

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0040915 Facility Name: FAIR OAKS HEALTH CARE CENTER Address: 471 W TERRA COTTA CRYSTAL LAKE 60014-3434 County: McHENRY Telephone Number: 815-455-0550 Fax # 815-455-0608 HFS ID Number: Date of Initial License for Current Owners: 5/1/1995 Type of Ownership: VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code 501 C (3) PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: JOYCE SURDICK Telephone Number: 815-455-0550 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 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) (Type or Print Name) JOYCE SURDICK (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) JT AND ASSOCIATES, LLC 700 PILGRIM PLWY, SUITE 200, ELM GROVE, WI 53112 (Telephone) 262-789-9945 Fax # MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number FAIR OAKS HEALTH CARE CENTER

0040915 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,790</u>	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	<u>46</u>	TOTALS	<u>46</u>	<u>16,790</u>	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	<u>2,434</u>	<u>7,417</u>	<u>4,707</u>	<u>14,558</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,434</u>	<u>7,417</u>	<u>4,707</u>	<u>14,558</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.71%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) _____

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ 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 05/95

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 40 and days of care provided 4,460

Medicare Intermediary ADMINISTAR FEDERAL /IL

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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.

STATE OF ILLINOIS

Facility Name & ID NumberFAIR OAKS HEALTH CARE CENTER#0040915Report Period Beginning:1/1/11Ending:12/31/11

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	
	A. General Services											
1	Dietary	164,529	10,652	16,408	191,589		191,589		191,589			1
2	Food Purchase		112,840		112,840		112,840		112,840			2
3	Housekeeping	109,769	11,287	2,469	123,525		123,525		123,525			3
4	Laundry		3,178	1,910	5,088		5,088		5,088			4
5	Heat and Other Utilities			68,160	68,160		68,160	(6,536)	61,624			5
6	Maintenance	73,237	21,606	42,971	137,814		137,814		137,814			6
7	Other (specify):*											7
8	TOTAL General Services	347,535	159,563	131,918	639,016		639,016	(6,536)	632,480			8
	B. Health Care and Programs											
9	Medical Director			9,167	9,167		9,167		9,167			9
10	Nursing and Medical Records	1,216,081	59,467	44,063	1,319,611		1,319,611		1,319,611			10
10a	Therapy		1,957	489,853	491,810		491,810		491,810			10a
11	Activities	61,617	2,125	3,780	67,522		67,522		67,522			11
12	Social Services	40,095		568	40,663		40,663		40,663			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,317,793	63,549	547,431	1,928,773		1,928,773		1,928,773			16
	C. General Administration											
17	Administrative	100,012			100,012		100,012		100,012			17
18	Directors Fees											18
19	Professional Services			225,431	225,431		225,431	(18,762)	206,669			19
20	Dues, Fees, Subscriptions & Promotions			5,390	5,390		5,390		5,390			20
21	Clerical & General Office Expenses	75,298	12,792	130,491	218,581		218,581		218,581			21
22	Employee Benefits & Payroll Taxes			281,281	281,281		281,281		281,281			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,046	18,046		18,046		18,046			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,320	21,320		21,320		21,320			26
27	Other (specify):*											27
28	TOTAL General Administration	175,310	12,792	681,959	870,061		870,061	(18,762)	851,299			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,840,638	235,904	1,361,308	3,437,850		3,437,850	(25,298)	3,412,552			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			75,623	75,623		75,623		75,623			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			320,172	320,172		320,172		320,172			32
33	Real Estate Taxes			52,607	52,607		52,607		52,607			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			448,402	448,402		448,402		448,402			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,863	36,577	209,440		209,440		209,440			39
40	Barber and Beauty Shops			8,543	8,543		8,543		8,543			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):*			89,799	89,799		89,799	(89,799)				43
44	TOTAL Special Cost Centers		172,863	160,104	332,967		332,967	(89,799)	243,168			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,840,638	408,767	1,969,814	4,219,219		4,219,219	(115,097)	4,104,122			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,536)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,936)	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	(65,608)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,189)	43		28
29	Other-Attach Schedule <u>Vending</u>	(2,066)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,335)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (96,335)		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 HEALTH CARE CENTER

