FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0051052

Facility Name: Crystal Pines Rehabilitation & Health Care Center

Address: 335 North Illinois Street (Number) Crystal Lake (City) 60014 (Zip Code)

County: McHenry

Telephone Number: 815-459-7791 **Fax #** 815-459-7680

HFS ID Number:

Date of Initial License for Current Owners: 10/28/2010

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA **Telephone Number:** 314-925-4446
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	114	Skilled (SNF)	114	41,610	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	114	TOTALS	114	41,610	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,777	7,015	10,036	31,828	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,777	7,015	10,036	31,828	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.49%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/28/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/28/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 114 and days of care provided 5,468

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care C # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		1,717	532,951	534,668		534,668	3,529	538,197			1
2	Food Purchase		19,740		19,740		19,740	(339)	19,401			2
3	Housekeeping		14,161	137,361	151,522		151,522		151,522			3
4	Laundry		9,651	90,653	100,304		100,304	729	101,033			4
5	Heat and Other Utilities			123,182	123,182		123,182		123,182			5
6	Maintenance	83,818	20,685	67,771	172,274		172,274	7,873	180,147			6
7	Other (specify):*											7
8	TOTAL General Services	83,818	65,954	951,918	1,101,690		1,101,690	11,792	1,113,482			8
	B. Health Care and Programs											
9	Medical Director					30,000	30,000		30,000			9
10	Nursing and Medical Records	2,535,919	138,641	26,712	2,701,272	(30,000)	2,671,272	17,291	2,688,563			10
10a	Therapy											10a
11	Activities	22,892	950	108,975	132,817		132,817		132,817			11
12	Social Services	76,413		2,576	78,989		78,989		78,989			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,635,224	139,591	138,263	2,913,078		2,913,078	17,291	2,930,369			16
	C. General Administration											
17	Administrative	127,349			127,349		127,349		127,349			17
18	Directors Fees											18
19	Professional Services			138,052	138,052		138,052	358,453	496,505			19
20	Dues, Fees, Subscriptions & Promotions			15,114	15,114		15,114	(2,539)	12,575			20
21	Clerical & General Office Expenses	182,138	25,033	719,089	926,260		926,260	(663,840)	262,420			21
22	Employee Benefits & Payroll Taxes			408,223	408,223		408,223		408,223			22
23	Inservice Training & Education			270	270		270		270			23
24	Travel and Seminar			3,591	3,591		3,591		3,591			24
25	Other Admin. Staff Transportation			6,062	6,062		6,062	(4,436)	1,626			25
26	Insurance-Prop.Liab.Malpractice			178,115	178,115		178,115	4,072	182,187			26
27	Other (specify):*											27
28	TOTAL General Administration	309,487	25,033	1,468,516	1,803,036		1,803,036	(308,290)	1,494,746			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,028,529	230,578	2,558,697	5,817,804		5,817,804	(279,207)	5,538,597			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 Rehabilitation & Health Care Center #0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			4,456	4,456		4,456	285,508	289,964			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,546	2,546		2,546	172,889	175,435			32
33	Real Estate Taxes			97,860	97,860		97,860	(3,202)	94,658			33
34	Rent-Facility & Grounds			417,127	417,127		417,127	(417,127)				34
35	Rent-Equipment & Vehicles			12,504	12,504		12,504		12,504			35
36	Other (specify):* **Mortgage Ins**							26,187	26,187			36
37	**TOTAL Ownership**			534,493	534,493		534,493	64,255	598,748			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,207	867,203	1,135,410		1,135,410		1,135,410			39
40	Barber and Beauty Shops			4,345	4,345		4,345		4,345			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,715	222,715		222,715		222,715			42
43	Other (specify):* **Marketing**	84,025		37,200	121,225		121,225	(121,225)				43
44	**TOTAL Special Cost Centers**	84,025	268,207	1,131,463	1,483,695		1,483,695	(121,225)	1,362,470			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,112,554	498,785	4,224,653	7,835,992		7,835,992	(336,177)	7,499,815			45

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(339)	02		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	3,536	30		9
10	Interest and Other Investment Income	(2,629)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(16,038)	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	(142,974)	21		24
25	Fund Raising, Advertising and Promotional	(37,200)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(95,628)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,272)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(39,905)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (39,905)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (336,177)		37

