



Facility Name & ID Number Crystal Pines Health Care Center

# 0028902 Report Period Beginning: 07/01/99 Ending: 06/30/00

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 10/15/99

	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	84	Skilled (SNF)	114	38,544	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	84	TOTALS	114	38,544	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	1,398	0	3,577	4,975	8
9	SNF/PED	0	0	0		9
10	ICF	13,430	11,242	755	25,427	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	14,828	11,242	4,332	30,402	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.88%

D. How many bed-hold days during this year were paid by Public Aid? 10 (Do not include bed-hold days in Section B.)

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

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

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 10/1/84

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/84 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 16 and days of care provided 3,152

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30 Fiscal Year: 6/30

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

STATE OF ILLINOIS

Facility Name & ID Number Crystal Pines Health Care Center # 0028902 Report Period Beginning: 07/01/99 Ending: 06/30/00

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	154,835	12,763	7,921	175,519		175,519	(80)	175,439		1
2	Food Purchase		126,937		126,937		126,937	(1,218)	125,719		2
3	Housekeeping	78,618	13,796		92,414		92,414		92,414		3
4	Laundry	39,575	20,309		59,884		59,884		59,884		4
5	Heat and Other Utilities			73,922	73,922		73,922	9	73,931		5
6	Maintenance	48,524	23,404	23,217	95,145		95,145		95,145		6
7	Other (specify):*			5,235	5,235		5,235		5,235		7
8	<b>TOTAL General Services</b>	321,552	197,209	110,295	629,056		629,056	(1,289)	627,767		8
<b>B. Health Care and Programs</b>											
9	Medical Director			10,590	10,590		10,590		10,590		9
10	Nursing and Medical Records	1,255,207	60,980	1,868	1,318,055		1,318,055		1,318,055		10
10a	Therapy										10a
11	Activities	48,655	3,209	3,960	55,824		55,824		55,824		11
12	Social Services	40,862	230	2,328	43,420		43,420		43,420		12
13	Nurse Aide Training					3,575	3,575		3,575		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,344,724	64,419	18,746	1,427,889	3,575	1,431,464		1,431,464		16
<b>C. General Administration</b>											
17	Administrative	61,318	(10)		61,308		61,308		61,308		17
18	Directors Fees										18
19	Professional Services			250,038	250,038		250,038	19,824	269,862		19
20	Dues, Fees, Subscriptions & Promotions			58,158	58,158		58,158	(25,365)	32,793		20
21	Clerical & General Office Expenses	127,118	26,875	88,039	242,032		242,032	(77,075)	164,957		21
22	Employee Benefits & Payroll Taxes			215,204	215,204		215,204		215,204		22
23	Inservice Training & Education			4,850	4,850	(3,575)	1,275		1,275		23
24	Travel and Seminar			10,022	10,022		10,022	820	10,842		24
25	Other Admin. Staff Transportation			5,210	5,210		5,210		5,210		25
26	Insurance-Prop.Liab.Malpractice			46,928	46,928		46,928	1,667	48,595		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	188,436	26,865	678,449	893,750	(3,575)	890,175	(80,129)	810,046		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,854,712	288,493	807,490	2,950,695		2,950,695	(81,418)	2,869,277		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Crystal Pines Health Care Center

#0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			158,812	158,812		158,812	54,414	213,226			30
31	Amortization of Pre-Op. & Org.			46,986	46,986		46,986	(46,986)	0			31
32	Interest			689,780	689,780		689,780	(27,948)	661,832			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,446	9,446		9,446	68	9,514			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			905,024	905,024		905,024	(20,452)	884,572			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,133	159,405	236,538		236,538	(46)	236,492			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,816	57,816		57,816		57,816			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		77,133	217,221	294,354		294,354	(46)	294,308			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,854,712	365,626	1,929,735	4,150,073		4,150,073	(101,916)	4,048,157			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning: 07/01/99

