		FOR BHF USE					

LL1

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.

I. IDPH License ID Number: 0051318

Facility Name: Pine Crest Health Care

Address: 3300 West 175th St (Number) Hazel Crest (City) 60429 (Zip Code)

County: Cook

Telephone Number: (708)335-2400 **Fax #** (708)335-1825

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2011

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 to 12/31/20 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) 05/13/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 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	199	Skilled (SNF)	199	72,834	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	199	TOTALS	199	72,834	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			2,051	2,051	8
9	SNF/PED					9
10	ICF	50,053	148	9,008	59,209	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,053	148	11,059	61,260	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.11%

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 03/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 199 and days of care provided 2,051

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	427,845	40,453	10,776	479,074		479,074		479,074			1
2	Food Purchase		318,772		318,772		318,772	(8)	318,764			2
3	Housekeeping	459,974	83,765		543,739		543,739	4,715	548,454			3
4	Laundry	113,419	24,609	4,546	142,574		142,574		142,574			4
5	Heat and Other Utilities			205,002	205,002		205,002	(20,175)	184,827			5
6	Maintenance	63,108	3	104,131	167,242		167,242	(12,524)	154,718			6
7	Other (specify):*							2,577	2,577			7
8	TOTAL General Services	1,064,346	467,602	324,455	1,856,403		1,856,403	(25,415)	1,830,988			8
	B. Health Care and Programs											
9	Medical Director			28,000	28,000		28,000		28,000			9
10	Nursing and Medical Records	2,912,395	343,267	181,505	3,437,167		3,437,167	(198,667)	3,238,500			10
10a	Therapy	153,570			153,570		153,570		153,570			10a
11	Activities	161,172	1,825		162,997		162,997		162,997			11
12	Social Services	309,529		4,367	313,896		313,896		313,896			12
13	CNA Training											13
14	Program Transportation			1,586	1,586		1,586		1,586			14
15	Other (specify):*							6,409	6,409			15
16	TOTAL Health Care and Programs	3,536,666	345,092	215,458	4,097,216		4,097,216	(192,258)	3,904,958			16
	C. General Administration											
17	Administrative	147,178		228,233	375,411		375,411	(104,596)	270,815			17
18	Directors Fees											18
19	Professional Services			616,931	616,931	(33,318)	583,613	(457,775)	125,838			19
20	Dues, Fees, Subscriptions & Promotions			66,082	66,082		66,082	(19,584)	46,498			20
21	Clerical & General Office Expenses	170,880		182,007	352,887		352,887	84,633	437,520			21
22	Employee Benefits & Payroll Taxes			731,815	731,815		731,815		731,815			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,432	19,432		19,432	1,062	20,494			24
25	Other Admin. Staff Transportation			508	508		508	5,371	5,879			25
26	Insurance-Prop.Liab.Malpractice			586,156	586,156		586,156	(15,074)	571,082			26
27	Other (specify):*							62,057	62,057			27
28	TOTAL General Administration	318,058		2,431,164	2,749,222	(33,318)	2,715,904	(443,906)	2,271,998			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,919,070	812,694	2,971,077	8,702,841	(33,318)	8,669,523	(661,579)	8,007,944			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 Pine Crest Health Care #0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			108,369	108,369		108,369	(19,473)	88,896			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,080	35,080		35,080	(16,758)	18,322			32
33	Real Estate Taxes			840,000	840,000	33,318	873,318	(92,561)	780,757			33
34	Rent-Facility & Grounds			1,405,433	1,405,433		1,405,433	0	1,405,433			34
35	Rent-Equipment & Vehicles			1,777	1,777		1,777		1,777			35
36	Other (specify):*											36
37	TOTAL Ownership			2,390,659	2,390,659	33,318	2,423,977	(128,792)	2,295,185			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	87,850	53,366	445,051	586,267		586,267		586,267			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			484,202	484,202		484,202	(9,586)	474,616			42
43	Other (specify):*			21,347	21,347		21,347	(21,347)	(0)			43
44	TOTAL Special Cost Centers	87,850	53,366	950,600	1,091,816		1,091,816	(30,933)	1,060,883			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,006,920	866,060	6,312,336	12,185,316		12,185,316	(821,304)	11,364,012			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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(23,219)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,473)	30		9
10	Interest and Other Investment Income	(25,824)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,373)	21		18
19	Entertainment				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	(97,417)	21		24
25	Fund Raising, Advertising and Promotional	(1,443)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(290)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(325,157)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (494,204)		$	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)	(327,101)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (327,101)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (821,305)		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

