

		FOR BHF USE				

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

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

<p>I. IDPH License ID Number: <u>0051052</u></p> <p>Facility Name: <u>Crystal Pines Rehab HCC</u></p> <p>Address: <u>335 N Illinois St</u> <u>Crystal Lake</u> <u>60014</u> Number City Zip Code</p> <p>County: <u>McHenry</u></p> <p>Telephone Number: <u>(815) 459-7791</u> Fax # <u>(815) 459-7680</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/28/2010</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title)</td> <td><u>Kevin Wellen, CPA</u> <u>Director</u></td> </tr> <tr> <td>(Firm Name & Address)</td> <td><u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td> </tr> <tr> <td>(Telephone)</td> <td><u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title)	<u>Kevin Wellen, CPA</u> <u>Director</u>	(Firm Name & Address)	<u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u>	(Telephone)	<u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>
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Facility Name & ID Number Crystal Pines Rehab HCC

0051052 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	114	Skilled (SNF)	114	41,724	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	41,724	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	13,634	2,247	7,149	23,030	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,634	2,247	7,149	23,030	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.20%

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

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 10/28/2010

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

YES Date 10/28/20210 NO

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

YES NO If YES, enter number of beds certified 114 and days of care provided 4,862

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Crystal Pines Rehab HCC # 0051052 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		13,081	539,131	552,212	552,212		552,212			1
2	Food Purchase		12,682		12,682	12,682		12,682			2
3	Housekeeping		14,819	146,834	161,653	161,653		161,653			3
4	Laundry		8,773	94,880	103,653	103,653		103,653			4
5	Heat and Other Utilities			134,385	134,385	134,385		134,385			5
6	Maintenance	65,258	15,366	97,082	177,706	177,706		177,706			6
7	Other (specify):*										7
8	TOTAL General Services	65,258	64,721	1,012,312	1,142,291	1,142,291		1,142,291			8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000	21,000		21,000			9
10	Nursing and Medical Records	2,283,386	156,752	21,311	2,461,449	2,461,449	(15,000)	2,446,449			10
10a	Therapy										10a
11	Activities	77,131	4,180	4,632	85,943	85,943		85,943			11
12	Social Services	100,422		2,340	102,762	102,762		102,762			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,460,939	160,932	49,283	2,671,154	2,671,154	(15,000)	2,656,154			16
	C. General Administration										
17	Administrative	112,634		362,473	475,107	475,107	10,384	485,491			17
18	Directors Fees										18
19	Professional Services			133,051	133,051	133,051	(45,556)	87,495			19
20	Dues, Fees, Subscriptions & Promotions			21,553	21,553	21,553	(1,607)	19,946			20
21	Clerical & General Office Expenses	183,930	23,826	171,923	379,679	379,679	(108,541)	271,138			21
22	Employee Benefits & Payroll Taxes			391,003	391,003	391,003		391,003			22
23	Inservice Training & Education			90	90	90		90			23
24	Travel and Seminar			4,775	4,775	4,775		4,775			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			150,109	150,109	150,109		150,109			26
27	Other (specify):*										27
28	TOTAL General Administration	296,564	23,826	1,234,977	1,555,367	1,555,367	(145,320)	1,410,047			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,822,761	249,479	2,296,572	5,368,812	5,368,812	(160,320)	5,208,492			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:

1/1/2020

Ending:

12/31/2020

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			19,540	19,540		19,540	160,455	179,995			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			602	602		602	155,479	156,081			32
33	Real Estate Taxes			96,609	96,609		96,609	(180)	96,429			33
34	Rent-Facility & Grounds			415,662	415,662		415,662	(415,662)				34
35	Rent-Equipment & Vehicles			9,482	9,482		9,482		9,482			35
36	Other (specify):* Mortgage Insurance Premiums							23,810	23,810			36
37	TOTAL Ownership			541,895	541,895		541,895	(76,098)	465,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		343,117	1,016,787	1,359,904		1,359,904		1,359,904			39
40	Barber and Beauty Shops			1,130	1,130		1,130		1,130			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,247	173,247		173,247		173,247			42
43	Other (specify):* Marketing	75,472		40,102	115,574		115,574	(115,574)				43
44	TOTAL Special Cost Centers	75,472	343,117	1,231,266	1,649,855		1,649,855	(115,574)	1,534,281			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,898,233	592,596	4,069,733	7,560,562		7,560,562	(351,992)	7,208,570			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 Rehab HCC