Ending: 06/30/00

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(80)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients	(46)	39		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,793)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(361)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	21		24
25	Fund Raising, Advertising and Promotional	(25,365)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	45,729			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (17,916)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense	(46,986)	31	33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(37,014)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (84,000)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (101,916)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0028902  
 Report Period Beginning: 07/01/99  
 Ending: 06/30/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Vendor Income	0	1
2	Barber and Beauty Revenue	0	40
3	Extraordinary Income (Expense)		3
4	(Gain)/Loss on Sale of Assets	(110)	30
5	Miscellaneous (Income)/Expense	(6,790)	21
6	Adjust Depreciation Expense to Schedule XI	54,234	30
7	Raw foods rebate	(1,210)	2
8	Offset bank fees	(711)	21
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
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76			76
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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	Total	45,729	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Crystal Pines Health Care Center

# 0028902 Report Period Beginning:

07/01/99

Ending:

06/30/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(80)	0	0	0	0	0	0	0	0	0	0	(80)	1
2	Food Purchase	(1,218)	0	0	0	0	0	0	0	0	0	0	(1,218)	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	9	0	0	0	0	0	0	0	0	0	9	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,298)</b>	<b>9</b>	<b>0</b>	<b>(1,289)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,824	0	0	0	0	0	0	0	0	0	19,824	19
20	Fees, Subscriptions & Promotions	(25,365)	0	0	0	0	0	0	0	0	0	0	(25,365)	20
21	Clerical & General Office Expenses	(19,828)	(57,247)	0	0	0	0	0	0	0	0	0	(77,075)	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	820	0	0	0	0	0	0	0	0	0	820	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	1,667	0	0	0	0	0	0	0	0	0	1,667	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(45,193)</b>	<b>(34,936)</b>	<b>0</b>	<b>(80,129)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(46,491)</b>	<b>(34,927)</b>	<b>0</b>	<b>(81,418)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Crystal Pines Health Care Center# 0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	54,414	0	0	0	0	0	0	0	0	0	0	54,414 30
31	Amortization of Pre-Op. & Org.	(46,986)	0	0	0	0	0	0	0	0	0	0	(46,986) 31
32	Interest	(25,793)	(2,155)	0	0	0	0	0	0	0	0	0	(27,948) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	68	0	0	0	0	0	0	0	0	0	68 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(18,365)</b>	<b>(2,087)</b>	<b>0</b>	<b>(20,452) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(46)	0	0	0	0	0	0	0	0	0	0	(46) 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(46)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(64,902)</b>	<b>(37,014)</b>	<b>0</b>	<b>(101,916) 45</b>								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached Listing				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Heat and Other Utilities	\$	MidAmerica Care Foundation	100.00%	\$ 9	\$	9
2	V	19 Professional Services		MidAmerica Care Foundation	100.00%	19,824		19,824
3	V	21 Clerical & Other General Office	57,468	MidAmerica Care Foundation	100.00%	221		(57,247)
4	V	24 Travel and Seminar		MidAmerica Care Foundation	100.00%	820		820
5	V	26 Insurance		MidAmerica Care Foundation	100.00%	1,667		1,667
6	V	32 Interest Expense		MidAmerica Care Foundation	100.00%	(2,155)		(2,155)
7	V	35 Rent-Equipment		MidAmerica Care Foundation	100.00%	68		68
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 57,468			\$ 20,454	\$ *	(37,014)

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

Facility Name & ID Number      Crystal Pines Health Care Center      #      0028902      Report Period Beginning:      07/01/99      Ending:      06/30/00

## 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	Michael A. Michaud	Director	President	0.00				BOD Fees	\$ 1,069	Ln 19, Col. 3	1
2	W. Terrence Brown	Director	Secretary	0.00				BOD Fees	1,069	Ln 19, Col. 3	2
3	Edward T. Weaver	Director	Treasurer	0.00				BOD Fees	1,069	Ln 19, Col. 3	3
4	Donald A. Idstuen	Director						BOD Fees	1,069	Ln 19, Col. 3	4
5	Michael F. Flanagan		Asst. Secretary	0.00				BOD Fees			5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,277		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center # 0028902 Report Period Beginning: 07/01/99 Ending: 06/30/00