Pine Crest Health Care

ID# 0051318

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (11,144)	21	1
2	Sequestration Expense	(40,821)	21	2
3	Miscellaneous Income	(15,864)	21	3
4	Drugs - Veterans	(82,338)	10	4
5	Marketing Expense	(947)	43	5
6	Capitalized R&M	(6,550)	06	6
7	PAC Dues	(18,348)	20	7
8	Prior Year Bed Tax	(9,586)	42	8
9	Prior Period Miscellaneous Expense	(1,492)	21	9
10	Prior Period Insurance Expense	(20,000)	26	10
11	Outside Agency RN	(3,234)	10	11
12	Non-Allowable Legal	(10,465)	19	12
13	Real Estate Tax Expense	(104,368)	33	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(325,157)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Pine Crest Health Care

IDH 0051318

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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													1
2	Food Purchase	(8)											(8)	2
3	Housekeeping			4,715									4,715	3
4	Laundry													4
5	Heat and Other Utilities	(23,219)		3,044									(20,175)	5
6	Maintenance	(6,550)		3,452		(9,426)							(12,524)	6
7	Other (specify):*					2,577							2,577	7
8	TOTAL General Services	(29,777)		11,211		(6,849)							(25,415)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(85,572)				(113,095)							(198,667)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,409							6,409	15
16	TOTAL Health Care and Programs	(85,572)				(106,686)							(192,258)	16
	C. General Administration													
17	Administrative			(139,419)		34,823							(104,596)	17
18	Directors Fees													18
19	Professional Services	(10,465)		(451,727)	1,830	2,587							(457,775)	19
20	Fees, Subscriptions & Promotions	(19,791)		126		81							(19,584)	20
21	Clerical & General Office Expenses	(168,401)		199,789		53,245							84,633	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			898		164							1,062	24
25	Other Admin. Staff Transportation					5,371							5,371	25
26	Insurance-Prop.Liab.Malpractice	(20,000)		1,940		2,986							(15,074)	26
27	Other (specify):*			46,823		15,234							62,057	27
28	TOTAL General Administration	(218,657)		(341,571)	1,830	114,491							(443,906)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(334,006)		(330,360)	1,830	956							(661,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(19,473)											(19,473)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,824)		7	2,611		6,449						(16,758)	32
33	Real Estate Taxes	(104,368)			3,005		8,802						(92,561)	33
34	Rent-Facility & Grounds			34,348	(14,878)		(19,470)						0	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(149,665)		34,355	(9,262)		(4,220)						(128,792)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(9,586)											(9,586)	42
43	Other (specify):*	(947)				(20,400)							(21,347)	43
44	**TOTAL Special Cost Centers**	(10,533)				(20,400)							(30,933)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(494,204)		(296,005)	(7,432)	(19,444)	(4,220)						(821,304)	45

