

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>114</u>	Skilled (SNF)	<u>114</u>	<u>41,610</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>114</u>	TOTALS	<u>114</u>	<u>41,610</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,407</u>	<u>4,045</u>	<u>9,014</u>	<u>35,466</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,407</u>	<u>4,045</u>	<u>9,014</u>	<u>35,466</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.23%

D. How many bed-hold days during this year were paid by the Department?

None (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?

Yes

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

YES NO

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

YES NO

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

Date started 10/28/2010

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

YES Date 10/28/2010 NO

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

YES NO If YES, enter number of beds certified 112 and days of care provided 5,951

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

* 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		8,174	561,403	569,577		569,577		569,577		1
2	Food Purchase		12,195		12,195		12,195	(1,489)	10,706		2
3	Housekeeping		28,095	133,935	162,030		162,030		162,030		3
4	Laundry		10,537	89,439	99,976		99,976		99,976		4
5	Heat and Other Utilities			133,393	133,393		133,393	1,586	134,979		5
6	Maintenance	82,758	15,365	85,171	183,294		183,294	2,494	185,788		6
7	Other (specify):*										7
8	TOTAL General Services	82,758	74,366	1,003,341	1,160,465		1,160,465	2,591	1,163,056		8
	B. Health Care and Programs										
9	Medical Director			28,000	28,000		28,000		28,000		9
10	Nursing and Medical Records	2,378,726	143,458	8,658	2,530,842		2,530,842	43,730	2,574,572		10
10a	Therapy										10a
11	Activities	86,645	3,178	2,480	92,303		92,303		92,303		11
12	Social Services	173,705		3,078	176,783		176,783		176,783		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							11,171	11,171		15
16	TOTAL Health Care and Programs	2,639,076	146,636	42,216	2,827,928		2,827,928	54,901	2,882,829		16
	C. General Administration										
17	Administrative	75,177		419,492	494,669		494,669	(419,490)	75,179		17
18	Directors Fees										18
19	Professional Services			56,908	56,908	(100)	56,808	(8,301)	48,507		19
20	Dues, Fees, Subscriptions & Promotions			68,392	68,392		68,392	(25,416)	42,976		20
21	Clerical & General Office Expenses	173,630	32,836	690,183	896,649		896,649	(449,698)	446,951		21
22	Employee Benefits & Payroll Taxes			408,978	408,978		408,978		408,978		22
23	Inservice Training & Education			835	835		835		835		23
24	Travel and Seminar			4,116	4,116		4,116	4,664	8,780		24
25	Other Admin. Staff Transportation			6,436	6,436		6,436	30,087	36,523		25
26	Insurance-Prop.Liab.Malpractice			109,004	109,004		109,004	2,172	111,176		26
27	Other (specify):*							34,259	34,259		27
28	TOTAL General Administration	248,807	32,836	1,764,344	2,045,987	(100)	2,045,887	(831,722)	1,214,165		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,970,641	253,838	2,809,901	6,034,380	(100)	6,034,280	(774,229)	5,260,051		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.

Facility Name & ID Number

Crystal Pines Rehab & HCC

#0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,945	7,945		7,945	242,641	250,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,364	2,364		2,364	218,829	221,193			32
33	Real Estate Taxes			84,000	84,000	100	84,100	1,362	85,462			33
34	Rent-Facility & Grounds			452,765	452,765		452,765	(452,765)	0			34
35	Rent-Equipment & Vehicles			15,361	15,361		15,361	5,903	21,264			35
36	Other (specify):*							28,074	28,074			36
37	TOTAL Ownership			562,435	562,435	100	562,535	44,044	606,579			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,616	866,957	1,179,573		1,179,573		1,179,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,701	241,701		241,701		241,701			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		312,616	1,108,658	1,421,274		1,421,274		1,421,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,970,641	566,454	4,480,994	8,018,089		8,018,089	(730,185)	7,287,904			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,469)	30		9
10	Interest and Other Investment Income	(3,504)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(9,388)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(404,795)	21		24
25	Fund Raising, Advertising and Promotional	(24,498)	20		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	(245,042)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (748,709)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,524		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,524		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (730,185)		37