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

Name of Related Organization MidAmerica Care Foundation  
 Street Address 7611 State Line Road, Suite 301  
 City / State / Zip Code Kansas City, Missouri 64114  
 Phone Number ( 816) 444-0900  
 Fax Number ( 816) 822-8799

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	5	Heat and Other Utilities	Patient Days	405,210	13	\$ 121	\$ 30,402	\$ 9	1
2	19	Professional Services	Patient Days	405,210	13	264,226	30,402	19,824	2
3	21	Clerical & Other General Office	Patient Days	405,210	13	2,944	30,402	221	3
4	24	Travel and Seminar	Patient Days	405,210	13	10,926	30,402	820	4
5	26	Insurance	Patient Days	405,210	13	22,213	30,402	1,667	5
6	32	Interest Expense	Patient Days	405,210	13	(28,728)	30,402	(2,155)	6
7	35	Rent-Equipment	Patient Days	405,210	13	912	30,402	68	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					\$ 272,614	\$	\$ 20,454	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO										Original	Balance			
		<b>A. Directly Facility Related</b>																
		<b>Long-Term</b>																
1		Crystal Pines Class 6(A) Bonds		X	Mortgage	Varies	09/02/84	\$ 3,750,000	\$ 3,938,223	07/01/16	13.75%	\$ 541,506	1					
2		Bank of America LOC		X	W/C - Construction	Varies			1,657,520		8.75%	148,275	2					
3													3					
4													4					
5													5					
		<b>Working Capital</b>																
6		Interest Income		X								(25,793)	6					
7		H/O Interest Income	X									(2,155)	7					
8													8					
9		<b>TOTAL Facility Related</b>						\$ 3,750,000	\$ 5,595,743			\$ 661,833	9					
		<b>B. Non-Facility Related*</b>																
10													10					
11													11					
12													12					
13													13					
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15		<b>TOTALS (line 9+line14)</b>						\$ 3,750,000	\$ 5,595,743			\$ 661,833	15					

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

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

Facility Name & ID Number Crystal Pines Health Care Center# 0028902 Report Period Beginning: 07/01/99 Ending: 06/30/00

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	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.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7
Real Estate Tax History:		
Real Estate Tax Bill for Calendar Year:	1995 _____ 8	
	1996 _____ 9	
	1997 _____ 10	
	1998 _____ 11	
	1999 _____ 12	
		<b>FOR OFF USE ONLY</b>
	13 FROM R. E. TAX STATEMENT FOR 1999 \$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902 Report Period Beginning:

07/01/99 Ending:

06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,000 B. General Construction Type: Exterior Brick and block Frame \_\_\_\_\_ 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 751,112 2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 46,986 4. Dates Incurred: Various

