

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0050963</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Fair Oaks Rehab HCC</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</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>1515 Blackhawk</u> <u>South Beloit</u> <u>61080</u>																																																		
Number City Zip Code																																																		
County: <u>Winnebago</u>																																																		
Telephone Number: <u>(815) 389-3911</u> Fax # <u>(815) 389-5065</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) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u></td></tr><tr><td>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</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>	(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u>	(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>	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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Date of Initial License for Current Owners: <u>7/1/2010</u>																																																		
Type of Ownership:																																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table>			☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	☐	_____			☒	Limited Liability Co.	☐	_____			☐	Trust	☐	_____			☐	Other	☐	_____
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In the event there are further questions about this report, please contact:																																																		
Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u>																																																		
Email Address: _____																																																		

Facility Name & ID Number Fair Oaks Rehab HCC

0050963 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>78</u>	Skilled (SNF)	<u>78</u>	<u>28,548</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>78</u>	TOTALS	<u>78</u>	<u>28,548</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>12,585</u>	<u>2,615</u>	<u>6,914</u>	<u>22,114</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>12,585</u>	<u>2,615</u>	<u>6,914</u>	<u>22,114</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.46%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 7/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 78 and days of care provided 3,795

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fair Oaks Rehab HCC # 0050963 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		8,351	412,344	420,695		420,695		420,695			1
2	Food Purchase		8,407		8,407		8,407	(149)	8,258			2
3	Housekeeping		18,068	102,411	120,479		120,479		120,479			3
4	Laundry		6,459	67,315	73,774		73,774		73,774			4
5	Heat and Other Utilities			134,374	134,374		134,374		134,374			5
6	Maintenance	85,649	14,554	82,714	182,917		182,917		182,917			6
7	Other (specify):*											7
8	TOTAL General Services	85,649	55,839	799,158	940,646		940,646	(149)	940,497			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,783,777	114,567	243,032	2,141,376		2,141,376	(15,000)	2,126,376			10
10a	Therapy											10a
11	Activities	75,242	10,720	6,586	92,548		92,548		92,548			11
12	Social Services	94,874	62	2,600	97,536		97,536		97,536			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,953,893	125,349	270,218	2,349,460		2,349,460	(15,000)	2,334,460			16
	C. General Administration											
17	Administrative	96,982		300,210	397,192		397,192	5,615	402,807			17
18	Directors Fees											18
19	Professional Services			81,583	81,583		81,583	(25,750)	55,833			19
20	Dues, Fees, Subscriptions & Promotions			22,640	22,640		22,640	(1,466)	21,174			20
21	Clerical & General Office Expenses	216,987	24,386	50,743	292,116		292,116	34,948	327,064			21
22	Employee Benefits & Payroll Taxes			315,242	315,242		315,242		315,242			22
23	Inservice Training & Education			680	680		680		680			23
24	Travel and Seminar			7,951	7,951		7,951		7,951			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			104,137	104,137		104,137		104,137			26
27	Other (specify):*											27
28	TOTAL General Administration	313,969	24,386	883,186	1,221,541		1,221,541	13,347	1,234,888			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,353,511	205,574	1,952,562	4,511,647		4,511,647	(1,802)	4,509,845			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			5,085	5,085		5,085	100,233	105,318			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			978	978		978	57,056	58,034			32
33	Real Estate Taxes			96,675	96,675		96,675	4,028	100,703			33
34	Rent-Facility & Grounds			255,817	255,817		255,817	(255,817)				34
35	Rent-Equipment & Vehicles			3,117	3,117		3,117		3,117			35
36	Other (specify):* Mortgage Insurance Premium							9,838	9,838			36
37	TOTAL Ownership			361,672	361,672		361,672	(84,662)	277,010			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,122	671,482	983,604		983,604		983,604			39
40	Barber and Beauty Shops			90	90		90		90			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,042	154,042		154,042		154,042			42
43	Other (specify):* Marketing	48,303	26,951		75,254		75,254	(75,254)				43
44	TOTAL Special Cost Centers	48,303	339,073	825,614	1,212,990		1,212,990	(75,254)	1,137,736			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,401,814	544,647	3,139,848	6,086,309		6,086,309	(161,718)	5,924,591			45

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

	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				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	(252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(15,886)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	70,198	21		24
25	Fund Raising, Advertising and Promotional	(23,058)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,175)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,173)		\$	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)	(138,545)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (138,545)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (161,718)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Portion of Dues	\$ (1,466)	20	1
2	Marketing Salaries	(48,303)	43	2
3	Marketing Benefits	(3,893)	43	3
4	Miscellaneous Income	(364)	21	4
5	Vending Machine Income	(149)	02	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(54,175)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Oaks Rehab HCC