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

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

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

Crystal Pines Rehab & HCC

ID# 0051052

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. Income - Medical Record Copies	\$ (1,204)	10	1
2	Vending Machine Income	(90)	02	2
3	RP Asset Mgmt Fees	(222,480)	21	3
4	Marketing Travel	(78)	25	4
5	Non-Allowable Legal	(8,705)	19	5
6	PAC Dues	(2,207)	20	6
7	Non-Allowable Seminar	(93)	24	7
8	Building Co- Taxes	(485)	21	8
9	Building Co- Professional Fees	(5,746)	19	9
10	Building Co- Amortization	(2,541)	31	10
11	Building Co- Bank Service Charge	(27)	21	11
12	Guest Meals	(1,385)	02	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		(245,042)	49

Crystal Pines Rehab & HCC

ID# 0051052

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,489)											(1,489)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,586								1,586	5
6	Maintenance			944	1,550								2,494	6
7	Other (specify):*													7
8	TOTAL General Services	(1,489)		944	3,136								2,591	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,204)		44,934									43,730	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,171									11,171	15
16	TOTAL Health Care and Programs	(1,204)		56,105									54,901	16
	C. General Administration													
17	Administrative			(398,516)		(20,974)							(419,490)	17
18	Directors Fees													18
19	Professional Services	(14,451)	5,746	187	127	90							(8,301)	19
20	Fees, Subscriptions & Promotions	(26,705)		1,289									(25,416)	20
21	Clerical & General Office Expenses	(637,175)	512	186,957	8								(449,698)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(93)		4,758									4,664	24
25	Other Admin. Staff Transportation	(78)		30,165									30,087	25
26	Insurance-Prop.Liab.Malpractice			2,066	107								2,172	26
27	Other (specify):*			34,259									34,259	27
28	TOTAL General Administration	(678,503)	6,258	(138,835)	242	(20,883)							(831,722)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(681,196)	6,258	(81,786)	3,378	(20,883)							(774,229)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14 Ending:

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(61,469)	294,303	7,645	2,161								242,641	30
31	Amortization of Pre-Op. & Org.	(2,541)	2,541											31
32	Interest	(3,504)	222,093		240								218,829	32
33	Real Estate Taxes			102	1,260								1,362	33
34	Rent-Facility & Grounds		(452,765)	10,818	(10,818)								(452,765)	34
35	Rent-Equipment & Vehicles			5,903									5,903	35
36	Other (specify):*		28,074										28,074	36
37	TOTAL Ownership	(67,514)	94,246	24,468	(7,156)								44,044	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(748,709)	100,504	(57,318)	(3,778)	(20,883)							(730,185)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6 Supp		See Pg 6 Supp		See Pg 6 Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32 Interest	\$ 103	TI Crystal Lake, LLC	100.00%	\$ 222,196	\$ 222,093	1
2	V	19 Professional Fees		TI Crystal Lake, LLC	100.00%	5,746	5,746	2
3	V	21 Taxes		TI Crystal Lake, LLC	100.00%	485	485	3
4	V	34 Rent	452,765	TI Crystal Lake, LLC	100.00%		(452,765)	4
5	V	36 MIP		TI Crystal Lake, LLC	100.00%	28,074	28,074	5
6	V	30 Depreciation		TI Crystal Lake, LLC	100.00%	294,303	294,303	6
7	V	31 Amortization		TI Crystal Lake, LLC	100.00%	2,541	2,541	7
8	V	21 Bank Service Charges		TI Crystal Lake, LLC	100.00%	27	27	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 452,868			\$ 553,372	\$ * 100,504	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	6 REPAIRS, MAINTENANCE & SECUR	\$	Tutera Health Care Services	100.00%	\$ 944	\$ 944
16	V	10 NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	247	247
17	V	10 NURSING SALARIES		Tutera Health Care Services	100.00%	44,687	44,687
18	V	15 NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	11,171	11,171
19	V	19 PROFESSIONAL FEES		Tutera Health Care Services	100.00%	187	187
20	V	20 DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	1,289	1,289
21	V	21 OFFICE EXPENSES		Tutera Health Care Services	100.00%	17,431	17,431
22	V	21 OFFICE SALARIES		Tutera Health Care Services	100.00%	169,526	169,526
23	V	24 BUSINESS SEMINAR		Tutera Health Care Services	100.00%	4,758	4,758
24	V	25 TRAVEL EXPENSES		Tutera Health Care Services	100.00%	30,165	30,165
25	V	26 INSURANCE		Tutera Health Care Services	100.00%	2,066	2,066
26	V	27 EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	34,259	34,259
27	V	30 DEPRECIATION		Tutera Health Care Services	100.00%	7,645	7,645
28	V	32 INTEREST EXPENSE		Tutera Health Care Services	100.00%		
29	V	33 REAL ESTATE TAXES		Tutera Health Care Services	100.00%	102	102
30	V	34 RENTAL OF SPACE		Tutera Health Care Services	100.00%	10,818	10,818
31	V	35 EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	884	884
32	V	35 AUTO RENTAL		Tutera Health Care Services	100.00%	5,019	5,019
33	V						
34	V	17 MANAGEMENT FEES	398,516	Tutera Health Care Services	100.00%		(398,516)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 398,516			\$ 341,198	\$ * (57,318)