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	84	72	\$ 2,319,500	\$ 77,317	30	\$ 77,317	\$ (0)	\$ 1,218,622	4
5	40	99	99	1,693,459	37,632	30	56,449	18,817	37,632	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Improvements 1984		84	71,905	2,430	29	2,479	49	37,679	9
10	Improvements 1986		86	956	35	16	60	25	493	10
11	Improvements 1987		87	2,619		5			2,619	11
12	Improvements 1988		88	1,884		10			1,884	12
13	Improvements 1989		89	8,875		10			8,855	13
14	Improvements 1990		90	74,641	5,077	12	6,220	1,143	66,236	14
15	Improvements 1991		91	36,076		7			35,977	15
16	Improvements 1992		92	50,544	581	7	7,221	6,640	50,468	16
17	Improvements 1993		93	15,759	2,252	7	2,251	(1)	15,165	17
18	Improvements 1994		94	23,729	2,734	8	2,966	232	16,177	18
19	Improvements 1995		95	1,558	184	8	195	11	888	19
20	Improvements 1996		96	4,104	586	7	586	0	2,260	20
21	Water Heater		97	5,726	286	20	286		954	21
22	Tile/Hallway		97	9,700	970	10	970		3,072	22
23	Heaters		97	8,118	812	10	812		2,503	23
24	Curtains		97	3,394	339	10	339		1,046	24
25	Screens		97	2,200	314	7	314	(0)	995	25
26	Hallway Remodel		98	24,706	1,647	15	1,647	0	3,431	26
27	Heat/AC Room 201		98	799	80	10	80	(0)	166	27
28	Wire Fence		99	1,150	230	5	230		307	28
29	Wallguard at Main Dr Chairrail		99	1,389	139	10	139	(0)	197	29
30	Wallpaper for Nurse Station		99	814	81	10	81	(0)	108	30
31	Pump/Pit Excavation		99	7,500	500	15	500		542	31
32	Shelving		99	1,126	103	10	113	9	103	32
33	Exhaust Fan for Kitchen		99	1,462	134	10	146	12	134	33
34	Keypad/Nurse Call/Security		99	931	93	10	93	0	93	34
35	Exit Lights for Dining Room		99	915	56	15	61	5	56	35
36	<b>TOTAL (lines 4 thru 35)</b>			\$ 4,375,538	\$ 134,613		\$ 161,555	\$ 26,943	\$ 1,508,663	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Counter Install		99	1,050	58	15	70	12	58	9
10	Rooftop 5 Ton Trane		99	8,049	805	10	805	(0)	805	10
11	Exhaust Fans In Oxygen Closet		99	1,450	89	15	97	8	89	11
12	Lawn for New Wing		99	2,535	254	10	254		254	12
13	Wire - Fire Alarm System		98	3,264	218	15	218		435	13
14	Storage Tank		99	1,043	104	10	104	(0)	140	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	<b>TOTAL (lines 4 thru 35)</b>			\$ 17,391	\$ 1,527		\$ 1,547	\$ 20	\$ 1,781	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 ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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 ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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 ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning:

07/01/99

Ending:

06/30/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 321,850	\$ 13,647	\$ 40,231	\$ 26,584	8	\$ 265,655	37
38	Current Year Purchases	26,193	1,742	2,619	877	10	1,742	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 348,043	\$ 15,389	\$ 42,851	\$ 27,462		\$ 267,397	41

D. Vehicle Depreciation (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	
42		1996 Dodge Van	97	\$ 36,417	\$ 7,283	\$ 7,283	\$ 0	5	\$ 26,099	42
43										43
44										44
45										45
46	TOTALS			\$ 36,417	\$ 7,283	\$ 7,283	\$ 0		\$ 26,099	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,777,389	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 158,812	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 213,236	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 54,424	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,803,940	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	WIP-New Construct Gen'l	\$ 10,504	58
59			59
60			60
61		\$ 10,504	61

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>      </u> /2001	\$ _____
13.	<u>      </u> /2002	\$ _____
14.	<u>      </u> /2003	\$ _____

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: \$ 9,446 Description: See attached detail

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 685	\$ 2,740	\$	\$ 3,425
2	Books and Supplies	30	120		150
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$ 715	\$ 2,860	\$	\$ 3,575
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,575			

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>15</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	2,231	\$ 44,624	\$ 298	2,231	\$ 44,922	1
2	Licensed Speech and Language Development Therapist		hrs		433	9,519	0	433	9,519	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,969	89,539	336	5,969	89,875	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	8,633	\$ 143,682	\$ 635	8,633	\$ 144,316	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning: 07/01/99

Ending:

06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 540,074	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	473,142	3
4	Supply Inventory (priced at )	12,373	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	(0)	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,025,589	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	2,535	13
14	Buildings, at Historical Cost	4,359,352	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	426,005	16
17	Accumulated Depreciation (book methods)	(2,173,635)	17
18	Deferred Charges	751,112	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):	3,711	22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,369,081	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,394,670	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 75,332	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	2,593,941	29
30	Accrued Salaries Payable	144,719	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	Other liab.'s and Patient Trust Dep	13,958	36
37	Due to affiliates		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,827,950	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,657,520	39
40	Mortgage Payable	3,938,223	40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,595,743	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,423,693	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,029,023)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,394,670	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (3,746,871)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (3,746,871)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(282,154)	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)	2	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (282,152)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (4,029,023)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Crystal Pines Health Care Center