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

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

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

STATE OF ILLINOIS

Crystal Pines Rehabilitation & Health Care Center

ID# 0051052

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (2,370)	20	1
2	Marketing Salaries	(84,025)	43	2
3	Marketing Mileage	(4,436)	25	3
4	Misc Income	(4,628)	21	4
5	Crystal Lake Chamber of Commerce	(169)	20	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
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24				24
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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**	(95,628)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center **#** 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	3,529	0	0	0	0	0	0	0	0	0	3,529	1
2	Food Purchase	(339)	0	0	0	0	0	0	0	0	0	0	(339)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	729	0	0	0	0	0	0	0	0	0	729	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	7,873	0	0	0	0	0	0	0	0	0	7,873	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(339)	12,131	0	0	0	0	0	0	0	0	0	11,792	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	17,291	0	0	0	0	0	0	0	0	0	17,291	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	17,291	0	0	0	0	0	0	0	0	0	17,291	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,950	349,503	0	0	0	0	0	0	0	0	358,453	19
20	Fees, Subscriptions & Promotions	(2,539)	0	0	0	0	0	0	0	0	0	0	(2,539)	20
21	Clerical & General Office Expenses	(168,640)	14,108	(509,308)	0	0	0	0	0	0	0	0	(663,840)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,436)	0	0	0	0	0	0	0	0	0	0	(4,436)	25
26	Insurance-Prop.Liab.Malpractice	0	4,072	0	0	0	0	0	0	0	0	0	4,072	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(175,615)	27,130	(159,805)	0	0	0	0	0	0	0	0	(308,290)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(175,954)	56,552	(159,805)	0	0	0	0	0	0	0	0	(279,207)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,536	270,544	11,428	0	0	0	0	0	0	0	0	285,508	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,629)	175,518	0	0	0	0	0	0	0	0	0	172,889	32
33	Real Estate Taxes	0	(3,202)	0	0	0	0	0	0	0	0	0	(3,202)	33
34	Rent-Facility & Grounds	0	(417,127)	0	0	0	0	0	0	0	0	0	(417,127)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,187	0	0	0	0	0	0	0	0	0	26,187	36
37	**TOTAL Ownership**	907	51,920	11,428	0	0	0	0	0	0	0	0	64,255	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(121,225)	0	0	0	0	0	0	0	0	0	0	(121,225)	43
44	**TOTAL Special Cost Centers**	(121,225)	0	0	0	0	0	0	0	0	0	0	(121,225)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(296,272)	108,472	(148,377)	0	0	0	0	0	0	0	0	(336,177)	45

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 417,127	TI Crystal Lake, LLC	100.00%	$	$ (417,127)	1
2	V	32	Interest		TI Crystal Lake, LLC	100.00%	151,683	151,683	2
3	V	19	Administrative		TI Crystal Lake, LLC	100.00%	8,950	8,950	3
4	V	36	Mortgage Insurance		TI Crystal Lake, LLC	100.00%	26,187	26,187	4
5	V	30	Depreciation		TI Crystal Lake, LLC	100.00%	270,544	270,544	5
6	V	32	Amortization of Financing Costs		TI Crystal Lake, LLC	100.00%	23,835	23,835	6
7	V	06	Maintenance		TI Crystal Lake, LLC	100.00%	7,873	7,873	7
8	V	33	Real Estate Taxes	97,860	TI Crystal Lake, LLC	100.00%	94,658	(3,202)	8
9	V	26	Insurance	8,400	TI Crystal Lake, LLC	100.00%	12,472	4,072	9
10	V	10	Nursing		TI Crystal Lake, LLC	100.00%	17,291	17,291	10
11	V	21	Clerical		TI Crystal Lake, LLC	100.00%	14,108	14,108	11
12	V	04	Laundry		TI Crystal Lake, LLC	100.00%	729	729	12
13	V	01	Dietary		TI Crystal Lake, LLC	100.00%	3,529	3,529	13
14	Total			$ 523,387			$ 631,859	$ * 108,472	14

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 5,766	CarePlus Health Plans		$ 5,766	$	15
16	V	19	Management - Operating	68,423	Tutera Health Care Services	100.00%	417,926	349,503	16
17	V	30	Management - Depreciation		Tutera Health Care Services	100.00%	11,428	11,428	17
18	V	21	Postage/Small Equipment	6,553	Walnut Creek Management		6,553		18
19	V	21	A&G - Purchased Services	10,839	Bethany Health Care and Rehab		10,839		19
20	V	10	Nursing Aides	1,022	Bethany Health Care and Rehab		1,022		20
21	V	21	Asset Management Fee	100,000	JCT Capital LLC			(100,000)	21
22	V	21	Management Fee	409,308	Tutera Health Care Services	100.00%		(409,308)	22
23	V	43	Advertising	239	Walnut Creek Management		239		23
24	V	20	Employee Want Ads	2,338	Walnut Creek Management		2,338		24
25	V	24	Travel & Seminar	1,188	Walnut Creek Management		1,188		25
26	V	26	Insurance	164,466	LTC Plus Insurance, Inc		164,466		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			$ 770,142			$ 621,765	$ * (148,377)	39