* 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	5 UTILITIES	\$	Columbia 7611, LLC	100.00%	\$ 1,586	\$	1,586	15
16	V	6 REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	1,550		1,550	16
17	V	19 PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	127		127	17
18	V	21 OFFICE EXPENSES		Columbia 7611, LLC	100.00%	8		8	18
19	V	26 INSURANCE		Columbia 7611, LLC	100.00%	107		107	19
20	V	30 DEPRECIATION		Columbia 7611, LLC	100.00%	2,161		2,161	20
21	V	32 INTEREST EXPENSE		Columbia 7611, LLC	100.00%	240		240	21
22	V	33 REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	1,260		1,260	22
23	V	34 RENT	10,818	Columbia 7611, LLC	100.00%			(10,818)	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		\$ 10,818			\$ 7,040	\$ *	(3,778)	39

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	17 Management Fees	\$ 419,491	Illinois Health Care Management LLC	100.00%	\$ 398,517	\$ (20,974)
16	V	19 Legal Expense		Illinois Health Care Management LLC	100.00%	90	90
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 419,491			\$ 398,608	\$ * (20,883)

* 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		\$			\$	\$ *	39

* 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: 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		
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		\$			\$	\$ *	39

* 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: 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		
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		\$			\$	\$ *	39

* 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		\$			\$	\$ *	39

* 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		\$			\$	\$ *	39

* 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: 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		
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		\$			\$	\$ *	39

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

Facility Name & ID Number

Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Tutera	100%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI Crystal Lake	Crystal Lake, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Management Comp	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Services, LLC	Kansas City, MO	Management Co	3
4			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Dixon Rehabilitation & Health Care Center	Dixon, IL	Walnut Creek- New England, LLC	Kansas City, MO	Management Co	5
6			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	Illinois Health Care Management I	Kansas City, MO	Management Co	6
7			Hamilton Memorial Rehabilitation & Health Care Center	McLeansboro, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	7
8			Highland Rehabilitation & Health Care Center	Kansas City, MO	The Atriums Senior Living Commu	Overland Park, KS	Independent/Assisted Living	8
9			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Carnegie Village Senior Living Com	Belton, MO	Independent/Assisted Living	9
10			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Home Health	Kansas/Missouri	Home Health	10
11			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Continua Hospice KS	Kansas	Hospice	11
12			Meridian Rehabilitation & Health Care Center	Wichita, KS	Continua Hospice MO	Missouri	Hospice	12
13			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Country Gardens Assisted Living	Muskogee, OK	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care Center	Independence, MO	Gentilly Gardens Senior Living Co	Statesboro, GA	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Lamar Court Assisted Living Com	Overland Park, KS	Assisted Living	15
16			The Pine Rehabilitation & Health Care Center	Lansing, MI	Oakley Courts Assisted Living Com	Freeport, IL	Assisted Living	16
17			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Rose Estates Assisted Living Comm	Overland Park, KS	Assisted Living	17
18			Charlton Place Rehabilitation & Health Care Center	Deatsville, AL	Stratford Commons Memory Care	Overland Park, KS	Memory Care	18
19			Westridge Gardens Rehabilitation & Health Care Center	Raytown, MO	Victory Hills Senior Living Commu	Kansas City, KS	Independent/Assisted Living	19
20			Willow Care Rehabilitation & Health Care Center	Hannibal, MO	Wesley Court Assisted Living Com	Boiling Springs, SC	Assisted Living	20
21			Holly Hill House	Sulphur, LA	Willow Place Assisted Living & Me	Laurinburg, NC	Assisted Living	21
22			Rosewood Nursing Center	Lake Charles, LA				22
23			Beautiful Savior	Belton, MO				23
24			Acuity - Mesa	Mesa, AZ				24
25			Acuity - Sun City	Sun City, AZ				25
26			Coulterville Rabilitation & Health Care Center	Coulterville, IL				26
27			Iola Rehabilitation & Health Care Center	Iola, KS				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Deseret Health & Rehab at Onaga	Onaga, KS				30