0051052

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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				9
10	Interest and Other Investment Income	(5,222)	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	(20,752)	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	(67,078)	21		24
25	Fund Raising, Advertising and Promotional	(34,098)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,794)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (211,944)		\$	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)	(140,048)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (140,048)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (351,992)		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: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Portion of Dues	\$ (1,607)	20	1
2	Marketing Salaries	(75,472)	43	2
3	Marketing Benefits	(6,004)	43	3
4	Miscellaneous Income	(1,711)	21	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
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23				23
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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	(84,794)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Crystal Pines Rehab HCC# 0051052

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	10,384	0	0	0	0	0	0	0	0	10,384	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,692	(58,248)	0	0	0	0	0	0	0	0	(45,556)	19
20	Fees, Subscriptions & Promotions	(1,607)	0	0	0	0	0	0	0	0	0	0	(1,607)	20
21	Clerical & General Office Expenses	(89,541)	0	(19,000)	0	0	0	0	0	0	0	0	(108,541)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(91,148)	12,692	(66,864)	0	0	0	0	0	0	0	0	(145,320)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,148)	12,692	(81,864)	0	0	0	0	0	0	0	0	(160,320)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Crystal Pines Rehab HCC

0051052

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	156,888	3,567	0	0	0	0	0	0	0	0	160,455	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,222)	161,303	(602)	0	0	0	0	0	0	0	0	155,479	32
33	Real Estate Taxes	0	(180)	0	0	0	0	0	0	0	0	0	(180)	33
34	Rent-Facility & Grounds	0	(415,662)	0	0	0	0	0	0	0	0	0	(415,662)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	23,810	0	0	0	0	0	0	0	0	0	23,810	36
37	TOTAL Ownership	(5,222)	(73,841)	2,965	0	0	0	0	0	0	0	0	(76,098)	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):*	(115,574)	0	0	0	0	0	0	0	0	0	0	(115,574)	43
44	TOTAL Special Cost Centers	(115,574)	0	0	0	0	0	0	0	0	0	0	(115,574)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(211,944)	(61,149)	(78,899)	0	0	0	0	0	0	0	0	(351,992)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 415,662	TI Crystal Lake LLC	100.00%	\$	\$ (415,662)
2	V	32 Interest		TI Crystal Lake LLC	100.00%	137,468	137,468
3	V	19 Accounting/Legal/Other Taxes		TI Crystal Lake LLC	100.00%	12,692	12,692
4	V	36 Mortgage Insurance		TI Crystal Lake LLC	100.00%	23,810	23,810
5	V	30 Depreciation		TI Crystal Lake LLC	100.00%	156,888	156,888
6	V	32 Amortization of Financing Costs		TI Crystal Lake LLC	100.00%	23,835	23,835
7	V	06 Maintenance		TI Crystal Lake LLC	100.00%		
8	V	33 Real Estate Taxes	96,609	TI Crystal Lake LLC	100.00%	96,429	(180)
9	V	26 Insurance	11,116	TI Crystal Lake LLC	100.00%	11,116	
10	V	10 Nursing Small Equip		TI Crystal Lake LLC	100.00%		
11	V						
12	V						
13	V						
14	Total		\$ 523,387			\$ 462,238	\$ * (61,149)