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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 [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Atied Associates	40.00%	Center Home Hispanic Elderly	Chicago	Premier HC & Finance	Skokie	Consulting Co.	1
2	EZ&A	0.98%	Park View Rehab Center	Chicago	Premier HC & Real Estate	Skokie	Building Company	2
3	Yaffa Kohen	2.45%	River View Rehab Center	Elgin	iCare Consutling Service	Skokie	Consulting Co.	3
4	Moshe Levovitz	0.98%	Forest City Rehab & Nursing Center	Rockford	8131 Monticello Realty	Skokie	Building Company	4
5	Nachman Levovitz	0.98%	Rock River Health Care	Rockford	iCare Health Services Incorporated	Burlington, VT	Insurance	5
6	Yeruchom Levovitz	14.85%	Prairie Oasis	South Holland				6
7	Jeffrey Sax	2.21%	Oak Park Oasis	Oak Park				7
8	Eli Webster	0.98%	Austin Oasis	Chicago				8
9	Jeffrey Webster	7.67%						9
10	Shimon Webster	16.81%						10
11	Howard Wengrow	9.63%						11
12	Marc Works	2.45%						12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	3	HOUSEKEEPING	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		$ 4,715	$ 4,715	15
16	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,044	3,044	16
17	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,452	3,452	17
18	V	17	ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		88,814	88,814	18
19	V	19	PROFESSIONAL FEES	456,467	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4,740	(451,727)	19
20	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		126	126	20
21	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		11,189	11,189	21
22	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		188,600	188,600	22
23	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		898	898	23
24	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,940	1,940	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		46,823	46,823	25
26	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		7	7	26
27	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		34,348	34,348	27
28	V	17	CONSULTING FEES	228,233	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(228,233)	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			$ 684,700			$ 388,695	$ * (296,005)	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		1,830	1,830	16
17	V	20	LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30	DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32	INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		2,611	2,611	19
20	V	33	REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		3,005	3,005	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	14,878	PREMIER HEALTHCARE REALTY, LLC			(14,878)	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			$ 14,878			$ 7,446	$ * (7,432)	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	6	REPAIRS AND MAINTENANCE	$ 31,200	ICARE CONSULTING SERVICES LLC		$ 21,774	$ (9,426)	15
16	V	7	R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		2,577	2,577	16
17	V	10	NURSING SALARIES	163,500	ICARE CONSULTING SERVICES LLC		50,405	(113,095)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		6,409	6,409	18
19	V	17	ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		34,823	34,823	19
20	V	19	PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		2,587	2,587	20
21	V	20	DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		81	81	21
22	V	21	CLERICAL AND GENERAL	43,600	ICARE CONSULTING SERVICES LLC		3,145	(40,455)	22
23	V	21	CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		93,700	93,700	23
24	V	24	SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		164	164	24
25	V	25	AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		5,371	5,371	25
26	V	26	INSURANCE		ICARE CONSULTING SERVICES LLC		2,986	2,986	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		15,234	15,234	27
28	V	43	MARKETING CONSULTANT	20,400	ICARE CONSULTING SERVICES LLC			(20,400)	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			$ 258,700			$ 239,256	$ * (19,444)	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V	19	PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20	LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30	DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32	INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		6,449	6,449	19
20	V	33	REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		8,802	8,802	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	19,470	8131 MONTICELLO REALTY, LLC			(19,470)	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			$ 19,470			$ 15,250	$ * (4,220)	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 541,335	ICARE HEALTH SERVICES INCORPORATED CELL		$ 541,335	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 541,335			$ 541,335	$ *	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Shimon Webster	Member	Administrative	16.81%	See Attached	6.84	17.10%	Alloc Salary	$ 23,813	17-7	1
2	Yeruchom Levovitz	Member	Administrative	14.85%	See Attached	6.84	17.10%	Alloc Salary	22,248	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 46,061		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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X]

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: PREMIER HEALTHCARE & FIN. SVCS, INC.
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 751-2027

	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	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	$ 27,572	$	61,329	$ 4,715	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798		61,329	3,044	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184		61,329	3,452	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	61,329	88,814	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719		61,329	4,740	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738		61,329	126	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	61,329	11,189	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850		61,329	188,600	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249		61,329	898	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347		61,329	1,940	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803		61,329	46,823	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39		61,329	7	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851		61,329	34,348	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					$ 2,272,926	$ 1,622,196		$ 388,695	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: PREMIER HEALTHCARE REALTY, LLC
Street Address: 8153 LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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						$	$		$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700		61,329	1,830	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			61,329		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			61,329		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267		61,329	2,611	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574		61,329	3,005	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					$ 43,541	$		$ 7,446	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: ICARE CONSULTING SERVICES LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 945-6107

