

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0040915</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>FAIR OAKS HEALTH CARE CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.																							
Address: <u>471 TERRA COTTA AVE</u> <u>CRYSTAL LAKE</u> <u>60014</u>																									
Number City Zip Code																									
County: <u>MCHENRY</u>																									
Telephone Number: <u>815-455-0550</u> Fax # <u>815-455-0608</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>JOYCE SURDICK</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, SUITE 200, ELM GROVE, WI 53122</u></td></tr><tr><td>(Telephone) <u>262-789-9945</u> Fax # () _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>JOYCE SURDICK</u>	(Title) <u>Administrator</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) <u>JT AND ASSOCIATES, LLC</u> <u>700 PILGRIM PKWY, SUITE 200, ELM GROVE, WI 53122</u>	(Telephone) <u>262-789-9945</u> Fax # () _____												
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	(Telephone) <u>262-789-9945</u> Fax # () _____																								
Date of Initial License for Current Owners: <u>5/1/1995</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501C(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501C(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code <u>501C(3)</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>JOYCE SURDICK</u> Telephone Number: <u>815-455-0550</u> Email Address: _____																									

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

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>16,836</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>16,836</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>2,101</u>	<u>7,324</u>	<u>3,953</u>	<u>13,378</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>2,101</u>	<u>7,324</u>	<u>3,953</u>	<u>13,378</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.46%

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?

YESG. 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

3,853Medicare Intermediary ADMINISTAR FEDERAL/IL

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐Tax Year: 12/31Fiscal Year: 12/31

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

	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	171,140	4,831	18,319	194,290		194,290		194,290		1
2	Food Purchase		105,029		105,029		105,029		105,029		2
3	Housekeeping	110,474	12,442	2,792	125,708		125,708		125,708		3
4	Laundry		4,049	2,294	6,343		6,343		6,343		4
5	Heat and Other Utilities			77,480	77,480		77,480	(6,887)	70,593		5
6	Maintenance	65,266	12,383	40,091	117,740		117,740		117,740		6
7	Other (specify):*										7
8	TOTAL General Services	346,880	138,734	140,976	626,590		626,590	(6,887)	619,703		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	1,089,575	50,340	32,982	1,172,897		1,172,897		1,172,897		10
10a	Therapy		5,752	408,451	414,203		414,203		414,203		10a
11	Activities	65,255	2,561	6,217	74,033		74,033		74,033		11
12	Social Services	39,086	50	2,544	41,680		41,680		41,680		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,193,916	58,703	460,194	1,712,813		1,712,813		1,712,813		16
	C. General Administration										
17	Administrative	100,000			100,000		100,000		100,000		17
18	Directors Fees										18
19	Professional Services			239,277	239,277		239,277	671	239,948		19
20	Dues, Fees, Subscriptions & Promotions			6,963	6,963		6,963		6,963		20
21	Clerical & General Office Expenses	90,899	6,381	72,365	169,645		169,645	(6,946)	162,699		21
22	Employee Benefits & Payroll Taxes			335,604	335,604		335,604		335,604		22
23	Inservice Training & Education			2,970	2,970		2,970		2,970		23
24	Travel and Seminar			8,054	8,054		8,054		8,054		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,077	24,077		24,077		24,077		26
27	Other (specify):*										27
28	TOTAL General Administration	190,899	6,381	689,310	886,590		886,590	(6,275)	880,315		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,731,695	203,818	1,290,480	3,225,993		3,225,993	(13,162)	3,212,831		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	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			73,058	73,058		73,058		73,058			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			268,043	268,043		268,043		268,043			32
33	Real Estate Taxes			45,025	45,025		45,025		45,025			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			386,126	386,126		386,126		386,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,546	23,290	95,836		95,836		95,836			39
40	Barber and Beauty Shops			7,885	7,885		7,885		7,885			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,244	81,244		81,244		81,244			42
43	Other (specify):*			535,577	535,577		535,577	(535,577)				43
44	TOTAL Special Cost Centers		72,546	647,996	720,542		720,542	(535,577)	184,965			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,731,695	276,364	2,324,602	4,332,661		4,332,661	(548,739)	3,783,922			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(6,887)	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	(6,946)	21		18
19	Entertainment	(5,163)	43		19
20	Contributions		43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(527,619)	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	(750)	43		28
29	Other-Attach Schedule Vending	(2,045)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (549,410)		\$	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	2	
		Amount	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (549,410)		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	
		Yes	No	Amount	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 CTR