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2			Windsor Rehab & Health Care Center	Terrell, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3			Bethany Rehab & Health Care Center	DeKalb, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Carlinville Rehab & Health Care Center	Carlinville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Coulterville Rehab & Health Care Center	Coulterville, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & HC Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, KS	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boiling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv	Laurinburg, NC	AL	11
12			Mattoon Rehab & Health Care Center	Mattoon, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Paradise Park Assisted	Fox Lake, IL	AL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL	TI - Crystal Lake	Crystal Lake, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LLC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & HC Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & HC Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New En	Kansas City, MO	Mgmt Company	19
20			Holly Hill Rehab & Health Care Center	Sulphur, LA	Tutera Investments, In	Kansas City, MO	Mgmt Company	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	21
22			Beautiful Savior Rehab & HC Center	Belton, MO	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Greenfield Manor	Greenfield, IA	LTC Plus Insurance, I	Kansas City, MO	Insurance Company	23
24			Griswold Care Center	Griswold, IA				24
25			Moweaqua Rehab & Health Care Center	Moweaqua, IL				25
26			Stratford Rehab & Health Care Center	Overland Park, KS				26
27			Carnegie Village Rehabilitation & Health Care C	Belton, MO				27
28			Tiffany Springs Rehabilitation & Health Care C	Kansas City, MO				28
29								29
30								30

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care (# 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fee - Operating	Direct Costs	168,868,621	42	$ 9,661,251	$ 7,250,104	7,304,863	$ 417,923	1
2	30	Management Fee - Depreciation	Direct Costs	168,868,621	42	264,186		7,304,863	11,428	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					$ 9,925,437	$ 7,250,104		$ 429,351	25

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care C # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 5,153,697			$ 151,933	1
2	Amortize Financing Costs - HUD		X								23,835	2
3												3
4												4
5												5
	Working Capital											
6	Tutera Investments LLC	X		Note Payable			1,076,365			0.0075	1,631	6
7	JCT Capital	X		Note Payable			1,065,000	795,379		0.0100	915	7
8	Interest Income Offset										(2,879)	8
9	TOTAL Facility Related						$ 2,141,365	$ 5,949,076			$ 175,435	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,141,365	$ 5,949,076			$ 175,435	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,187 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 Rehabilitation & Health Care Center **#** 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 92,575	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.)		$ 93,617	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,042	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,616	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 94,658	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	88,662	8
	2013	91,617	9
	2014	93,201	10
	2015	92,575	11
	2016	93,617	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crystal Pines Rehabilitation & Health Care Center COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051052

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

TELEPHONE 314-925-4446 FAX #: 314-925-4350

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-33-151-007	Long-Term Care	$ 93,616.58	$ 93,616.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,616.58	$ 93,616.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long-Term Care	23,000	2010	$ 488,000	1
2					2
3	TOTALS	23,000		$ 488,000	3

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	114		2010	1972	$ 4,697,000	$ 120,436	39	$ 120,436	$	$ 863,124	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	200/400 HALL DESIGN, RENOVATION, LIGHTING, FLOOR COVER			2013	158,903	7,945	20	7,945		35,874	9
10	FURNACE HEAT EXCHANGER			2017	8,488	47	15	47		47	10
11											11
12	HOME OFFICE ALLOCATION					11,428		11,428			12
13											13
14	200/400 HALLWAYS & PT RM-FLOORING, WALLS (TI CRYSTAL L			2013	189,822	4,867	39	4,867		24,336	14
15	CONFERENCE ROOM (TI CRYSTAL LAKE)			2014	13,058	871	15	871		3,047	15
16	PARKING LOT REPAIRS (TI CRYSTAL LAKE)			2016	146,642	9,776	15	9,776		12,220	16
17	HVAC (TI CRYSTAL LAKE)			2017	10,100	1,443	7	1,443		1,443	17
18	WATER HEATER (TI CRYSTAL LAKE)			2017	9,985	1,426	7	1,426		1,426	18
19	PAINTING DOORFRAMES/WALLS - ENTIRE FACILITY (TI CRYST			2017	7,000	700	10	700		700	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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 176,830	$ 22,096	$ 22,096	$	Various	$ 102,131	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	915,000	108,929	108,929		7	915,000	73
74								74
75	TOTALS	$ 1,091,830	$ 131,025	$ 131,025	$		$ 1,017,131	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,820,828	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 289,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 289,964	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,959,348	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.

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 [X] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,504 Description: Dietary, Laundry, Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-3	hrs	$	3,374	$ 221,968	$	3,374	$ 221,968	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		1,779	111,062		1,779	111,062	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		6,691	429,901	1,997	6,691	431,898	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				148,263		148,263	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB					104,272	117,947		222,219	13
14	TOTAL			$	11,844	$ 867,203	$ 268,207	11,844	$ 1,135,410	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.