# 0028902

Report Period Beginning: 07/01/99

Ending:

06/30/00

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,670,657	1
2	Discounts and Allowances for all Levels	(1,267,076)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,403,581</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	397,386	6
7	Oxygen	15,054	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 412,440</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	80	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	46	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 126</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	25,793	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 25,793</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Extraordinary Income/Loss &amp; Misc.</b>	<b>25,989</b>	<b>28</b>
28a	<b>G/L on Sale of Asset</b>	<b>(10)</b>	<b>28a</b>
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 25,979</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,867,919</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	629,056	31
32	Health Care	1,427,889	32
33	General Administration	893,750	33
<b>B. Capital Expense</b>			
34	Ownership	905,024	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	236,538	35
36	Provider Participation Fee	57,816	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,150,073</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(282,154)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (282,154)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Crystal Pines Health Care Center**

# **0028902**

Report Period Beginning: **07/01/99**

Ending:

**06/30/00**

**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	6,244	\$ 6,118	\$ 139,636	\$ 22.82	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	12,944	14,833	291,558	19.66	3
4	Licensed Practical Nurses	6,813	7,365	130,960	17.78	4
5	Nurse Aides & Orderlies	55,378	57,257	664,333	11.60	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	5,451	5,458	48,655	8.91	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	3,271	3,326	40,862	12.29	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	18,191	18,521	154,835	8.36	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,210	3,641	48,524	13.33	17
18	Housekeepers	10,800	10,647	78,618	7.38	18
19	Laundry	5,712	6,050	39,575	6.54	19
20	Administrator	1,962	1,860	61,318	32.97	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	9,224	8,310	127,118	15.30	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	2,849	2,933	28,720	9.79	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)			1		33
34	TOTAL (lines 1 - 33)	142,049	146,319	\$ 1,854,712 *	\$ 12.68	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	200	\$ 7,921	line 1, col 3	35
36	Medical Director	143	10,590	line 9, col 3	36
37	Medical Records Consultant			line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	126	1,868	line 10, col 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	36	2,328	line 11, col 3	44
45	Social Service Consultant	47	2,328	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	\$ 25,035		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses	0	Ln 10, Col 1	51
52	Nurse Aides	1,246	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)	1,246	\$ 25,845	53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lamb, Pamela	Administrator		\$ 61,318	Workers' Compensation Insurance	\$ 54,284	IDPH License Fee	\$ 198	
				Unemployment Compensation Insurance	22,735	Advertising: Employee Recruitment	24,960	
				FICA Taxes	114,992	Health Care Worker Background Check	1,299	
				Employee Health Insurance	20,679	(Indicate # of checks performed <u>108</u> )		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,336	
				Other Benefits	2,514	Advertising PR & Other	25,365	
				Home Office Allocation	0	Reclassifications	0	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(25,365)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,318	TOTAL (agree to Schedule V, line 22, col.8)	\$ 215,204	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,793	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	10,022
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Home Office Allocation	820
							Seminar Expense	
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 10,842
Various	Purch Serv		\$ 416					
Tutera Health Care Mgt	Management Fees		210,714					
Various	Legal Fees		749					
Various	Accounting Fees		22,524					
Various	D/P Fees		9,192					
Various	Professional Serv		1,787					
Various	Trustee Expenses		4,656					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 250,038	TOTAL		\$		

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Crystal Pines Health Care Center# 0028902Report Period Beginning: 07/01/99Ending: 06/30/00**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N
- (2) Are there any dues to nursing home associations included on the cost report? N  
If YES, give association name and amount. 0
- (3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report? 0
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Y If YES, what is the capacity? 110
- (5) Have you properly capitalized all major repairs and equipment purchases? Y  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES N NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,816  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y
- (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? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Y Indicate the amount. \$ 80
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? N  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- 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? Y
- g. Does the facility transport residents to and from day training? N**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Y  
Firm Name: Donnelly, Meiners, Jordan & Kline The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not yet complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Y
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**