* 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	22 Insurance	\$ 2,887	CarePlus Health Plus		\$ 2,887	\$	15	
16	V	22 Insurance	85,819	Cost Plus Insurance		85,819		16	
17	V	26 Insurance	132,250	LTC Plus Insurance, Inc.		132,250		17	
18	V	17 Management-Operating	362,473	Tutera Health Care Service		372,857	10,384	18	
19	V	19 Management-Data Processing	58,248	Tutera Health Care Service			(58,248)	19	
20	V	30 Management-Depreciation		Tutera Health Care Service		3,567	3,567	20	
21	V	10 Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000)	21	
22	V	21 Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000)	22	
23	V	32 Interest	602	Tutera Investments			(602)	23	
24	V	10 Nursing Admin - SM Equip	915	Walnut Creek Management Company, LLC		915		24	
25	V	24 Travel & Seminar	88	Walnut Creek Management Company, LLC		88		25	
26	V	43 Marketing	288	Walnut Creek Management Company, LLC		288		26	
27	V	1 Dietary - SM Equip & Equip Repair	7,123	Walnut Creek Management Company, LLC		7,123		27	
28	V	19 Purchased Svs	7,566	Walnut Creek Management Company, LLC		7,566		28	
29	V	20 Help Wanted Ads & Licenses	4,013	Walnut Creek Management Company, LLC		4,013		29	
30	V	21 Supplies, Sm Equip, Postage	8,621	Walnut Creek Management Company, LLC		8,621		30	
31	V	10 Pharmacy Consultant	6,195	Critical Care Rx, LLC		6,195		31	
32	V	39 Drugs	213,956	Critical Care Rx, LLC		213,956		32	
33	V	39 IV Therapy & Supplies	40,082	Critical Care Rx, LLC		40,082		33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 965,126			\$ 886,227	\$ *	(78,899)	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:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Tutera Investments, LLC	99%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT FLP, LLC	1%	Bethany Rehab & Health Care Center	DeKlb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Carlinsville Rehab & Health Care Center	Carlinsville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Auburn Rehab & Health Care Center	Auburn, 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 & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Seni	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL				14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			St. Paul's Senior Community	Belleville, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Tutera Investments, LI	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Crystal Pines Rehab HCC # 0051052 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	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 Fee- Operating	Direct Costs	287,210,821	71	\$ 15,078,459	\$ 10,830,799	7,102,020	\$ 372,853	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		7,102,020	3,566	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 15,222,689	\$ 10,830,799		\$ 376,419	25

Facility Name & ID Number

Crystal Pines Rehab HCC

0051052

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD		x	Mortgage			\$	\$ 4,669,068		\$ 137,468	1									
2	Amortize Financing Costs - HUD		x							23,835	2									
3	Interest Income Offset									(5,222)	3									
4											4									
5											5									
Working Capital																				
6	JCT Capital/Tutera Investments	x		Note Payable			350,000			0.0100	602	6								
7	Related Party Offset									(602)	7									
8											8									
9	TOTAL Facility Related						\$ 350,000	\$ 4,669,068		\$ 156,081	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 350,000	\$ 4,669,068		\$ 156,081	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,810 Line # 36

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.		\$	<u>95,498</u>	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.)		\$	<u>96,788</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,290</u>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>95,139</u>	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.		\$	<u>96,429</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<u>92,575</u>	8	
	2016	<u>92,575</u>	9	
	2017	<u>94,069</u>	10	
	2018	<u>92,684</u>	11	
	2019	<u>96,788</u>	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crystal Pines Rehab HCC COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051052

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-33-151-007</u>	<u>Long-Term Care</u>	\$ <u>96,788.44</u>	\$ <u>96,788.44</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>96,788.44</u></u>	\$ <u><u>96,788.44</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 X NO

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,571 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Long-Term Care</u>	<u>14,571</u>	<u>2010</u>	<u>\$ 488,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>14,571</u>		<u>\$ 488,000</u>	<u>3</u>

