

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

IMPORTANT NOTICE

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

I. IDPH License ID Number: 0040915

Facility Name: Fair Oaks Health Care Center

Address: 471 Terra Cotta Ave 60014
Number City Zip Code

County: McHenry

Telephone Number: 815-455-0550 Fax # 815-455-0608

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☒ Charitable Corp.

☐ Trust

IRS Exemption Code 501C(3)

☐ PROPRIETARY

☐ Individual

☐ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other

☐ GOVERNMENTAL

☐ State

☐ County

☐ Other

In the event there are further questions about this report, please contact:

Name: Noreen Zaio Telephone Number: 815-455-0550

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from to and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Noreen Zaio (Date)

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title) Gary Johnsen Partner, CPA (Date)

(Firm Name & Address) JT and Associates, LLC 700 Pilgrim Pkwy, Ste 200, Elm Grove, WI 53122

(Telephone) 262-789-9945 Fax # 262-289-9480

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

Fair Oaks Health Care Center

0040915

Report Period Beginning:

Ending:

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	51	Skilled (SNF)	51	18,615
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	51	TOTALS	51	18,615

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment							
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total
				Medicaid Primary	Medicare Primary				
8	SNF	388				4,099	9,144	1,540	15,171
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	388				4,099	9,144	1,540	15,171

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

81.50%

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

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

F. Does the facility maintain a daily midnight census?

Yes

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

YES

x

NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

x

I. On what date did you start providing long term care at this location?

Date started

05/95

J. Was the facility purchased or leased after January 1, 1978?

YES

x

Date

05/95

NO

K. Was the facility certified for Medicare during the reporting year?

YES

x

NO

If YES, enter certified beds.

number of certified beds

51

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

x

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

x

NO

Tax Year:

12/31

Fiscal Year:

12/31

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	386,493	22,326	38,314	447,133		447,133		447,133			1
2	Food Purchase		159,329		159,329		159,329		159,329			2
3	Housekeeping	264,161	26,220		290,381		290,381		290,381			3
4	Laundry		2,127		2,127		2,127		2,127			4
5	Heat and Other Utilities			168,128	168,128		168,128	(32,495)	135,633			5
6	Maintenance	76,757	38,427	39,568	154,752		154,752		154,752			6
7	Other (specify):*											7
8	TOTAL General Services	727,411	248,429	246,010	1,221,850		1,221,850	(32,495)	1,189,355			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	2,395,635	127,966	685,927	3,209,528		3,209,528		3,209,528			10
10a	Therapy	785,203	1,280	41,250	827,733		827,733		827,733			10a
11	Activities	103,157	5,748	4,355	113,260		113,260		113,260			11
12	Social Services	63,975		1,440	65,415		65,415		65,415			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,347,970	134,994	748,572	4,231,536		4,231,536		4,231,536			16
	C. General Administration											
17	Administrative	150,097			150,097		150,097		150,097			17
18	Directors Fees											18
19	Professional Services			586,720	586,720		586,720	18,446	605,166			19
20	Dues, Fees, Subscriptions & Promotions			55,844	55,844		55,844		55,844			20
21	Clerical & General Office Expenses	403,558	19,919	100,797	524,274		524,274		524,274			21
22	Employee Benefits & Payroll Taxes			620,773	620,773		620,773		620,773			22
23	Inservice Training & Education			28,032	28,032		28,032		28,032			23
24	Travel and Seminar			9,438	9,438		9,438		9,438			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			165,096	165,096		165,096		165,096			26
27	Other (specify):*											27
28	TOTAL General Administration	553,655	19,919	1,566,700	2,140,274		2,140,274	18,446	2,158,720			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,629,036	403,342	2,561,282	7,593,660		7,593,660	(14,049)	7,579,611			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			204,220	204,220		204,220		204,220			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			254,369	254,369		254,369		254,369			32
33	Real Estate Taxes			90,257	90,257		90,257		90,257			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Amort. Of Intangibles			28,896	28,896		28,896		28,896			36
37	TOTAL Ownership			577,742	577,742		577,742		577,742			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		362,462		362,462		362,462		362,462			39
40	Barber and Beauty Shops			4,255	4,255		4,255		4,255			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,045	62,045		62,045		62,045			42
43	Other (specify):*			83,007	83,007		83,007	(83,007)				43
44	TOTAL Special Cost Centers		362,462	149,307	511,769		511,769	(83,007)	428,762			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,629,036	765,804	3,288,331	8,683,171		8,683,171	(97,056)	8,586,115			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(32,495)	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	(1,429)	43		18
19	Entertainment	(13,775)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,210)	43		24
25	Fund Raising, Advertising and Promotional	(12,593)	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 Other				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (115,502)		\$	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)	18,446	VII, 14B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,446		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (97,056)		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