Facility Name & ID Number

Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Crystal Pines Rehab & HCC # 0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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 Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Tutera Health Care Services
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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

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	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE	160,764,752	31	\$ 20,697	\$ 7,331,151	\$ 944	1
2	10	NURSING & MEDICAL RECO	OPERATING EXPENSE	160,764,752	31	5,416	7,331,151	247	2
3	10	NURSING SALARIES	OPERATING EXPENSE	160,764,752	31	979,937	979,937	44,687	3
4	15	NURSING TAXES & BENEFITS	OPERATING EXPENSE	160,764,752	31	244,977	7,331,151	11,171	4
5	19	PROFESSIONAL FEES	OPERATING EXPENSE	160,764,752	31	4,102	7,331,151	187	5
6	20	DUES, FEES, LICENSES, MEM	OPERATING EXPENSE	160,764,752	31	28,269	7,331,151	1,289	6
7	21	OFFICE EXPENSES	OPERATING EXPENSE	160,764,752	31	382,252	7,331,151	17,431	7
8	21	OFFICE SALARIES	OPERATING EXPENSE	160,764,752	31	3,717,531	3,717,531	169,526	8
9	24	BUSINESS SEMINAR	OPERATING EXPENSE	160,764,752	31	104,327	7,331,151	4,758	9
10	25	TRAVEL EXPENSES	OPERATING EXPENSE	160,764,752	31	661,487	7,331,151	30,165	10
11	26	INSURANCE	OPERATING EXPENSE	160,764,752	31	45,302	7,331,151	2,066	11
12	27	EMP BENEFITS & PAYROLL T	OPERATING EXPENSE	160,764,752	31	751,270	7,331,151	34,259	12
13	30	DEPRECIATION	OPERATING EXPENSE	160,764,752	31	167,643	7,331,151	7,645	13
14	32	INTEREST EXPENSE	OPERATING EXPENSE	160,764,752	31		7,331,151		14
15	33	REAL ESTATE TAXES	OPERATING EXPENSE	160,764,752	31	2,226	7,331,151	102	15
16	34	RENTAL OF SPACE	OPERATING EXPENSE	160,764,752	31	237,236	7,331,151	10,818	16
17	35	EQUIPMENT RENTAL	OPERATING EXPENSE	160,764,752	31	19,392	7,331,151	884	17
18	35	AUTO RENTAL	OPERATING EXPENSE	160,764,752	31	110,058	7,331,151	5,019	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,482,120	\$ 4,697,468	\$ 341,198	25

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Columbia 7611, LLC
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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

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	5	UTILITIES	OPERATING EXPENSE 160,764,752	31	\$ 34,777	\$	7,331,151	\$ 1,586	1
2	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE 160,764,752	31	33,996		7,331,151	1,550	2
3	19	PROFESSIONAL FEES	OPERATING EXPENSE 160,764,752	31	2,779		7,331,151	127	3
4	21	OFFICE EXPENSES	OPERATING EXPENSE 160,764,752	31	182		7,331,151	8	4
5	26	INSURANCE	OPERATING EXPENSE 160,764,752	31	2,337		7,331,151	107	5
6	30	DEPRECIATION	OPERATING EXPENSE 160,764,752	31	47,396		7,331,151	2,161	6
7	32	INTEREST EXPENSE	OPERATING EXPENSE 160,764,752	31	5,268		7,331,151	240	7
8	33	REAL ESTATE TAXES	OPERATING EXPENSE 160,764,752	31	27,638		7,331,151	1,260	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				\$ 154,373	\$		\$ 7,040	25