Report Period Beginning: ID# 0040915
Ending: 1/1/11
12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ (2,066)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,066)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WISCONSIN ILLINOIS SENIOR HOUSING 100		GENEVA LAKE MANOR	LAKE GENEVA, WI			
		WILD ROSE MANOR	WILD ROSE, WI			
		HOLTON MANOR	ELKHORN, WI			
		SHELTERED VILLAGE	RIPON, WI			
		MONTELLO CARE CENTER	MONTELLO, WI			
		EAST TROY MANOR	EAST TROY, 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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	HOME OFFICE COSTS	\$ 34,500	WISCONSIN ILLINOIS SENIOR HOUSING	100.00%	\$ 15,738	\$ (18,762)	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			\$ 34,500			\$ 15,738	\$ * (18,762)	14

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

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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: 1/1/11 Ending: 12/31/11

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

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	SERIES A/B 2010		X	PURCH. BULD & EQUIP	\$23,018.00	5/12/10	\$ 5,055,033	\$ 4,942,009			\$ 320,172	1	
2				& BUILD NEW BLD.								2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$23,018.00		\$ 5,055,033	\$ 4,942,009			\$ 320,172	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,055,033	\$ 4,942,009			\$ 320,172	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.)

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 2010 report.		\$	62,043	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.)		\$	59,443	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,600)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	55,207	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.		\$	52,607	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	46,603	8	
		2007	47,840	9	
		2008	54,423	10	
		2009	55,650	11	
		2010	59,443	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

FACILITY NAME	<u>FAIR OAKS HEALTH CARE CENTER</u>	COUNTY	<u>McHENRY</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)		(B)		(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-31-426-020	LT1		\$ 59,443.00	\$ 59,443.00
2.				\$	\$
3.				\$	\$
4.				\$	\$
5.				\$	\$
6.				\$	\$
7.				\$	\$
8.				\$	\$
9.				\$	\$
10.				\$	\$
TOTALS				\$ 59,443.00	\$ 59,443.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES	X	NO
-----	---	----

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,629

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☒ (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?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF		1999	\$ 200,000	1
2					2
3	TOTALS			\$ 200,000	3

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		\$ 421,319
5			2001		3,671					3,671
6										
7										
8										
	Improvement Type**									
9	WOODEN FLOORS, CARPENTING, LIGHT FIXTURES			2001	39,077	1,339		1,339		39,077
10	FLOORING, PLUMBING, COUNTERTOPS			2003	16,324	783		783		14,946
11	FIRE ALARM SYSTEM, CARPET, FURNISHINGS			2005	22,694	2,822		2,822		18,706
12	SPRINKLER SYSTEM			2006	72,000	2,880		2,880		17,280
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICALWORK			2008	26,941	1,057		1,057		3,653
14	WINDOW, FLOORING			2009	37,161	3,818		3,818		9,219
15	FLOORING, TILES			2011	7,710	687		687		687
16										
17										
18										
19										
20	LAND IMPROVEMENTS									
21	REMOVE REPLACE CONCRETE			2000	11,660	686		686		7,634
22	PARKING LOT			2004	15,000	750		750		5,625
23	LANDSCAPING (OAK TREES)			2006	3,450	230		230		1,227
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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)		\$ 1,584,488	\$ 49,124		\$ 49,124	\$	\$ 543,044	70

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

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	\$ 646,044	\$ 24,350	\$ 24,350	\$		\$ 581,123	71
72	Current Year Purchases	19,772	2,150	2,150			2,150	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 665,816	\$ 26,500	\$ 26,500	\$		\$ 583,273	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)	\$ 2,450,304	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,624	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,624	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)	\$ 1,126,317	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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)	\$			

(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)	
TOTAL TRAINED	

(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.)

		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	L10A, C3	hrs	\$		\$ 197,283	\$		\$ 197,283	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs			67,143			67,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs			225,264			225,264	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>RESPIRATORY THEI</u>	L10A, C3				163			163	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 489,853	\$		\$ 489,853	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.