0050963

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	(149)	0	0	0	0	0	0	0	0	0	0	(149)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	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	(149)	0	0	0	0	0	0	0	0	0	0	(149)	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	(15,000)	0	0	0	0	0	0	0	0	(15,000)	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	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	5,615	0	0	0	0	0	0	0	0	5,615	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,826	(39,576)	0	0	0	0	0	0	0	0	(25,750)	19
20	Fees, Subscriptions & Promotions	(1,466)	0	0	0	0	0	0	0	0	0	0	(1,466)	20
21	Clerical & General Office Expenses	53,948	0	(19,000)	0	0	0	0	0	0	0	0	34,948	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	52,482	13,826	(52,961)	0	0	0	0	0	0	0	0	13,347	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	52,333	13,826	(67,961)	0	0	0	0	0	0	0	0	(1,802)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	97,308	2,925	0	0	0	0	0	0	0	0	100,233	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(252)	58,286	(978)	0	0	0	0	0	0	0	0	57,056	32
33	Real Estate Taxes	0	4,028	0	0	0	0	0	0	0	0	0	4,028	33
34	Rent-Facility & Grounds	0	(255,817)	0	0	0	0	0	0	0	0	0	(255,817)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	9,838	0	0	0	0	0	0	0	0	0	9,838	36
37	TOTAL Ownership	(252)	(86,357)	1,947	0	0	0	0	0	0	0	0	(84,662)	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):*	(75,254)	0	0	0	0	0	0	0	0	0	0	(75,254)	43
44	TOTAL Special Cost Centers	(75,254)	0	0	0	0	0	0	0	0	0	0	(75,254)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(23,173)	(72,531)	(66,014)	0	0	0	0	0	0	0	0	(161,718)	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
See PG6-Supp		See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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	34	Rent	\$ 255,817	TI - South Beloit	100.00%	\$	\$ (255,817)	1
2	V	32	Interest		TI - South Beloit	100.00%	58,286	58,286	2
3	V	19	Legal & Accounting		TI - South Beloit	100.00%	13,826	13,826	3
4	V	36	Mortgage Insurance		TI - South Beloit	100.00%	9,838	9,838	4
5	V	30	Depreciation		TI - South Beloit	100.00%	97,308	97,308	5
6	V	33	Real Estate Taxes	96,675	TI - South Beloit	100.00%	100,703	4,028	6
7	V	26	Insurance	9,662	TI - South Beloit	100.00%	9,662		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 362,154			\$ 289,623	\$ * (72,531)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V	2 Line	3	4	5	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22Insurance	\$2,164	CarePlus Health Plus		\$2,164	\$	15
16	V	22Insurance	85,792	Cost Plus Insurance		85,792		16
17	V	26Insurance	90,487	LTC Plus Insurance, Inc.		90,487		17
18	V	17Management-Operating	300,210	Tutera Health Care Service		305,825	5,615	18
19	V	19Management-Data Processing	39,576	Tutera Health Care Service			(39,576)	19
20	V	30Management-Depreciation		Tutera Health Care Service		2,925	2,925	20
21	V	10Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000)	21
22	V	21Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000)	22
23	V	32Interest	978	Tutera Investments			(978)	23
24	V	10Nursing Admin - SM Equip	3,582	Walnut Creek Management Company, LLC		3,582		24
25	V	24Travel & Seminar	7,746	Walnut Creek Management Company, LLC		7,746		25
26	V	43Marketing	288	Walnut Creek Management Company, LLC		288		26
27	V	19Purchased Svs/Data Processing	6,624	Walnut Creek Management Company, LLC		6,624		27
28	V	20Help Wanted Ads & Licenses	5,119	Walnut Creek Management Company, LLC		5,119		28
29	V	21Supplies, Sm Equip, Postage	11,424	Walnut Creek Management Company, LLC		11,424		29
30	V	10Pharmacy Consultant	5,925	Critical Care Rx, LLC		5,925		30
31	V	39Drugs	142,024	Critical Care Rx, LLC		142,024		31
32	V	39IV Therapy & Supplies	17,854	Critical Care Rx, LLC		17,854		32
33	V	21A&G - Misc	32	Critical Care Rx, LLC		32		33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$753,825			\$687,811	\$*(66,014)	39

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

Facility Name & ID Number

Fair Oaks Rehab HCC

0050963

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Tutera Investments, LLC	99%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT INV LLC	1%	Bethany Rehab & Health Care Center	DeKlb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Carlinsville Rehab & Health Care Center	Carlinsville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Auburn Rehab & Health Care Center	Auburn, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Seni	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL				14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			St. Paul's Senior Community	Belleville, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Tutera Investments, LI	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fair Oaks Rehab HCC# 0050963