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Illinois Health Care Services LLC
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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

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	17	Management Fees	Direct Expense		\$	\$		\$ 398,517	1
2	19	Legal Expense	Operating Expense	20,264,854	3	250	7,331,151	90	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				\$ 250	\$		\$ 398,608	25

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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 Crystal Pines Rehab & HCC

0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Crystal Pines Rehab & HCC

0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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 Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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 Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

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**					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	Mortgage		X				\$	\$ 5,569,337			\$ 222,196	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	Tutera Group		X	Note payable				681,000			2,364	6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$ 6,250,337			\$ 224,560	9				
B. Non-Facility Related*																
10	Interest Income		X								(3,504)	10				
11	Allocated from Columbia 7611, LLC		X								240	11				
12	Building Co Interest Income		X								(103)	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (3,367)	14				
15	TOTALS (line 9+line14)						\$	\$ 6,250,337			\$ 221,193	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,074 Line # 36

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

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2013 report.		\$	88,662		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.)		\$	92,979		2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,317		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	81,045		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.)		\$	100		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	85,462		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY	
	2010	_____	9		
	2011	82,068	10		
	2012	88,662	11		
	2013	91,617	12		
2014 Accrual = \$91,617 x 0.88 = \$81,045 (Rounded)					
Allocated from Tutera Health Care Services- \$102				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
Allocated from Columbia 7611, LLC- \$1,260				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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crystal Pines Rehab & HCC COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051052

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-33-151-007</u>	<u>Long Term Care Facility</u>	\$ <u>91,617.04</u>	\$ <u>91,617.04</u>
2. <u>47-920-06-15-02-0-00-000</u>	<u>Allocated from Management</u>	\$ <u>69,638.00</u>	\$ <u>1,260.32</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>161,255.04</u></u>	\$ <u><u>92,877.36</u></u>

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? X YES NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

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 & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,000 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2010</u>	<u>\$ 488,000</u>	<u>1</u>
2	<u>Allocated from Columbia 7611, LLC</u>			<u>5,158</u>	<u>2</u>
3	TOTALS			\$ 493,158	3

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	114		2010	1972	\$ 4,697,000	\$ 132,322	39	\$ 120,436	\$ (11,886)	\$ 602,180	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											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67			261,087		13,054	13,054	28,869	67				
68			56,537	2,643	1,740	(903)	39,815	68				
69				7,946		(7,946)		69				
70		\$	5,014,624	\$	142,911	\$	135,230	\$	(7,681)	\$	670,864	70

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,014,624	\$ 142,911		\$ 135,230	\$ (7,681)	\$ 670,864	1
2	200&400 Hallways & Pt Rm - Flooring, Wall Finishes, Lighting, Ha	2013	162,727		20	8,136	8,136	16,273	2
3	Generator Repair	2013	4,241		20	212	212	424	3
4	200&400 Hallways&Pt Rm - Flooring And Base, Signage	2013	4,176		20	209	209	418	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	TOTAL (lines 1 thru 33)		\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	34

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

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		
1	Totals from Page 12B, Carried Forward		\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	34