	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	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	$ 145,610	$ 145,409	258,700	$ 21,774	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		258,700	2,577	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	258,700	50,405	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		258,700	6,409	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	258,700	34,823	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		258,700	2,587	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		258,700	81	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		258,700	3,145	8
9	21	CLERICAL & GENERAL WAGE	CONSULTING FEES	1,730,000	8	626,600	626,600	258,700	93,700	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		258,700	164	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		258,700	5,371	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		258,700	2,986	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		258,700	15,234	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					$ 1,599,973	$ 1,341,950		$ 239,256	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 8131 MONTICELLO REALTY, LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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						$	$		$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8			61,329		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			61,329		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			61,329		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708		61,329	6,449	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468		61,329	8,802	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					$ 89,176	$		$ 15,250	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: ICARE HEALTH SERVICES INCORP. CELL
Street Address: 30 MAIN STREET, SUITE 330
City / State / Zip Code: BURLINGTON, VERMONT 05401
Phone Number: ( )
Fax Number: ( )

	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	26	INSURANCE	DIRECT ALLOCATION			$	$		$ 541,335	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 541,335	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X	Line of Credit							35,080	6
7	Allocated From Premier HC		X								7	7
8	See Supplemental Schedule										9,060	8
9	TOTAL Facility Related						$	$			$ 44,147	9
	B. Non-Facility Related*											
10	Interest Income										(25,824)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,824)	14
15	TOTALS (line 9+line14)						$	$			$ 18,323	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* 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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	747,439	2
3. Under or (over) accrual (line 2 minus line 1).	$	747,439	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	33,318	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 $ 50,417 For 2017 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.	$	780,757	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	607,446	8
2016	634,096	9
2017	734,769	10
2018	786,455	11
2019	735,632	12

Facility is not owned, thus no real estate tax is accrued
Allocated from Premier Realty - $3,005
Allocated from Monticello Realty - $8,802

	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 Pine Crest Health Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051318

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-26-402-004-0000	Long Term Care Property	$ 735,632.45	$ 735,632.45
2.	10-23-324-045-0000	Allocated from Monticello Realty	$ 51,467.63	$ 8,801.53
3.	10-23-324-047-0000	Allocated from Premier Healthcare	$ 34,381.62	$ 5,879.64
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 821,481.70	$ 750,313.62

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pine Crest Health Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051318

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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 [X] (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	Allocated Premiere Healthcare Realty, LLC		2011	$ 3,249	1
2	Allocated from 8131 N. Monticello		2019	8,251	2
3	TOTALS			$ 11,500	3

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	212,147		20	10,609	10,609	156,435	9
10	Various			2012	222,434		20	6,881	6,881	144,426	10
11	Various			2013	317,426		20	11,058	11,058	188,742	11
12	Various			2014	124,950		20	6,248	6,248	38,606	12
13	Various			2015	50,848		20	2,445	2,445	16,390	13
14	Various			2016	133,450		20	6,673	6,673	31,315	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		333,450			12,128	12,128	75,389	68
69	Financial Statement Depreciation			108,369			(108,369)		69
70	TOTAL (lines 4 thru 69)		$ 1,394,705	$ 108,369		$ 56,042	$ (52,327)	$ 651,303	70