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Tutera Health Care Services

Street Address

7611 State Line Road

City / State / Zip Code

Kansas City, Missouri 64114

Phone Number

(816) 444-0900

Fax Number

(816) 822-0081

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fee- Operating	Direct Costs	287,210,821	71	\$ 15,078,459	\$ 10,830,799	5,825,352	\$ 305,829	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		5,825,352	2,925	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					\$ 15,222,689	\$ 10,830,799		\$ 308,754	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	HUD		X	Mortgage			\$	1,982,342			\$ 58,286	1
2	Interest Income Offset										(252)	2
3												3
4												4
5												5
	Working Capital											
6												6
7	Tutera Investments	X		Working Capital Note			360,343			0.0100	978	7
8	Related Party Offset										(978)	8
9	TOTAL Facility Related						\$ 360,343	\$ 1,982,342			\$ 58,034	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 360,343	\$ 1,982,342			\$ 58,034	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,838 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$	96,793	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	96,675	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(118)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	100,821	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.		\$	100,703	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	94,149	8	
		2016	94,638	9	
		2017	96,104	10	
		2018	96,793	11	
		2019	96,675	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks Rehab HCC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0050963

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

TELEPHONE (816) 444-0900 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 04-07-258-002	Long-Term Care	\$ 96,675.04	\$ 96,675.04
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 96,675.04	\$ 96,675.04

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,217

B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	Long-Term Care	11,217	2010	\$ 233,678	1
2					2
3	TOTALS	11,217		\$ 233,678	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	78		2010	1975	\$ 2,249,148	\$ 81,787	27	\$ 81,787	\$	\$ 858,765	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP HVAC			2013	6,946	381	7	381		6,946	9
10	CEILING INSULATION			2013	6,625	383	7	383		6,625	10
11	ROOF REPLACEMENT			2018	75,365	2,749	27	2,749		5,956	11
12											12
13											13
14	WATER HEATER (TI - SOUTH BELOIT)			2012	5,886		7			5,886	14
15	FIRE SPRINKLER SYSTEM (TI - SOUTH BELOIT)			2013	6,071	405	15	405		2,867	15
16	WATER HEATER (TI - SOUTH BELOIT)			2014	5,243	524	10	524		3,583	16
17	REPLACE EXTERIOR DOORS/FRAMES w/ ALUMINUM DOORS (TI -			2017	5,010	334	15	334		1,308	17
18	VINYL FLOORING (All Hallways) (TI - SB)			2017	20,009	1,334	15	1,334		5,225	18
19	SHOWER REPAIR - Vinyl shower walls in all three locations (TI-SB)			2017	8,200	820	10	820		3,213	19
20											20
21	Home Office Depreciation					2,925		2,925			21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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	N/A		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,388,503	\$ 91,642		\$ 91,642	\$	\$ 900,374	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	\$119,647	\$13,414	\$13,414	\$	Various	\$76,708	71	
72	Current Year Purchases							72	
73	Fully Depreciated Assets	459,555	262	262		Various	459,555	73	
74								74	
75	TOTALS	\$579,202	\$13,676	\$13,676	\$		\$536,263	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	Patient Transport	Van	2012	\$ 57,910	\$	\$	\$	5	\$ 57,910	76
77										77
78										78
79										79
80	TOTALS			\$ 57,910	\$	\$	\$		\$ 57,910	80

E. Summary of Care-Related Assets					1	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)				\$3,259,293	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$105,318	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$105,318	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)				\$1,494,547	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Work in Progress	\$21,428
93		
94		
95		\$21,428

* 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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ 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: \$ 3,117 Description: Dishwasher, Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$	4,159	\$ 289,658	\$	4,159	\$ 289,658	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,097	83,914		1,097	83,914	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		4,307	285,336	684	4,307	286,020	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescripts				139,907		139,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy	V39-03			4	248		4	248	12
13	Other (specify): See WTB	V39-02,03				12,326	171,531		183,857	13
14	TOTAL			\$	9,567	\$ 671,482	\$ 312,122	9,567	\$ 983,604	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	\$ 934,727	\$ 944,098	1
2	Cash-Patient Deposits	36,607	36,607	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	401,797	401,797	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,741	109,985	6
7	Other Prepaid Expenses	349,475	356,153	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		172,843	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,829,347	\$ 2,021,483	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		233,678	13
14	Buildings, at Historical Cost		2,299,567	14
15	Leasehold Improvements, at Historical Cost	88,936	88,936	15
16	Equipment, at Historical Cost	18,266	637,112	16
17	Accumulated Depreciation (book methods)	(30,777)	(1,494,547)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	264,702	(360,653)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 341,127	\$ 1,404,093	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,170,474	\$ 3,425,576	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 482,258	\$ 483,391	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,607	36,607	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,320	190,320	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,699	54,699	31
32	Accrued Real Estate Taxes(Sch.IX-B)		100,821	32
33	Accrued Interest Payable		4,791	33
34	Deferred Compensation	857,594	857,594	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fees Payable	(3,255)	(3,255)	36
37	Intercompany	(420)	(420)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,617,803	\$ 1,724,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,982,342	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Rent Payable		(61,402)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,920,940	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,617,803	\$ 3,645,488	46
47	TOTAL EQUITY(page 18, line 24)	\$ 552,671	\$ (219,912)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,170,474	\$ 3,425,576	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 543,119	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 543,119	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,896	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) Prior Period Adjustment	7,656	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 9,552	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)	\$ 552,671	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fair Oaks Rehab HCC