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (2,045)	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	(2,045)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR OAKS HEALTH CARE CTR # 0040915 Report Period Beginning: 1/1/12 Ending: 12/31/12
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,887)	0	0	0	0	0	0	0	0	0	0	(6,887)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,887)	0	0	0	0	0	0	0	0	0	0	(6,887)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	671	0	0	0	0	0	0	0	0	0	671	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,946)	0	0	0	0	0	0	0	0	0	0	(6,946)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(6,946)	671	0	0	0	0	0	0	0	0	0	(6,275)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,833)	671	0	0	0	0	0	0	0	0	0	(13,162)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(535,577)	0	0	0	0	0	0	0	0	0	0	(535,577)	43
44	TOTAL Special Cost Centers	(535,577)	0	0	0	0	0	0	0	0	0	0	(535,577)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(549,410)	671	0	0	0	0	0	0	0	0	0	(548,739)	45

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			
		WILE ROSE MANOR	WILD ROSE, WI			
		HOLTON MANOR	ELKHORN, WI			
		MONTELLO CARE CENTER	MONTELLO WI			
		EAST TROY MANOR	EAST TROY, WI			
		EDGERTON CARE CENTER	EDGERTON, WI			
		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:	
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 HIOUSING	100.00%	\$ 35,171	\$ 671	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			\$ 35,171	\$ * 671	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 CTR # 0040915 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 BLD & EQUIP		5/12/10	\$ 5,055,033	\$			\$ 266,039	1		
2				& BUILD NEW BLD								2		
3	SERIES 2012		X	BUILDING NEW ADDITION		8/1/12		5,820,977				3		
4												4		
5												5		
	Working Capital													
6												6		
7												7		
8												8		
9	TOTAL Facility Related						\$ 5,055,033	\$ 5,820,977			\$ 266,039	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	\$ 5,820,977			\$ 266,039	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

[illegible]

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

FAIR OAKS HEALTH CARE CTR

COUNTY

MCHENRY

FACILITY IDPH LICENSE NUMBER

0040915

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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	\$ 45,025.00	\$ 45,025.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 45,025.00	\$ 45,025.00

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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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?

X(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

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

YES

X NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	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		\$ 455,390
5			2001		3,671					3,671
6										
7										
8										
	Improvement Type**									
9	WOODEN FLOORS, CARPENTING, LIGHT FIXTURES			2001	39,077					39,077
10	FLOORING, PLUMBING, COUNTERTOPS			2003	16,324	783		783		15,729
11	FIRE ALARM SYSTEM, CARPET, FURNISHINGS			2005	22,694	941		941		19,647
12	SPRINKLER SYSTEM			2006	72,000	2,880		2,880		20,160
13	UTILITY POLE, FLOORING, CEILING TILE, ELECTRICALWORK			2008	26,941	1,057		1,057		4,710
14	WINDOW, FLOORING			2009	37,161	3,818		3,818		13,037
15	FLOORING, TILES			2011	7,710	1,275		1,275		1,962
16	PLANK FLOORING			2012	2,321	116		116		116
17										
18										
19										
20	LAND IMPROVEMENTS									
21	REMOVE REPLACE CONCRETE			2000	11,660	686		686		8,320
22	PARKING LOT			2004	15,000	750		750		6,375
23	LANDSCAPING (OAK TREES)			2006	3,450	230		230		1,457
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		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			\$	\$		\$	\$	\$	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)		\$1,586,809	\$46,608		\$46,608	\$	\$589,651	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	\$ 665,816	\$ 26,302	\$ 26,302	\$		\$ 609,576	71
72	Current Year Purchases	1,775	148	148			148	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 667,591	\$ 26,450	\$ 26,450	\$		\$ 609,724	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	2	
	Reference	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)	\$ 2,454,400	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,058	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,058	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)	\$ 1,199,375	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 156,664	\$		\$ 156,664	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs			82,624			82,624	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs			168,938			168,938	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): RESPIRATORY THE	L10A, C3				225			225	12
13	Other (specify):									13
14	TOTAL			\$		\$ 408,451	\$		\$ 408,451	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 164,191	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	576,141		3
4	Supply Inventory (priced at)	15,540		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,350		7
8	Accounts Receivable (owners or related parties)	2,943,440		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,700,662	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	66,741		11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	1,562,370		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	710,782		16
17	Accumulated Depreciation (book methods)	(1,196,204)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: LOAN/BOND COSTS)	40,085		22
23	Other(specify): CIP	3,823,784		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,207,558	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,908,220	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 567,567	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,022		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,265		32
33	Accrued Interest Payable	150,723		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY LOANS	23,825		36
37	AP RETAINAGE FOR CIP	163,232		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,173,634	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,820,977		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)	\$ 5,820,977	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,994,611	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,913,609	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,908,220	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,262,921	1
2	Restatements (describe):		2
3	DEPRECIATION ADJ	(6,065)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,256,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(343,247)	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)	\$ (343,247)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,913,609	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		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 2,967,561	1	
2Discounts and Allowances for all Levels	(40,739)	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,926,822	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	749,479	6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 749,479	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care	9,863	13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs	159,990	17	
18Sale of Supplies to Non-Patients		18	
19Laboratory	25,352	19	
20Radiology and X-Ray	8,189	20	
21Other Medical Services	65,544	21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 268,938	23	
D. Non-Operating Revenue			
24Contributions	21,416	24	
25Interest and Other Investment Income***	4,638	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,054	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28VENDING, EMPLOYEE MEALS	18,121	28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,121	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,989,414	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	626,590	31	
32Health Care	1,712,813	32	
33General Administration	886,590	33	
B. Capital Expense			
34Ownership	386,126	34	
C. Ancillary Expense			
35Special Cost Centers	639,298	35	
36Provider Participation Fee	81,244	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,332,661	40	
41Income before Income Taxes (line 30 minus line 40)**	(343,247)	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (343,247)	43	