STATE OF ILLINOIS

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 435,704	$ 466,619	1
2	Cash-Patient Deposits	35,530	35,530	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,366,336	1,366,336	3
4	Supply Inventory (priced at)	11,785	11,785	4
5	Short-Term Investments		132,033	5
6	Prepaid Insurance	245,833	252,315	6
7	Other Prepaid Expenses	454,937	478,290	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets		4,200	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,550,125	$ 2,747,108	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		4,926,965	14
15	Leasehold Improvements, at Historical Cost	167,391	314,033	15
16	Equipment, at Historical Cost		1,091,830	16
17	Accumulated Depreciation (book methods)	(35,921)	(1,959,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Long-Term Assets	17,230	(1,243,657)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 148,700	$ 3,617,824	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,698,825	$ 6,364,932	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 573,305	$ 573,305	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,530	35,530	28
29	Short-Term Notes Payable	795,379	795,379	29
30	Accrued Salaries Payable	218,545	218,545	30
31	Accrued Taxes Payable (excluding real estate taxes)	110,710	110,710	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,617	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fees Payable	99,926	99,926	36
37	Rent Payable		43,616	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,833,395	$ 1,970,628	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,904,039	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,904,039	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,833,395	$ 6,874,667	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 865,430	$ (509,735)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,698,825	$ 6,364,932	48

***(See instructions.)**

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center **#** 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 939,295	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 939,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	357,436	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	(431,301)	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)**	$ (73,865)	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)**	$ 865,430	24 *

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,651,438	1
2	Discounts and Allowances for all Levels	(4,585,286)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,066,152	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,482,797	6
7	Oxygen	43,770	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,526,567	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	339	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	320,871	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,271	19
20	Radiology and X-Ray		20
21	Other Medical Services	248,971	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 593,452	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,629	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,629	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	4,628	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,628	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,193,428	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,101,690	31
32	Health Care	2,913,078	32
33	General Administration	1,803,036	33
	B. Capital Expense		
34	Ownership	534,493	34
	C. Ancillary Expense		
35	Special Cost Centers	1,260,980	35
36	Provider Participation Fee	222,715	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,835,992	40
41	**Income before Income Taxes (line 30 minus line 40)****	357,436	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 357,436	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,703,473	44
45	Private Pay - Net Inpatient Revenue	1,633,723	45
46	Medicare - Net Inpatient Revenue	(1,089,249)	46
47	Other-(specify) Managed Care	(181,795)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,066,152	49

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

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

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

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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,453	5,926	$ 212,146	$ 35.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,594	34,610	962,074	27.80	3
4	Licensed Practical Nurses	10,278	11,064	301,631	27.26	4
5	CNAs & Orderlies	64,814	67,361	1,020,493	15.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,760	2,342	22,892	9.77	10
11	Social Service Workers	3,084	3,541	76,413	21.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,533	3,983	83,818	21.04	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,912	2,080	127,349	61.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,426	11,553	182,138	15.77	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	1,845	2,095	39,575	18.89	31
32	Other Health Care(specify)			0		32
33	Other(specify) Marketing	3,694	4,028	84,025	20.86	33
34	TOTAL (lines 1 - 33)	139,393	148,583	$ 3,112,554 *	$ 20.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 532,951	V01-3	35
36	Medical Director	Monthly	30,000	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,903	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	97,297	V11-3	44
45	Social Service Consultant	Monthly	2,576	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 671,727		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Krug	Administrator	0	$ 127,349
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,349

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lathrop & Gage LLP	Legal	$ 10,261
Daniel Maher Law Offices	Legal	1,690
Forte LLC	Legal	102
Heyl Royster Voelker & Allen	Legal	13,059
IL Secretary of State	Legal	250
CliftonLarsonAllen LLP	Accounting/Cost Report	7,699
Walnut Creek Mgmt Co, LLC	Data Processing	68,426
Ability Network Inc	Data Processing	2,294
PointClickCare Technologies	Data Processing	30,004
Allscripts Healthcare LLC	Professional Services	2,280
Pinnacle Quality Insight	Professional Services	1,887
Property Valuation Services	Professional Services	100
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 138,052

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,815
Unemployment Compensation Insurance	
FICA Taxes	259,271
Employee Health Insurance	61,707
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	8,430
TOTAL (agree to Schedule V, line 22, col.8)	$ 408,223

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,424
Health Care Worker Background Check	
(Indicate # of checks performed 234)	2,349
Patient Background Checks	
IL Health Care Association	7,887
AHCA	730
Chamber of Commerce	169
McHenry County Dept Health	300
Other Misc	1,255
Less: Public Relations Expense	(2,539)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,575

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,591
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,591

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Crystal Pines Rehabilitation & Health Care Center # 0051052 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 Health Care Association $7,887**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,607** 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. $ **227,715**
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? **N/A** 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? **Yes** Indicate the amount. $ **339**

(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%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(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