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,185,768	\$ 142,911		\$ 143,788	\$ 876	\$ 687,979	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Wireless Infrastructure & Wiring	2012	32,117		20	1,606	1,606	6,156	9
10	Water Heater	2012	14,644		20	732	732	2,196	10
11	Gas/Electric Rooftop Unit	2012	7,100		20	355	355	1,065	11
12	200&400 Hallways & PT Rm - Flooring, Paint, Fire-rated Walls...	2013	181,822		20	9,091	9,091	18,182	12
13									13
14	Conference Room-Putting up Walls, a Window, Doors,								14
15	Painting, Flooring, Lighting, etc.	2014	13,058		20	653	653	653	15
16	Hotwater Heater & Storage Tank	2014	12,346		20	617	617	617	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	TOTAL (lines 1 thru 33)		\$ 261,087	\$		\$ 13,054	\$ 13,054	\$ 28,869	34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 261,087	\$		\$ 13,054	\$ 13,054	\$ 28,869		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 261,087	\$		\$ 13,054	\$ 13,054	\$ 28,869		34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Columbia 7611, LLC	1989	44,599	1,739	35	1,274	(465)	33,130	3
4	Allocated from Columbia 7611, LLC	1990	5,102	186	35	146	(40)	3,645	4
5	Allocated from Columbia 7611, LLC	1991	674	25	35	19	(6)	462	5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Columbia 7611, LLC	1989	24		20			24	9
10	Allocated from Columbia 7611, LLC	1994	127	4	20		(4)	127	10
11	Allocated from Columbia 7611, LLC	1995	197	6	20	10	4	197	11
12	Allocated from Columbia 7611, LLC	1996	365	6	20	18	12	347	12
13	Allocated from Columbia 7611, LLC	2003	142	4	20	7	3	85	13
14	Allocated from Columbia 7611, LLC	2006	691		20	35	35	311	14
15	Allocated from Columbia 7611, LLC	2008	1,090	34	20	54	20	381	15
16	Allocated from Columbia 7611, LLC	2011	303	9	20	15	6	61	16
17									17
18	Allocated from Walnut Creek Management Company	2006	1,933		20	97	97	870	18
19	Allocated from Walnut Creek Management Company	2007	46	2	20	2		18	19
20	Allocated from Walnut Creek Management Company	2014	1,092	628	20	55	(573)	55	20
21									21
22	Allocated from LTC Services, LLC	2001	79		20	4	4	55	22
23	Allocated from LTC Services, LLC	2002	73		20	4	4	47	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 56,537	\$ 2,643		\$ 1,740	\$ (903)	\$ 39,815	34

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

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward		\$ 56,537	\$ 2,643		\$ 1,740	\$ (903)	\$ 39,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 56,537	\$ 2,643		\$ 1,740	\$ (903)	\$ 39,815	34

**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	\$ 1,049,045	\$ 161,189	\$ 104,905	\$ (56,284)	10	\$ 607,031	71
72	Current Year Purchases	12,882	7,554	1,288	(6,266)	10	1,288	72
73	Fully Depreciated Assets	13,441	148	374	226	10	13,441	73
74								74
75	TOTALS	\$ 1,075,368	\$ 168,891	\$ 106,567	\$ (62,324)		\$ 621,760	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		Allocated from Walnut Creek M	2014	\$ 4,912	\$ 252	\$ 231	\$ (21)	5	\$ 4,451	76
77		Allocated from LTC Services	2014	1,829				5	1,829	77
78										78
79										79
80	TOTALS			\$ 6,741	\$ 252	\$ 231	\$ (21)		\$ 6,280	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)	\$ 6,761,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 312,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 250,586	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,469)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,316,019	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 16,245 Description: See Attached Schedule

(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	<u>Allocated from Tutores Health Care Services</u>		\$	\$ <u>5,019</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>5,019</u>	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.

Facility Name & ID Number Crystal Pines Rehab & HCC # 0051052 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" 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>2. CLASSROOM PORTION:</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 CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 246,965	\$		\$ 246,965	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,529			123,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			424,117	1,334		425,451	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				161,371		161,371	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					72,346	149,911		222,257	13
14	TOTAL			\$		\$ 866,957	\$ 312,616		\$ 1,179,573	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.