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,394,705	$ 108,369		$ 56,042	$ (52,327)	$ 651,303	1
2	1 4-Ton Rtu - Laundry Area With New Condensate Connections	2017	6,250		20	313	313	1,094	2
3	2 Hot Water Tanks-Mechanic Room With Piping & Ducts	2018	13,913		20	696	696	1,682	3
4	Replacement Of Copper Supply Line & Valve Circulating Pump	2018	2,900		20	145	145	435	4
5	Rodding & Replacement Of Iron Piping & Dreains In Kitchen	2018	8,535		20	427	427	1,281	5
6	Anunciator Replacements	2019	5,166		20	258	258	366	6
7	Installed New Cylinders On Elevators 1 & 2	2019	63,600		20	3,180	3,180	4,469	7
8	Rtu 7-1/2 Ton Rtu Compressor 2400 Wing	2019	4,250		20	213	213	302	8
9	Installed New Oem Direct Replacement Heat Exchanger	2019	2,937		20	147	147	282	9
10	Commercial Water Heater Replacement - A.O Smith Btr-199	2019	7,370		20	369	369	707	10
11	Repaired Rodding/Camera Service/Mainline From Basin	2019	4,015		20	201	201	402	11
12	Sewer Repairs	2019	3,842		20	192	192	192	12
13	Replace Kitchen Exf Fan On Roof	2020	5,963		20	298	298	298	13
14	Install Heating And Cooling 7.5 Ton Rooftop Unit - 2300Wing	2020	10,675		20	534	534	534	14
15	Install Heating And Cooling 7.5 Ton Rooftop Unit - 2400 Carrier	2020	10,675		20	534	534	534	15
16	Laundry/Kitchen Plumbing - Repair Damaged Pipes And Valves	2020	5,929		20	593	593	593	16
17	Plumbing Work - Pipe Repairs In Medical Room	2020	23,233		20	1,162	1,162	1,162	17
18	Rooftop Unit 2200Wing - Replace Heat Exchanger	2020	2,825		20	141	141	141	18
19	2300 Wing Roof Fan Repair - New Belt Drive	2020	3,725		20	186	186	186	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,580,507	$ 108,369		$ 65,631	$ (42,738)	$ 665,962	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	63,686		20	1,820	1,820	16,526	3
4	Allocated Premiere Healthcare Realty, LLC	2012	8,108		20	232	232	2,085	4
5	Allocated from 8131 N. Monticello	2019	140,272		20	4,008	4,008	8,016	5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Premier HC & Financial Services	2012	1,445		20	72	72	651	10
11	Allocated from Premier HC & Financial Services	2016	3,386		20	169	169	847	11
12									12
13	Allocated Premiere Healthcare Realty, LLC	2011	113,269		20	5,663	5,663	45,787	13
14	Allocated Premiere Healthcare Realty, LLC	2012	3,283		20	164	164	1,478	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 333,450	$		$ 12,128	$ 12,128	$ 75,389	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 333,450	$		$ 12,128	$ 12,128	$ 75,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 333,450	$		$ 12,128	$ 12,128	$ 75,389	34

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 200,837	$	$ 20,083	$ 20,083	10	$ 149,141	71
72	Current Year Purchases	31,815		3,182	3,182	10	3,182	72
73	Fully Depreciated Assets	113,553				10	113,553	73
74								74
75	TOTALS	$ 346,205	$	$ 23,265	$ 23,265		$ 265,876	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		McCormick Auto - transportatio	2012	$ 9,504	$	$	$	5	$ 9,504	76
77										77
78										78
79										79
80	TOTALS			$ 9,504	$	$	$		$ 9,504	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)	$ 1,947,717	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,369	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,896	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,473)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 941,342	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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Imperial Real Estate LLC

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:		199		$ 1,405,433			3
4	Additions							4
5	Allocated From Premier HC & Financial							5
6								6
7	TOTAL		199		$ 1,405,433 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 1,777 Description: See Attached
(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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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	39 - 03	hrs	$		$ 188,719	$		$ 188,719	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,287			56,287	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			189,175			189,175	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				21,587		21,587	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			87,850		10,870	31,779		130,499	13
14	TOTAL			$ 87,850		$ 445,051	$ 53,366		$ 586,267	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 Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 2,380,398	$	1
2	Cash-Patient Deposits	7,588		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	893,951		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	715,034		6
7	Other Prepaid Expenses	19,066		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,657		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,017,694	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,140,770		15
16	Equipment, at Historical Cost	347,905		16
17	Accumulated Depreciation (book methods)	(1,071,484)		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): See Attached	1,065,661		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,482,852	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,500,546	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 590,333	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,688		30
31	Accrued Taxes Payable (excluding real estate taxes)	269,188		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,060,019		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,155,228	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,155,228	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,345,318	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,500,546	$	48

*(See instructions.)