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	\$ 120,436	39	\$ 120,436	\$	\$ 1,224,432	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	2013 IMPROVEMENTS		2013	158,903	7,945	20	7,945		59,709	9
10	FURNACE HEATER EXCHANGE		2017	8,488	566	15	566		1,745	10
11	HOT WATER HEATER REPAIR		2020	3,589	214		214		214	11
12										12
13	HOME OFFICE ALLOCATION				3,567		3,567			13
14										14
15	2013 IMPROVEMENTS (TI CRYSTAL LAKE)		2013	189,822	4,867	39	4,867		38,938	15
16	CONFERENCE ROOM (TI CRYSTAL LAKE)		2014	13,058	871	15	871		5,659	16
17	PARKING LOT REPAIRS (TI CRYSTAL LAKE)		2016	146,642	9,776	15	9,776		41,549	17
18	HVAC (TI CRYSTAL LAKE)		2016	10,100	1,443	7	1,443		5,771	18
19	WATER HEATER (TI CRYSTAL LAKE)		2016	9,985	1,426	7	1,426		5,706	19
20	PAINTING DOORFRAMES/WALLS - ENTIRE FACILITY (TI CRYSTA		2017	7,000	700	10	700		2,800	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 N/A		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,244,587	\$ 151,811		\$ 151,811	\$	\$ 1,386,523	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 126,814	\$ 14,734	\$ 14,734	\$	Various	\$ 81,654	71
72	Current Year Purchases	5,879	441	441		Various	441	72
73	Fully Depreciated Assets	1,007,030	3,287	3,287		7	1,007,030	73
74								74
75	TOTALS	\$ 1,139,723	\$ 18,462	\$ 18,462	\$		\$ 1,089,125	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Van	2017	\$ 48,609	\$ 9,722	\$ 9,722	\$	5	\$ 35,647	76
77										77
78										78
79										79
80	TOTALS			\$ 48,609	\$ 9,722	\$ 9,722	\$		\$ 35,647	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,920,919	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,995	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,995	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)	\$ 2,511,295	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	WIP - Reserves	\$ 18,993	92
93			93
94			94
95		\$ 18,993	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.	<u> </u>	<u>/2021</u>	\$ <u> </u>
13.	<u> </u>	<u>/2022</u>	\$ <u> </u>
14.	<u> </u>	<u>/2023</u>	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,482 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 Rehab HCC # 0051052 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

1	Service	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	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$	4,865	\$ 375,590	\$	4,865	\$ 375,590	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,537	122,502		1,537	122,502	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		5,614	410,906	1,629	5,614	412,535	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescripts				196,122		196,122	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Therapy</u>	V39-03			280	16,264		280	16,264	12
13	Other (specify): <u>See WTB</u>	V39-02,03				91,525	145,366		236,891	13
14	TOTAL			\$	12,296	\$ 1,016,787	\$ 343,117	12,296	\$ 1,359,904	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

0051052

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(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	\$ 507,651	\$ 529,843	1
2	Cash-Patient Deposits	44,947	44,947	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	614,167	614,167	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	155,967	159,700	6
7	Other Prepaid Expenses	478,868	499,828	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	191,889	433,713	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,993,489	\$ 2,282,198	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		5,073,607	14
15	Leasehold Improvements, at Historical Cost	170,979	170,979	15
16	Equipment, at Historical Cost	60,575	1,188,333	16
17	Accumulated Depreciation (book methods)	(98,841)	(2,511,295)	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 (spe WIP & FA ADJ)	(106,949)	(1,184,739)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,764	\$ 3,224,885	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,019,253	\$ 5,507,083	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 727,735	\$ 727,735	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,947	44,947	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,345	247,345	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,769	34,769	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,138	32
33	Accrued Interest Payable		11,284	33
34	Deferred Compensation	909,833	909,833	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Management Fees Payable	21,708	21,708	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,986,337	\$ 2,092,759	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,669,068	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)	\$	\$ 4,669,068	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,986,337	\$ 6,761,827	46
47	TOTAL EQUITY(page 18, line 24)	\$ 32,916	\$ (1,254,744)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,019,253	\$ 5,507,083	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 109,435	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 109,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(76,519)	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)	\$ (76,519)	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)	\$ 32,916	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Crystal Pines Rehab HCC

0051052

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,995,804	1
2	Discounts and Allowances for all Levels	(4,174,807)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,820,997	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,845,853	6
7	Oxygen	12,630	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,858,483	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	(2,674)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	410,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,113	19
20	Radiology and X-Ray	12,935	20
21	Other Medical Services	151,351	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 606,651	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,222	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,222	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,711	28
28a	<u>COVID-19 PHE Funding</u>	190,979	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 192,690	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,484,043	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,142,291	31
32	Health Care	2,671,154	32
33	General Administration	1,555,367	33
B. Capital Expense			
34	Ownership	541,895	34
C. Ancillary Expense			
35	Special Cost Centers	1,476,608	35
36	Provider Participation Fee	173,247	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,560,562	40
41	Income before Income Taxes (line 30 minus line 40)**	(76,519)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (76,519)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,723,540	44
45	Private Pay - Net Inpatient Revenue	378,460	45
46	Medicare - Net Inpatient Revenue	(1,124,179)	46
47	Other-(specify) <u>Managed Care</u>	(354,500)	47
48	Other-(specify) <u>Hospice</u>	197,676	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,820,997	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 Rehab HCC