ID#

0040915

Report Period Beginning:

Ending:

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Other expenses			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	0		49

Summary A

Ending:

[illegible]

Summary B

Ending:

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Wisconsin Illinois Senior Housing	100	Geneva Lake Maor	Geneva Lake, WI	Transitions at Home	Elkhorn, WI	Home Health
		Holton Manor	Elkhorn, WI	Transitions at Home	Stevens Point, WI	Home Health
		Montello Care Center	Montello, WI	Transitions at Home	Mt. Horeb, WI	Home Health
		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		Home Office Costs	\$ 128,082	Wisconsin Illinois Senior Housing	100.00%	\$ 146,528	\$ 18,446	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			\$ 128,082			\$ 146,528	\$ * 18,446	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		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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Ownership Listing-2

ID# 0040915

Ending:

-Names of trust beneficiaries must be listed.

Ownership

Ownership

Ownership

First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
76							76
77							77
78							78
79							79
80							80
81							81
82							82
83							83
84							84
85							85
86							86
87							87
88							88
89							89
90							90
91							91
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138							138
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140							140
141							141
142							142
143							143
144							144
145							145
146							146
147							147
148							148
149							149
150							150

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Fair Oaks Health Care Center # 0040915 Report Period Beginning: _____ Ending: _____

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Fair Oaks Health Care Center # 0040915 Report Period Beginning: _____ Ending: _____

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	Bond Series		x	Building, New Addition		8/12	\$ 5,260,252	\$ 4,887,270			\$ 252,834	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,260,252	\$ 4,887,270			\$ 252,834	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,260,252	\$ 4,887,270			\$ 252,834	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	68,295	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	79,276	2
3. Under or (over) accrual (line 2 minus line 1).			\$	10,981	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	79,276	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.			\$		6
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.			\$	90,257	7
Assessed Value from Real Estate Tax Bill:	2024	925,319	8		
Real Estate Tax Bill for Calendar Year:	2020	81,362	9		
	2021	82,756	10		
	2022	86,481	11		
	2023	77,388	12		
	2024	79,276	13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Oaks Health Care Center COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0040915

CONTACT PERSON REGARDING THIS REPORT Noreen Zaio

TELEPHONE 815-455-0550 FAX #: 815-455-0608

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	14-31-426-020	LT1	\$ 79,276.00	\$ 79,276.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 79,276.00	\$ 79,276.00

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,962 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	SNF			1995	\$	200,000	1
2							2
3	TOTALS				\$	200,000	3

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning:

Ending:

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	46		1999		\$ 1,328,800	\$ 34,071		\$ 34,071	\$	\$ 898,324
5			2001		3,671					3,671
6	5			2013	4,437,265	111,322		111,322		1,450,103
7										
8										
	Improvement Type**									
9	Wooden Floors, Carpeting, Light Fixtures			2001	39,077					39,077
10	Flooring, Plumbing, Countertops			2003	16,234					16,324
11	Fire Alarm Systems, Carpet Furnishings			2005	22,381	163		163		22,544
12	Sprinkler System			2006	72,000	2,880		2,880		57,600
13	Utility Pole, Flooring, Ceiling Tile, Electrical Work			2008	26,941	1,058		1,058		18,449
14	Window, Flooring			2009	37,161					37,161
15	Flooring, Tiles			2011	7,710					7,710
16	Plank Flooring			2012	2,321					2,321
17	Regulator for Water Temps in Resident Rooms			2014	4,985					4,985
18	New Carpet - Main Hall			2014	9,790					9,790
19	Generator Updates and Additions			2014	10,020					10,020
20	Automatic Kitchen Door			2014	3,855					3,855
21	Plumbing - Mixing Valves (Mighty Oaks)			2014	4,025	268		268		2,973
22	Vinyl Flooring, Wood Blinds (Remodel of Bedroom)			2014	3,127					3,127
23	Sprinkler System Valve (Mighty Oaks)			2014	2,850	114		114		1,283
24	Fire Door			2015	4,734	237		237		2,506
25	Plumbing -Dishwasher			2015	1,521	76		76		817
26	Automatic Door Closer			2015	1,540	103		103		1,104
27	Kitchen Door - Replace			2016	1,797	90		90		815
28	Plumbing - Hot Water Heater			2016	2,172	108		108		986
29	Ceramic & Vinyl Flooring			2018	9,020	902		902		6,314
30	PVC Pipe Replacement (Main Kitchen Drain)			2019	2,503	100		100		667
31	Install Water Heater (Kitchen Area)			2020	4,504	450		450		2,477
32	West Wing Resident Room 1-9 remodel, 4 rooms remodeled, 4 rooms cony			2021	791,042	31,642		31,642		142,388
33	shared bathrooms became private, removed exisiting closet & replaced with free standing wardrobes									
34	new studs, drywall, flooring, painting, plumbing & fixutres, new file on bathroom wass, new PTAC A/C units & lighting fitures									
35	West Wing Main Line Sewer Cleanout Installation to prevent plumbing b			2022	7,182	479		479		1,876
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning:

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kitchen Air Handler for main kitchen	2023	\$ 4,140	\$ 828		\$ 828		\$ 1,932	37
38	Recirculation Pump for Acorn Unit	2023	1,529	153		153		357	38
39	Hot Water Tank & Pipe Repair for east and west side of home	2023	16,850	674		674		1,348	39
40	& kitchen.								40
41	Grease Trap Piping for kitchen to parking lot and back into Might	2025	10,530	35		35		35	41
42	into Might Oaks. Includes repairing concrete walkway torn up during repair.								42
43	LAND IMPROVMENTS:								43
44	Remove/Replace concrete	2000	11,660					11,660	44
45	Parking Lot	2004	15,000					15,000	45
46	Landscaping (oak trees)	2006	3,450					3,450	46
47	Landscaping/Tree Replacement	2016	2,435					2,435	47
48	Remove/Replace Sidewalks	2016	4,650	310		310		2,974	48
49	Parking Lot - employee lot in back of home	2023	26,872	3,359		3,359		8,118	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,955,344	\$ 189,422		\$ 189,422		\$ 2,796,576	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	\$ 993,509	\$ 13,721	\$ 13,721	\$		\$ 902,628	71
72	Current Year Purchases	17,041	1,077	1,077			1,077	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,010,550	\$ 14,798	\$ 14,798	\$		\$ 903,705	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,165,894	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,220	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 204,220	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)	\$ 3,700,281	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?
16. Rental Amount for movable equipment: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	4848	hrs	\$ 208,642		\$	4,848	\$ 208,642	1
2	Licensed Speech and Language Development Therapist	L10A, C3	2385	hrs	130,108			2,385	130,108	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	L10A,C3	10065	hrs	446,453			10,065	446,453	4
5	Physician Care			visits						5
6	Dental Care			visits						6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy			# of prescrpts						9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Respiratory Therapist</u>	L10, C3				117	4,718	117	4,718	12
13	Other (specify): <u></u>									13
14	TOTAL				\$ 785,203	117	\$ 4,718	\$ 17,415	\$ 789,921	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 170,347	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 43,758)	828,063		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,542		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	996,077		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,107,029	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000		13
14	Buildings, at Historical Cost	6,934,488		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,048,027		16
17	Accumulated Depreciation (book methods)	(3,712,222)		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 (spec Cap Software net Amort 9,725			22
23	Other(specify): ROU - Lease	169,985		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,650,003	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,757,032	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 481,308	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	419,645		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,513		32
33	Accrued Interest Payable	60,506		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ST Lease Liability	40,567		36
37	Intercompany Payables	664,734		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,742,273	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,887,270		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Bond Closing net Amort	(149,874)		43
44	LT Lease Liability	129,418		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,866,814	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,609,087	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 147,945	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,757,032	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 27,719	1
2	Restatements (describe):		2
3	Changes from PY	(2,364)	3
4	Depr Adj	(59)	4
5	Real Estate Tax Adj	12,857	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 38,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,792	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)	\$ 109,792	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)	\$ 147,945	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning:

Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,426,224	1
2	Discounts and Allowances for all Levels	(2,239,357)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,186,867	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,373,636	6
7	Oxygen	103,350	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,476,986	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	4,020	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	719,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	117,861	19
20	Radiology and X-Ray	75,491	20
21	Other Medical Services	187,268	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,104,367	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,118	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,118	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other, Rebates	23,625	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,625	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,792,963	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,221,850	31
32	Health Care	4,231,536	32
33	General Administration	2,140,274	33
	B. Capital Expense		
34	Ownership	577,742	34
	C. Ancillary Expense		
35	Special Cost Centers	449,724	35
36	Provider Participation Fee	62,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,683,171	40
41	Income before Income Taxes (line 30 minus line 40)**	109,792	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 109,792	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 127,562.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,422,229.00	48
49	Medicare Part A	6,327,889.00	49
50	Other-(specify) Medicare Replacement	547,900.00	50
51	Other-(specify) Medicaid Hospice	644.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,426,224	56

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	1,998	2,080	\$ 98,850	\$ 47.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,451	23,867	891,277	37.34	3
4	Licensed Practical Nurses	7,592	7,904	168,502	21.32	4
5	CNAs & Orderlies	68,327	72,713	1,194,162	16.42	5
6	CNA Trainees					6
7	Licensed Therapist	16,120	17,298	785,203	45.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	965	1,221	29,822	24.42	9
10	Activity Assistants	3,884	4,517	73,335	16.24	10
11	Social Service Workers	2,000	2,080	63,975	30.76	11
12	Dietician					12
13	Food Service Supervisor	2,081	2,224	61,188	27.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,258	17,271	325,305	18.84	15
16	Dishwashers					16
17	Maintenance Workers	2,344	2,610	76,757	29.41	17
18	Housekeepers	12,682	14,027	264,161	18.83	18
19	Laundry					19
20	Administrator	1,948	2,120	150,097	70.80	20
21	Assistant Administrator	1,544	1,680	67,355	40.09	21
22	Other Administrative	8,407	9,206	230,387	25.03	22
23	Office Manager	3,582	3,745	105,816	28.26	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,055	2,105	42,844	20.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,238	186,668	\$ 4,629,036 *	\$ 24.80	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	510	\$ 38,314	L1, C2	35
36	Medical Director	24	15,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,600	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	20	1,340	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)	586	\$ 58,294		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,603	\$ 187,327	L10, C3	50
51	Licensed Practical Nurses	1,662	92,775	L10, C3	51
52	Certified Nurse Assistants/Aides	4,301	154,403	L10, C3	52
53	TOTAL (lines 50 - 52)	8,566	\$ 434,505		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Noreen Zaio	Administrator		\$ 150,097
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 150,097
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
See Professional Servcies Schedule	Legal		\$ 126
Carriage Healthcare	Management Fees		341,544
See Professional Servcies Schedule	Data Processing		84,092
See Professional Servcies Schedule	Accounting		32,876
Wisconsin Illinois Senior Housing	Owners Fees		128,082
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 586,720
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 34,176
Unemployment Compensation Insurance			15,596
FICA Taxes			348,066
Employee Health Insurance			201,010
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension & Retirement			19,515
Life Insurance			2,410
TOTAL (agree to Schedule V, line 22, col.8)			\$ 620,773
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			15,879
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Association Dues (total from pg 22, #4)			4,496
Dues & Subscriptson			35,469
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 55,844
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
General Business Travel			9,438
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 9,438

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	2,711
HEALTH CARE COUNCIL OF IL (HCCI)	1,785
	4,496 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
HEALTH CARE COUNCIL OF IL (HCCI)	
	Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	2,711
HEALTH CARE COUNCIL OF IL (HCCI)	1,785
	4,496 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ Line
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 62,045

This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) 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? Indicate the amount. \$
- (12) Travel and Transportation

a. Are there costs included for out-of-state travel?

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?

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?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: KCOE ISOM, LLP

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

Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

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