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,868,225	1
2	Restatements (describe):		2
3	Bad Debt Expense	56,263	3
4	Sequestration Expense	(1,550)	4
5	Rounding	(2)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,922,936	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,422,382	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)**	$ 1,422,382	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)**	$ 3,345,318	24 *

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 11,030,120	1
2	Discounts and Allowances for all Levels	21,233	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,051,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,593	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 279,593	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,824	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,824	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,250,928	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,250,928	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,607,698	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,856,403	31
32	Health Care	4,097,216	32
33	General Administration	2,749,222	33
	B. Capital Expense		
34	Ownership	2,390,659	34
	C. Ancillary Expense		
35	Special Cost Centers	607,614	35
36	Provider Participation Fee	484,202	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,185,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,422,382	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,422,382	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,038,076	44
45	Private Pay - Net Inpatient Revenue	20,293	45
46	Medicare - Net Inpatient Revenue	1,188,159	46
47	Other-(specify) Insurance	46,021	47
48	Other-(specify) Veterans & Hospice	1,758,804	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,051,353	49

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

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

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

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,230	1,324	$ 67,854	$ 51.25	1
2	Assistant Director of Nursing	1,522	1,639	67,819	41.38	2
3	Registered Nurses	22,645	25,946	817,501	31.51	3
4	Licensed Practical Nurses	27,624	29,752	862,387	28.99	4
5	CNAs & Orderlies	69,821	75,201	1,063,367	14.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,934	8,546	153,570	17.97	8
9	Activity Director	1,765	1,901	32,906	17.31	9
10	Activity Assistants	9,477	10,207	128,266	12.57	10
11	Social Service Workers	11,322	12,195	309,529	25.38	11
12	Dietician					12
13	Food Service Supervisor	2,006	2,161	45,584	21.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,625	28,677	382,261	13.33	15
16	Dishwashers					16
17	Maintenance Workers	3,070	3,307	63,108	19.08	17
18	Housekeepers	33,130	35,683	459,974	12.89	18
19	Laundry	8,007	8,624	113,419	13.15	19
20	Administrator	2,608	2,809	147,178	52.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,040	10,814	170,880	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,957	2,108	33,467	15.88	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	6,462	6,960	87,850	12.62	33
34	TOTAL (lines 1 - 33)	247,245	267,854	$ 5,006,920 *	$ 18.69	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	230	$ 10,776	01-03	35
36	Medical Director	Monthly	28,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	166,500	10-03	38
39	Pharmacist Consultant	Monthly	13,405	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	72	4,367	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	$ 224,648		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lucille Hoffman	Administrator	0	$ 35,701
Ava Mitchell	Administrator	0	19,012
David Zaruba	Administrator	0	92,465
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,178

B. Administrative - Other

Description	Amount
Consulting Fees- Premier HC & Financial Services	$ 228,233
TOTAL (agree to Schedule V, line 17, col. 3)	$ 228,233
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 15,900
Premier HC & Financial Services	Bookkeeping	456,467
Point Click Care	Data Processing	39,622
Reliable Health Care	Data Processing	17,010
Creative Technologies	IT Support	18,589
EON Applications	Computer Services	978
Ability Network	Medicare Billing	1,917
OnShift	HR Consulting	13,824
Zirmed	Data Processing	640
Galaxy Software	Data Processing	1,200
See Attached	Legal	11,552
See Supplemental Schedule		39,233
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 616,932

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,585
Unemployment Compensation Insurance	32,420
FICA Taxes	383,029
Employee Health Insurance	173,556
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	41,433
Other Employee Expense	7,018
Holiday Expense	2,774
TOTAL (agree to Schedule V, line 22, col.8)	$ 731,815

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,430
Advertising: Employee Recruitment	19,258
Health Care Worker Background Check	
(Indicate # of checks performed 261)	
Patient Background Checks	2,609
Dues IL Council	18,348
Licenses & Fees	4,646
See Supplemental Schedule	207
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,498

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	19,432
See Supplemental Schedule	1,062
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,494

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $36,696**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,568** 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. $ **474,616**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
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? **Yes**
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 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.