Facility Name & ID Number Crystal Pines Rehab & HCC# 0051052Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,581	\$ 72,114	1
2	Cash-Patient Deposits	58,359	58,359	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,651,843	1,651,843	3
4	Supply Inventory (priced at)	12,782	12,782	4
5	Short-Term Investments			5
6	Prepaid Insurance	246,767	248,899	6
7	Other Prepaid Expenses	24,636	47,603	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	95,841	95,841	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,092,809	\$ 2,187,441	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		488,000	13
14	Buildings, at Historical Cost		4,899,880	14
15	Leasehold Improvements, at Historical Cost	158,903	158,903	15
16	Equipment, at Historical Cost		1,084,177	16
17	Accumulated Depreciation (book methods)	(12,038)	(1,123,550)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		76,219	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,586)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	25,231	160,244	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 172,096	\$ 5,733,287	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,264,905	\$ 7,920,728	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 100,023	\$ 125,428	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,359	58,359	28
29	Short-Term Notes Payable	681,000	681,000	29
30	Accrued Salaries Payable	187,578	187,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,019	57,019	31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,662	81,045	32
33	Accrued Interest Payable		18,332	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36			25,363	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,172,641	\$ 1,234,124	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,569,337	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	222,480	222,480	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 222,480	\$ 5,791,817	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,395,121	\$ 7,025,941	46
47	TOTAL EQUITY(page 18, line 24)	\$ 869,784	\$ 894,787	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,264,905	\$ 7,920,728	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 712,342	1
2	Restatements (describe):		2
3	Asset Mgmt Fee	(222,480)	3
4	Accumulated Depr Adjustment	1,865	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 491,727	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	378,057	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)	\$ 378,057	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)	\$ 869,784	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 8,031,314	1	
2	Discounts and Allowances for all Levels	(1,995,089)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,036,225	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,828,257	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,828,257	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	331,524	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	70,756	19	
20	Radiology and X-Ray		20	
21	Other Medical Services	124,586	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 526,866	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	3,504	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,504	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See Supplemental Schedule</u>	1,294	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,294	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,396,146	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,160,465	31	
32	Health Care	2,827,928	32	
33	General Administration	2,045,987	33	
B. Capital Expense				
34	Ownership	562,435	34	
C. Ancillary Expense				
35	Special Cost Centers	1,179,573	35	
36	Provider Participation Fee	241,701	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,018,089	40	
41	Income before Income Taxes (line 30 minus line 40)**	378,057	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 378,057	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,850,695	44
45	Private Pay - Net Inpatient Revenue	963,218	45
46	Medicare - Net Inpatient Revenue	1,116,823	46
47	Other-(specify) <u>Insurance</u>	105,489	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,036,225	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	7,001	7,586	\$ 304,019	\$ 40.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,145	29,041	796,721	27.43	3
4	Licensed Practical Nurses	9,447	10,197	242,749	23.81	4
5	CNAs & Orderlies	75,691	80,966	987,322	12.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,137	6,743	86,645	12.85	10
11	Social Service Workers	7,557	8,315	173,705	20.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,957	4,334	82,758	19.10	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,576	1,790	75,177	42.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,135	10,986	173,630	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,812	2,076	33,986	16.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	936	1,187	13,929	11.73	33
34	TOTAL (lines 1 - 33)	151,394	163,221	\$ 2,970,641 *	\$ 18.20	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 561,403	01-03	35
36	Medical Director	Monthly	28,000	09-03	36
37	Medical Records Consultant	24	1,320	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	1,225	7,338	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,480	11-03	44
45	Social Service Consultant	43	3,078	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,330	\$ 603,619		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Samuel Biber	Administrator	0	\$ 58,211	Workers' Compensation Insurance	\$ 115,678	IDPH License Fee	\$ 1,990		
Amrit Jacob	Administrator	0	16,965	Unemployment Compensation Insurance		Advertising: Employee Recruitment	30,553		
				FICA Taxes	224,820	Health Care Worker Background Check (Indicate # of checks performed <u>100</u>)	1,500		
				Employee Health Insurance	57,070	Patient Background Checks			
				Employee Meals		Dues and Subscriptions	6,149		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	1,495		
				Other Employee Benefits	11,410	Allocated from Tuter Health Care Services	1,289		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,177						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 408,978	Less: Public Relations Expense	()		
IL Health Care Management- Management Fees			\$ 419,492			Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 419,492	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal		\$ 22,426				Out-of-State Travel	\$	
E-Health Data	Data Processing		5,190						
Emdeon	Data Processing		541				In-State Travel		
Pinnacle Quality Insight	Customer Satisfaction Survey		1,416						
Westcom Solutions	Data Processing		17,345						
FR&R	Accounting		7,000				Seminar Expense	4,022	
Gottlieb Flekier & Copa	Accounting		1,885				Allocated from Tuter Health Care Services	4,758	
Thomas & Thorngren	Unemployment Consulting		1,005						
Property Valuation Services	Property Valuation		100				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 56,908	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 8,780

* Attach copy of IMRF notifications

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

Facility Name & ID Number Crystal Pines Rehab & HCC

0051052

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Healthcare Association \$5,750
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,034 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 241,701
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- 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? No
- 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
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.