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	\$ 355,896	\$	1
2	Cash-Patient Deposits	100		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	873,455		3
4	Supply Inventory (priced at)	10,065		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,350		7
8	Accounts Receivable (owners or related parties)	4,816,904		8
9	Other(specify): <u>SHORT TERM LOAN REC.</u>	18,942		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,076,712	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	1,560,049		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	702,977		16
17	Accumulated Depreciation (book methods)	(1,123,146)		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 <u>LOAN/BOND COSTS</u>	42,089		22
23	Other(specify): <u>NOTES REC/ADV. PRJ COSTS</u>	439,437		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,821,406	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,898,118	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 257,129	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,278		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,443		32
33	Accrued Interest Payable	130,324		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>INTERCOMPANY LOANS</u>	18,984		36
37	<u>DEF. REV.</u>	6,030		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 693,188	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,942,009		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,942,009	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,635,197	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,262,921	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,898,118	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,966,419	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENTS	(7,808)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,958,611	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	304,310	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)	\$ 304,310	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)	\$ 2,262,921	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,118,760	1
2	Discounts and Allowances for all Levels	(275,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,843,137	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,212,217	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,212,217	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,236	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	344,781	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,296	19
20	Radiology and X-Ray	10,909	20
21	Other Medical Services	55,977	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 456,199	23
	D. Non-Operating Revenue		
24	Contributions	468	24
25	Interest and Other Investment Income***	4,077	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,545	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING MACHINE, EMPLOYEE MEALS	7,431	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,431	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,523,529	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	639,016	31
32	Health Care	1,928,773	32
33	General Administration	870,061	33
	B. Capital Expense		
34	Ownership	448,402	34
	C. Ancillary Expense		
35	Special Cost Centers	209,440	35
36	Provider Participation Fee	25,185	36
	D. Other Expenses (specify):		
37	BARBER & BEAUTY	8,543	37
38	ADVERTISING & ENTERTAINMENT	89,799	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,219,219	40
41	Income before Income Taxes (line 30 minus line 40)**	304,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 304,310	43

* 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.

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	2,341	2,264	\$ 65,002	\$ 28.71	1
2	Assistant Director of Nursing	1,993	2,217	54,082	24.39	2
3	Registered Nurses	14,422	15,014	340,009	22.65	3
4	Licensed Practical Nurses	11,161	12,111	210,577	17.39	4
5	CNAs & Orderlies	47,855	50,512	576,329	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	31,970	15.37	9
10	Activity Assistants	3,418	3,570	29,647	8.30	10
11	Social Service Workers	1,777	2,012	40,095	19.93	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	29,823	14.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,378	13,423	134,706	10.04	15
16	Dishwashers					16
17	Maintenance Workers	3,678	3,958	73,237	18.50	17
18	Housekeepers	10,202	11,116	109,769	9.87	18
19	Laundry					19
20	Administrator	2,000	2,080	100,012	48.08	20
21	Assistant Administrator					21
22	Other Administrative	2,074	2,294	25,991	11.33	22
23	Office Manager	2,544	2,624	49,307	18.79	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	1,725	1,849	24,164	13.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,568	129,204	\$ 1,894,720 *	\$ 14.66	34

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	144	\$ 12,261	L1, C3	35
36	Medical Director	33	9,996	L9, C3	36
37	Medical Records Consultant	12	640	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	20	900	L10, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	2,318	L11, C3	44
45	Social Service Consultant	12	1,424	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 27,539		49

C. CONTRACT NURSES

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

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

** See instructions.

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?
If YES, give association name and amount.

NO

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
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?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO

(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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES

NO

X

(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.

\$

25,185

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO
- (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?
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.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$

N/A

Indicate the amount.

\$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

\$

c.

What percent of all travel expense relates to transportation of nurses and patients?

N/A

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO

\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

YES

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)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

YES

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Seminar 2011

Attendee	Title	Date of Seminar	Location	Title of Seminar	Sponsor of Seminar	Cost
All staff	In house training	01/01-12/31/11	Internet Courses	Misc	Silver Chair	\$2,719.00
J Surdic	Administrator	3/11/2011	Chicago, IL	INHA	LSN	\$535.00
C. Ison	DON	3/11/2011	Chicago, IL	INHA	LSN	\$535.00
C.Ison, Csmith,	DON, C N A Supv	4/11/2011	Chicago, IL	IL Challenging Geriatric Be	Pesi	\$507.00
C Smith	C N A Sup	2/11/2011	Webinar	Alzheimers 36 hour day	Univ Maryland	\$200.00
J Surdick	Administrator	2/11/2011	Webinar	Misc	AMDA	\$101.00
M Nickett & P.Ry	MDS & ADON	5/11/2011	Bloomngdale IL	Care Plans	Healthcare Info Networ	\$358.00
J Surdick&C.Ison	Administrator/DON	Spring	California	Spring Seminar	CHC	\$3,750.00
JS & Ltapaninen	Administrator/BOM	Fall	Philadelphia	Fall Seminar	CHC	\$3,000.00
J.Surdick	Admin	3/11/2011	Chicago, IL	INHA	LSN	\$535.00
P Rygh	ADON	01/11/11	Westmont IL	ICD coding	Pathway	\$169.00
Jim Surdick	Soc Ser	2/11/2011	Springfield IL	INHA Seminar	INHA	\$401.00
						\$12,810.00
						Cost
				No single travel item greater than \$250.		\$5,236.00
						\$18,046.00