0051052

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,904	2,080	\$ 93,813	\$ 45.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,623	26,159	872,115	33.34	3
4	Licensed Practical Nurses	10,721	12,015	389,858	32.45	4
5	CNAs & Orderlies	45,005	47,713	879,531	18.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,815	2,036	46,387	22.78	9
10	Activity Assistants	2,507	2,689	30,744	11.43	10
11	Social Service Workers	3,707	4,227	100,422	23.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,684	3,224	65,258	20.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,992	2,080	112,634	54.15	20
21	Assistant Administrator					21
22	Other Administrative	624	624	14,375	23.04	22
23	Office Manager					23
24	Clerical	9,877	10,562	183,930	17.41	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	1,552	1,816	33,694	18.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,557	2,794	75,472	27.01	33
34	TOTAL (lines 1 - 33)	108,568	118,019	\$ 2,898,233 *	\$ 24.56	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	\$ 13,999	V01-3	35
36	Medical Director	Monthly	21,000	V09-5	36
37	Medical Records Consultant	Monthly	1,255	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,195	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	3,732	V11-3	44
45	Social Service Consultant	Monthly	2,340	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,521		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	203	\$ 15,722	V10-3	50
51	Licensed Practical Nurses	210	10,345	V10-3	51
52	Certified Nurse Assistants/Aides	103	2,954	V10-3	52
53	TOTAL (lines 50 - 52)	516	\$ 29,021		53

Facility Name & ID Number Crystal Pines Rehab HCC

0051052

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	
<u>Jim Standish</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 112,634</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 54,286</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	<u>10,562</u>	
				<u>FICA Taxes</u>	<u>224,183</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>102,047</u>	<u>(Indicate # of checks performed <u>14</u>)</u>	<u>150</u>	
				<u>Employee Meals</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>IL Health Care Association</u>	<u>5,848</u>	
				<u>Other Benefits</u>	<u>10,487</u>	<u>Other Licenses</u>	<u>458</u>	
						<u>Other Dues and Subscriptions</u>	<u>2,245</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 112,634			<u>McHenry County Dept Health</u>	<u>300</u>	
(List each licensed administrator separately.)								
B. Administrative - Other						<u>Less: Public Relations Expense</u>	<u>(1,607)</u>	
Description			Amount			<u>Non-allowable advertising</u>	<u>()</u>	
<u>Tutera Health Care Services - Management Fee</u>			<u>\$ 362,473</u>			<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 362,473	TOTAL (agree to Schedule V, line 22, col.8)	\$ 391,003	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,946	
(Attach a copy of any management service agreement)								
C. Professional Services			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
<u>Other Accruals</u>	<u>Legal Services</u>		<u>\$ 18,000</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Daniel Maher Law Offices</u>	<u>Legal Services</u>		<u>200</u>					
<u>Heyl Royster Voelker & Allen</u>	<u>Legal Services</u>		<u>2,208</u>					
<u>CliftonLarsonAllen</u>	<u>Taxes/Cost Reports</u>		<u>12,140</u>				<u>In-State Travel</u>	
<u>Walnut Creek Mgmt Co LLC</u>	<u>Data Processing - Billing</u>		<u>6,035</u>					
<u>Providigm LLC</u>	<u>Data Processing</u>		<u>2,100</u>					
<u>PointClickCare Technologies Inc</u>	<u>Data Processing</u>		<u>32,060</u>					
<u>Walnut Creek Mgmt Co LLC</u>	<u>Data Processing - Other</u>		<u>58,248</u>				<u>Seminar Expense</u>	<u>4,775</u>
<u>Pinnacle Quality Insight</u>	<u>Professional Services</u>		<u>530</u>					
<u>Property Valuation Services</u>	<u>Professional Services</u>		<u>100</u>					
<u>Walnut Creek Mgmt Co LLC</u>	<u>Professional Services</u>		<u>1,430</u>					
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ 133,051	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 4,775
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Crystal Pines Rehab HCC# 0051052

Report Period Beginning:

1/1/2020Ending: 12/31/2020**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 \$5,848
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,112 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. \$ 173,247
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? No Indicate the amount. \$ 0
- (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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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.