III. Net Inpatient Revenue detailed by Payer Source		
44Medicaid - Net Inpatient Revenue	\$	44
45Private Pay - Net Inpatient Revenue		45
46Medicare - Net Inpatient Revenue		46
47Other-(specify)		47
48Other-(specify)		48
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,892	2,080	\$ 67,918	\$ 32.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,192	11,000	328,891	29.90	3
4	Licensed Practical Nurses	6,249	6,841	164,299	24.02	4
5	CNAs & Orderlies	35,522	38,095	506,234	13.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,902	1,998	31,342	15.69	9
10	Activity Assistants	3,928	4,181	33,913	8.11	10
11	Social Service Workers	1,964	2,080	39,086	18.79	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,080	30,000	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,751	3,955	76,308	19.29	15
16	Dishwashers	8,131	9,171	64,832	7.07	16
17	Maintenance Workers	3,387	3,799	65,266	17.18	17
18	Housekeepers	10,118	10,836	110,474	10.20	18
19	Laundry					19
20	Administrator	2,000	2,080	100,000	48.08	20
21	Assistant Administrator					21
22	Other Administrative	1,640	2,063	23,177	11.23	22
23	Office Manager	3,795	4,011	67,722	16.88	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	1,826	1,942	22,233	11.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,233	106,212	\$ 1,731,695 *	\$ 16.30	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	148	\$ 10,145	L1, C3	35
36	Medical Director	12	10,000	L9, C3	36
37	Medical Records Consultant	12	720	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	894	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	42	2,747	L11, C3	44
45	Social Service Consultant	20	1,440	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	\$ 25,946		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.

FAIR OAKS HEALTH CARE CENTER - CRYSTAL LAKE
ID NUMBER: 0040915
Seminar 2012

Attendee	Title	Date of Seminar	Location	Title of Seminar	Sponsor of Seminar	Cost
C. Ison	DON	Spring	IL/ IA	Spring Seminar	CHC	\$1,275.00
J. Surdick	Administrator	Fall	Jackson, WY	Fall Seminar	CHC	\$3,500.00
						\$4,775.00
Travel to CHC Seminars						
Destination		Reason	Mileage	Rates	Time Frame	Cost
Joyce Surdick	Varied	alz. Walk	736	.55 per mile	2 weeks	\$408.48
Joyce Surdick	Jackso WY	fall CHC			27-Aug	\$1,111.10
Carrie Porter	CHM/CHW	Refferals	187.25	.55 per mile	11/1-11/31	\$103.33
Joyce Surdick	Jackso WY	Fall CHC			Nov	\$150.00
Carrie Porter	CHM/CHW	Refferals	191.49	.55 per mile	12/1-12/31	\$105.32
						\$1,878.23
						Cost
No single travel item greater than \$250.						\$1,401.00
						\$8,054.23

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?

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 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?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

HFS 3745 (N-4-99)

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