		76		437	25
26	AUTOMATIC DOOR CLOSER		2015	1,540	103		103		591	26
27	KITCHEN DOOR - REPLACE		2016	1,797	90		90		367	27
28	PLUMBING - HOT WATER HEATER		2016	2,172	109		109		444	28
29	CERAMIC & VINYL FLOORING		2018	9,020	902		902		1,804	29
30	PVC PIPE REPLACEMENT (MAIN KITCHEN DRAIN)		2019	2,503	100		100		167	30
31	INSTALL WATER HEATER (KITCHEN AREA)		2020	4,504	225		225		225	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 HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	LAND IMPROVEMENTS:		\$			\$		\$ 11,660	37
38	REMOVE/REPLACE CONCRETE	2000	11,660	252		252		11,660	38
39	PARKING LOT	2004	15,000	750		750		12,375	39
40	LANDSCAPING (OAK TREES)	2006	3,450	230		230		3,297	40
41	LANDSCAPE/TREE REPLACEMENT	2015	2,435	244		244		1,461	41
42	REMOVE/REPLACE CONCRETE SIDEWALKS	2016	4,650	310		310		1,421	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)		\$ 6,097,602	\$ 156,036		\$ 156,036	\$	\$ 1,880,212	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:

Ending:

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	\$ 880,969	\$ 21,205	\$ 21,205	\$		\$ 822,440	71
72	Current Year Purchases	26,912	2,462	2,462			2,462	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 907,881	\$ 23,667	\$ 23,667	\$		\$ 824,902	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)	\$ 7,205,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,703	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,703	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)	\$ 2,705,114	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	REMODEL	\$ 721,724	92
93			93
94			94
95		\$ 721,724	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.

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2021                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2022                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2023                      \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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	<b>TOTAL</b>		\$	\$	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: \_\_\_\_\_ Ending: \_\_\_\_\_

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	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	L10A,C3	3610 hrs	\$ 147,755		\$	\$	3,610	\$ 147,755	1
2	Licensed Speech and Language Development Therapist	L10A, C3	644 hrs	45,246				644	45,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	7611 hrs	315,015				7,611	315,015	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapist</u>	L10,C3				4,935			4,935	12
13	Other (specify):									13
14	TOTAL			\$ 508,016		\$ 4,935	\$	11,865	\$ 512,951	14

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

Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 314,541	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 322,850 )	258,706		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,626		6
7	Other Prepaid Expenses	1,125		7
8	Accounts Receivable (owners or related parties)	2,516,485		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,122,483	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	6,074,922		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	946,778		16
17	Accumulated Depreciation (book methods)	(2,705,394)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>Bond Closing Costs ne</b> 234,178	234,178		22
23	Other(specify): <b>Cap Software net Amort, CIP</b> 729,932	729,932		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 5,480,416	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 8,602,899	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 776,038	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	294,208		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,587		32
33	Accrued Interest Payable	72,357		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>INTERCOMPANY PAYABLES</b>	73,101		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,322,291	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,339,452		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,339,452	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,661,743	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,941,156	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 8,602,899	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,983,857</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>REAL ESTATE ADJUSTMENT</b>	<b>(8,820)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,975,037</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(33,885)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>4</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(33,881)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,941,156</b>	<b>24</b> *

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



Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

**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.**

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,822,490	1
2	Discounts and Allowances for all Levels	(172,865)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,649,625	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	956,321	6
7	Oxygen	50,474	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,006,795	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	679,144	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,305	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	513,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	121,518	19
20	Radiology and X-Ray	26,704	20
21	Other Medical Services	91,710	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,433,568	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,065	24
25	Interest and Other Investment Income***	17	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,082	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>EMPLOYEE &amp; GUEST MEALS, FEES, REBATES</b>	3,343	28
28a	<b>PPP LOAN FORGIVENESS</b>	727,912	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 731,255	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,824,325	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	928,833	31
32	Health Care	3,297,792	32
33	General Administration	1,448,963	33
<b>B. Capital Expense</b>			
34	Ownership	505,240	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	677,382	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,858,210	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(33,885)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (33,885)	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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:

Ending:

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,904	2,096	\$ 100,964	\$ 48.17	1
2	Assistant Director of Nursing	1,830	1,966	82,633	42.03	2
3	Registered Nurses	21,269	23,597	791,679	33.55	3
4	Licensed Practical Nurses	10,452	11,354	344,599	30.35	4
5	CNAs & Orderlies	50,484	55,137	844,071	15.31	5
6	CNA Trainees					6
7	Licensed Therapist	10,882	11,865	508,016	42.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,120	44,327	20.91	9
10	Activity Assistants	4,056	4,322	48,452	11.21	10
11	Social Service Workers	3,432	3,724	71,104	19.09	11
12	Dietician					12
13	Food Service Supervisor	1,955	2,059	48,939	23.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,452	16,800	249,050	14.82	15
16	Dishwashers					16
17	Maintenance Workers	2,756	3,331	68,401	20.53	17
18	Housekeepers	11,937	12,693	160,366	12.63	18
19	Laundry					19
20	Administrator	1,971	2,153	104,785	48.67	20
21	Assistant Administrator					21
22	Other Administrative	7,695	8,189	165,889	20.26	22
23	Office Manager	1,925	2,112	56,604	26.80	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	1,978	2,386	44,795	18.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,066	165,904	\$ 3,734,674 *	\$ 22.51	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	336	\$ 19,781	L1, C3	35
36	Medical Director	12	10,833	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1	400	L10, C3	38
39	Pharmacist Consultant	9	675	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	16	1,072	L11, C3	44
45	Social Service Consultant	12	864	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	386	\$ 33,625		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	27	\$ 1,370	L10, C3	50
51	Licensed Practical Nurses	182	8,366	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	209	\$ 9,736		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nicole Lopez	Administrator		\$ 104,785	Workers' Compensation Insurance	\$ 75,930	IDPH License Fee	\$	
				Unemployment Compensation Insurance	10,129	Advertising: Employee Recruitment	15,677	
				FICA Taxes	276,504	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	149,517	Patient Background Checks		
				Employee Meals		Dues and Subscriptions	34,598	
				Illinois Municipal Retirement Fund (IMRF)*				
				Group Life	6,894			
				Pension & Retirement	21,956			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,785					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Professional Services Schedule	Legal Fees		\$ 2,862			\$	Out-of-State Travel	\$
Carriage Healthcare Inc	Management Fees		252,960					
See Professional Services Schedule	Data Processing		62,365					
See Professional Services Schedule	Accounting		18,484				In-State Travel	
Wisconsin Illinois Senior Housing	Owner Fees		63,240					
							Seminar Expense	
							General Business Travel	713
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 399,911	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 713

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number FAIR OAKS HEALTH CARE CENTER

# 0040915

Report Period Beginning:

Ending:

**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? NO  
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. \$ \_\_\_\_\_  
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? N/A  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (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.