0050963

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,052,314	1
2	Discounts and Allowances for all Levels	(3,636,853)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,415,461	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,046,327	6
7	Oxygen	2,193	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,048,520	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		13
14	Non-Patient Meals	(4,253)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,300	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,429	19
20	Radiology and X-Ray	7,587	20
21	Other Medical Services	78,398	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 374,461	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	252	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 252	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	364	28
28a	<u>COVID-19 PHE Funding</u>	249,147	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 249,511	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,088,205	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	940,646	31
32	Health Care	2,349,460	32
33	General Administration	1,221,541	33
	B. Capital Expense		
34	Ownership	361,672	34
	C. Ancillary Expense		
35	Special Cost Centers	1,058,948	35
36	Provider Participation Fee	154,042	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,086,309	40
41	Income before Income Taxes (line 30 minus line 40)**	1,896	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,896	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,373,766	44
45	Private Pay - Net Inpatient Revenue	278,011	45
46	Medicare - Net Inpatient Revenue	(1,228,089)	46
47	Other-(specify) <u>Managed Care</u>	(407,387)	47
48	Other-(specify) <u>Hospice</u>	399,160	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,415,461	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	1,474	1,552	\$ 76,526	\$ 49.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,283	16,075	630,901	39.25	3
4	Licensed Practical Nurses	11,782	12,581	348,153	27.67	4
5	CNAs & Orderlies	39,922	42,131	699,173	16.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,028	2,199	32,742	14.89	9
10	Activity Assistants	3,909	4,149	42,500	10.24	10
11	Social Service Workers	3,643	4,160	94,874	22.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,241	3,432	85,649	24.96	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,872	2,080	96,982	46.63	20
21	Assistant Administrator					21
22	Other Administrative	689	689	10,649	15.46	22
23	Office Manager					23
24	Clerical	8,271	8,961	216,987	24.21	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	1,003	1,345	18,375	13.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,928	2,080	48,303	23.22	33
34	TOTAL (lines 1 - 33)	95,045	101,434	\$ 2,401,814 *	\$ 23.68	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,429	V01-3	35
36	Medical Director	Monthly	18,000	V09-3	36
37	Medical Records Consultant	Monthly	2,152	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,925	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,185	V11-3	44
45	Social Service Consultant	Monthly	2,600	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,291		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	560	\$ 55,645	V10-3	50
51	Licensed Practical Nurses	1,137	112,908	V10-3	51
52	Certified Nurse Assistants/Aides	1,445	43,528	V10-3	52
53	TOTAL (lines 50 - 52)	3,142	\$ 212,081		53

STATE OF ILLINOIS

0050963

Report Period Beginning:

1/1/2020

Page 21

Ending: 12/31/2020

Facility Name & ID Number

Fair Oaks Rehab HCC

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Tricker	Administrator	0	\$ 96,982
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,982

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fees	\$ 300,210
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 300,210

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Offices	Legal Services	\$ 200
Other Accruals	Legal Services	1,752
CliftonLarsonAllen	Taxes & Cost Reports	6,355
Walnut Creek Mgmt Co LLC	Data Processing	45,047
PointClickCare Inc	Data Processing	24,457
Providigm LLC	Data Processing	2,100
Walnut Creek Mgmt Co LLC	Professional Services	1,136
Pinnacle Quality Insight	Professional Services	436
Property Valuation Services	Professional Services	100
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 81,583

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 22,673
Unemployment Compensation Insurance	
FICA Taxes	222,788
Employee Health Insurance	68,748
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	1,033
TOTAL (agree to Schedule V, line 22, col.8)	\$ 315,242

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	10,840
Health Care Worker Background Check (Indicate # of checks performed 32)	334
IL Health Care Association	5,335
Other Licenses	1,099
Other Dues & Subscriptions	1,052
Less: Public Relations Expense	(1,466)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,174

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Hotel stay for Interim Nurse Mgr	4,235
Hotel stay for Interim DON	3,411
Mileage/Meals for Tutera Inservice	305
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,951

* Attach copy of IMRF notifications

**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.

IL Health Care Association \$5,335

Yes

(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

N/A

(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

N/A

(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

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 21,496

Line 10

(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

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES
NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

N/A

(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.

\$ 154,042

(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

No

Indicate the amount. \$ 0
- (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

\$ N/A

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

100%

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

\$ N/A
- (17)

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

No

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes