FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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, LLC

Address: 3300 West 175th Street (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: Joshua S. Banach **Telephone Number:** (773) 945-9528
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 01/01/2018 to 12/31/2018 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) Joshua S. Banach, CPA
(Title) Asst. Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	72,635	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	72,635	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	53,241	407	8,391	62,039	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,241	407	8,391	62,039	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.41%

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 1,777

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	324,023	32,808	13,083	369,914		369,914		369,914			1
2	Food Purchase		307,456		307,456		307,456	(3,519)	303,937			2
3	Housekeeping	266,347	29,692		296,039		296,039	4,149	300,188			3
4	Laundry	100,232	17,603		117,835		117,835		117,835			4
5	Heat and Other Utilities			241,294	241,294		241,294	(18,741)	222,553			5
6	Maintenance	72,636		114,884	187,520		187,520	(21,166)	166,354			6
7	Other (specify):*											7
8	TOTAL General Services	763,238	387,559	369,261	1,520,058		1,520,058	(39,277)	1,480,781			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,562,137	135,388	176,870	2,874,395		2,874,395	(214,703)	2,659,692			10
10a	Therapy	84,249	13,219		97,468		97,468		97,468			10a
11	Activities	155,526	6,000		161,526		161,526		161,526			11
12	Social Services	283,854		2,082	285,936		285,936		285,936			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,586	5,586			15
16	TOTAL Health Care and Programs	3,085,766	154,607	208,952	3,449,325		3,449,325	(209,117)	3,240,208			16
	C. General Administration											
17	Administrative	110,697		617,000	727,697		727,697	(504,266)	223,431			17
18	Directors Fees											18
19	Professional Services			114,470	114,470		114,470	2,442	116,912			19
20	Dues, Fees, Subscriptions & Promotions			80,207	80,207		80,207	(18,888)	61,319			20
21	Clerical & General Office Expenses	136,124		126,760	262,884		262,884	97,596	360,480			21
22	Employee Benefits & Payroll Taxes			643,699	643,699		643,699		643,699			22
23	Inservice Training & Education											23
24	Travel and Seminar			699	699		699	1,565	2,264			24
25	Other Admin. Staff Transportation			2,879	2,879		2,879	6,282	9,161			25
26	Insurance-Prop.Liab.Malpractice			557,686	557,686		557,686	2,611	560,297			26
27	Other (specify):*							50,707	50,707			27
28	TOTAL General Administration	246,821		2,143,400	2,390,221		2,390,221	(361,951)	2,028,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,095,825	542,166	2,721,613	7,359,604		7,359,604	(610,345)	6,749,259			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.

Pine Crest Healthcare
Travel Detail
12/31/2018

Account Number	Date	Employee	Function	Description	
8600.6	12/31/2018	Janessa Drayton	Admissions	Mileage around Chicago South Suburbs	2,818.72
8600.6	12/31/2018	Various A&G Employees	A&G	Mileage for Facility Errands	60.00
	12/31/2018	Allocated From iCare Consulting			6,282.00
		Total			9,160.72

Facility Name & ID Number Pine Crest Health Care, LLC #0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			3,600	3,600		3,600	88,153	91,753			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,931	2,931		2,931	(2,931)				32
33	Real Estate Taxes			636,250	636,250		636,250	5,805	642,055			33
34	Rent-Facility & Grounds			1,293,743	1,293,743		1,293,743	22,495	1,316,238			34
35	Rent-Equipment & Vehicles			4,875	4,875		4,875		4,875			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,941,399	1,941,399		1,941,399	113,522	2,054,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,919	538,145	633,064		633,064		633,064			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			468,812	468,812		468,812		468,812			42
43	Other (specify):*			27,778	27,778		27,778	(27,778)				43
44	**TOTAL Special Cost Centers**		94,919	1,034,735	1,129,654		1,129,654	(27,778)	1,101,876			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,095,825	637,085	5,697,747	10,430,657		10,430,657	(524,601)	9,906,056			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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,376)	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	88,153	30		9
10	Interest and Other Investment Income	(5,551)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(1,516)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,331)	21		24
25	Fund Raising, Advertising and Promotional	(2,759)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,699)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(164,138)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (178,737)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (178,737)		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, LLC

ID# 0051318

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (16,739)	21	1
2	Vending Income	(6,360)	02	2
3	Marketing	(378)	43	3
4	Bank Charges	(7,843)	21	4
5	Veterans Pharmacy	(97,397)	10	5
6	PAC Dues	(16,109)	20	6
7	Medical Record Income	(143)	10	7
8	Capitalized R&M	(11,435)	06	8
9	Miscellaneous Income	(4,237)	21	9
10	Non-Allowable Legal	(3,497)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(164,138)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,380)	0	2,104	0	757	0	0	0	0	0	0	(3,519)	2
3	Housekeeping	0	0	4,149	0	0	0	0	0	0	0	0	4,149	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(21,376)	0	2,635	0	0	0	0	0	0	0	0	(18,741)	5
6	Maintenance	(11,435)	0	3,892	0	(13,623)	0	0	0	0	0	0	(21,166)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(39,191)	0	12,780	0	(12,866)	0	0	0	0	0	0	(39,277)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(97,540)	0	0	0	(117,163)	0	0	0	0	0	0	(214,703)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	5,586	0	0	0	0	0	0	5,586	15
16	**TOTAL Health Care and Programs**	(97,540)	0	0	0	(111,577)	0	0	0	0	0	0	(209,117)	16
	C. General Administration													
17	Administrative	0	0	(529,922)	0	25,656	0	0	0	0	0	0	(504,266)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,497)	0	1,621	145	4,173	0	0	0	0	0	0	2,442	19
20	Fees, Subscriptions & Promotions	(19,368)	0	414	11	55	0	0	0	0	0	0	(18,888)	20
21	Clerical & General Office Expenses	(101,365)	0	146,934	0	52,027	0	0	0	0	0	0	97,596	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	920	0	645	0	0	0	0	0	0	1,565	24
25	Other Admin. Staff Transportation	0	0	0	0	6,282	0	0	0	0	0	0	6,282	25
26	Insurance-Prop.Liab.Malpractice	0	0	780	0	1,831	0	0	0	0	0	0	2,611	26
27	Other (specify):*	0	0	35,443	0	15,264	0	0	0	0	0	0	50,707	27
28	**TOTAL General Administration**	(124,230)	0	(343,810)	156	105,933	0	0	0	0	0	0	(361,951)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,961)	0	(331,030)	156	(18,510)	0	0	0	0	0	0	(610,345)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	88,153	0	0	0	0	0	0	0	0	0	0	88,153	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,551)	0	0	2,620	0	0	0	0	0	0	0	(2,931)	32
33	Real Estate Taxes	0	0	0	5,805	0	0	0	0	0	0	0	5,805	33
34	Rent-Facility & Grounds	0	0	32,944	(10,449)	0	0	0	0	0	0	0	22,495	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	82,602	0	32,944	(2,024)	0	0	0	0	0	0	0	113,522	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(378)	0	0	0	(27,400)	0	0	0	0	0	0	(27,778)	43
44	**TOTAL Special Cost Centers**	(378)	0	0	0	(27,400)	0	0	0	0	0	0	(27,778)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(178,737)	0	(298,086)	(1,868)	(45,910)	0	0	0	0	0	0	(524,601)	45

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 & Financ	Skokie	Consulting Co.	1
2	EZ&A	0.980%	Park View Rehab Center	Chicago	Premier HC Real Esta	Skokie	Building Co.	2
3	Yaffa Kohen	2.451%	River View Rehab Center	Elgin	iCare Consutling Servi	Skokie	Consulting Co.	3
4	Moshe Levovitz	0.980%	Forest City Rehab & Nursing Center	Rockford				4
5	Nachman Levovitz	0.980%	Rock River Health Care	Rockford				5
6	Yeruchom Levovitz	14.853%	Pearl Pavilion	Freeport				6
7	Jeffrey Sax	2.206%	Prairie Oasis	South Holland				7
8	Eli Webster	0.980%	Oak Park Oasis	Oak Park				8
9	Jeffrey Webster	7.672%	Austin Oasis	Chicago				9
10	Shimon Webster	16.814%						10
11	Howard Wengrow	9.632%						11
12	Marc Works	2.451%						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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	Premier Healthcare & Financial Services	100.00%	$ 2,104	$ 2,104	15
16	V	03	Housekeeping		Premier Healthcare & Financial Services	100.00%	4,149	4,149	16
17	V	05	Utilities		Premier Healthcare & Financial Services	100.00%	2,635	2,635	17
18	V	06	Repairs & Maintenance		Premier Healthcare & Financial Services	100.00%	3,892	3,892	18
19	V	17	Administrative Expenses		Premier Healthcare & Financial Services	100.00%	87,078	87,078	19
20	V	19	Professional Fees		Premier Healthcare & Financial Services	100.00%	1,621	1,621	20
21	V	20	Dues & Subscriptions		Premier Healthcare & Financial Services	100.00%	414	414	21
22	V	21	Clerical & General Salaries		Premier Healthcare & Financial Services	100.00%	139,054	139,054	22
23	V	21	Clerical & General Other Costs		Premier Healthcare & Financial Services	100.00%	7,880	7,880	23
24	V	24	Seminar & Education		Premier Healthcare & Financial Services	100.00%	920	920	24
25	V	26	Insurance		Premier Healthcare & Financial Services	100.00%	780	780	25
26	V	27	Employee Benefits		Premier Healthcare & Financial Services	100.00%	35,443	35,443	26
27	V	34	Rent Expense		Premier Healthcare & Financial Services	100.00%	32,944	32,944	27
28	V	17	Consulting Fees	617,000	Premier Healthcare & Financial Services	100.00%		(617,000)	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			$ 617,000			$ 318,914	$ * (298,086)	39

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	19	Professional Fees	$	Premier HC Real Estate	100.00%	$ 145	$ 145	15
16	V	20	Dues & Subscriptions		Premier HC Real Estate	100.00%	11	11	16
17	V	32	Interest Expense		Premier HC Real Estate	100.00%	2,620	2,620	17
18	V	33	Real Estate Taxes		Premier HC Real Estate	100.00%	5,805	5,805	18
19	V	34	Rental Income	10,449	Premier HC Real Estate	100.00%		(10,449)	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			$ 10,449			$ 8,581	$ * (1,868)	39

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	iCare Consulting Services LLC	100.00%	$ 757	$ 757	15
16	V	06	Maint & Plant Operation Salary	28,800	iCare Consulting Services LLC	100.00%	15,177	(13,623)	16
17	V	10	Nursing Salary	161,600	iCare Consulting Services LLC	100.00%	44,437	(117,163)	17
18	V	15	Nursing Benefits/Taxes		iCare Consulting Services LLC	100.00%	5,586	5,586	18
19	V	17	Admin Salary- Non Related		iCare Consulting Services LLC	100.00%	25,656	25,656	19
20	V	19	Professional Fees		iCare Consulting Services LLC	100.00%	4,173	4,173	20
21	V	20	Dues & Subscriptions		iCare Consulting Services LLC	100.00%	55	55	21
22	V	21	A&G Expenses	31,600	iCare Consulting Services LLC	100.00%	3,023	(28,577)	22
23	V	21	A&G Salaries		iCare Consulting Services LLC	100.00%	80,604	80,604	23
24	V	24	Seminars & Education		iCare Consulting Services LLC	100.00%	645	645	24
25	V	25	Auto & Travel		iCare Consulting Services LLC	100.00%	6,282	6,282	25
26	V	26	Insurance		iCare Consulting Services LLC	100.00%	1,831	1,831	26
27	V	27	Employee Benefits/PR Taxes		iCare Consulting Services LLC	100.00%	15,264	15,264	27
28	V	43	Marketing Consultant	27,400	iCare Consulting Services LLC	100.00%		(27,400)	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			$ 249,400			$ 203,490	$ * (45,910)	39

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	5.81	14.51%	Alloc Salary	$ 29,026	17-7	1
2	Yeruchom Levovitz	Member	Administrative	14.85%	See Attached	5.81	14.51%	Alloc Salary	29,026	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,052		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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 & Financial Services
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	02	Food	Resident Days	427,478	10	$ 14,500	$	62,039	$ 2,104	1
2	03	Housekeeping	Resident Days	427,478	10	28,586		62,039	4,149	2
3	05	Utilities	Resident Days	427,478	10	18,155		62,039	2,635	3
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817		62,039	3,892	4
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	62,039	87,077	5
6	19	Professional Fees	Resident Days	427,478	10	11,167		62,039	1,621	6
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851		62,039	414	7
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	62,039	139,054	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299		62,039	7,880	9
10	24	Seminar & Education	Resident Days	427,478	10	6,339		62,039	920	10
11	26	Insurance	Resident Days	427,478	10	5,376		62,039	780	11
12	27	Employee Benefits	Resident Days	427,478	10	244,216		62,039	35,443	12
13	34	Rent Expense	Resident Days	427,478	10	227,000		62,039	32,944	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					$ 2,197,453	$ 1,558,147		$ 318,913	25

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 HC Real Estate
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	19	Professional Fees	Resident Days	427,478	10	$ 1,000	$	62,039	$ 145	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75		62,039	11	2
3	32	Interest Expense	Resident Days	427,478	10	18,053		62,039	2,620	3
4	33	Real Estate Taxes	Resident Days	427,478	10	40,000		62,039	5,805	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					$ 59,128	$		$ 8,581	25

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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
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	02	Food	Resident Days	313,091	7	$ 3,818	$	62,039	$ 757	1
2	06	Maint & Plant Operation Salary	Resident Days	313,091	7	76,592	76,576	62,039	15,177	2
3	10	Nursing Salary	Resident Days	313,091	7	224,262	224,262	62,039	44,437	3
4	15	Nursing Benefits/Taxes	Resident Days	313,091	7	28,189		62,039	5,586	4
5	17	Admin Salary- Non Related	Resident Days	313,091	7	129,477	129,477	62,039	25,656	5
6	19	Professional Fees	Resident Days	313,091	7	21,060		62,039	4,173	6
7	20	Dues & Subscriptions	Resident Days	313,091	7	280		62,039	55	7
8	21	A&G Expenses	Resident Days	313,091	7	15,257		62,039	3,023	8
9	21	A&G Salaries	Resident Days	313,091	7	406,781	406,781	62,039	80,604	9
10	24	Seminars & Education	Resident Days	313,091	7	3,253		62,039	645	10
11	25	Auto & Travel	Resident Days	313,091	7	31,703		62,039	6,282	11
12	26	Insurance	Resident Days	313,091	7	9,242		62,039	1,831	12
13	27	Employee Benefits/PR Taxes	Resident Days	313,091	7	77,031		62,039	15,264	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					$ 1,026,943	$ 837,096		$ 203,490	25

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	MB Financial		X	Line of Credit		4/20/2011		55,000		0.0450	2,931	6
7	Allocated From Premier RE		X								2,620	7
8												8
9	TOTAL Facility Related						$	$ 55,000			$ 5,551	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,551)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,551)	14
15	TOTALS (line 9+line14)						$	$ 55,000			$	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, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	641,805	2
3. Under or (over) accrual (line 2 minus line 1).	$	641,805	3
4. Real Estate Tax accrual used for 2018 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.)**	$	250	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	642,055	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	455,257	8
	2014	592,503	9
	2015	607,446	10
	2016	634,096	11
	2017	734,769	12

Facility is not owned, thus no real estate tax is accrued
Allocated From Premier Realty $5,805

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pine Crest Health Care, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051318

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (773) 945-9528 FAX #: (773) 945-9521

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 734,769.04	$ 734,769.04
2.	10-23-324-047-0000	Home Office Allocation	$ 36,245.26	$ 5,260.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 771,014.30	$ 740,029.24

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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 [ ] (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 From Premier RE			$ 2,757	1
2					2
3	TOTALS			$ 2,757	3

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	10,607	10,607	121,296	9
10	Various			2012	222,434		20	11,122	11,122	134,780	10
11	Various			2013	317,426		20	15,871	15,871	156,360	11
12	Various			2014	124,950		20	6,248	6,248	29,051	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Pine Crest Heathcare
12/31/2018
Capital Report Reconciliation

During 2018, the 6/30/2017 capital report was finalized.

The following 2017 improvements were included on the final 6/30/2017 capital report

Page	Line	Description	Cost	
		(None)		
		Total	$	-

The following 2017 improvements were added between 7/1/17-12/31/17

Page	Line	Description	Cost	
12B	15	1 4 Ton RTU- Laundry Area wit New Condensate Connections	$	6,250
		Total	$	6,250
		Total 2017 Improvements	$	6,250

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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
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52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 876,957	$		$ 43,848	$ 43,848	$ 441,487	70

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 876,957	$		$ 43,848	$ 43,848	$ 441,487	1
2	Elevator Door Modernization	2015	17,000		20	850	850	3,400	2
3	DVR and Camera	2015	2,911		20	146	146	1,844	3
4	Laundry Room Roof Replacement & Entire Roof Coating	2015	30,937		20	1,547	1,547	5,285	4
5	Control System - Elevator #1	2016	12,463		20	623	623	1,714	5
6	Control System - Elevator #1	2016	24,924		20	1,246	1,246	3,115	6
7	Control System - Elevator #2	2016	53,442		20	2,672	2,672	7,126	7
8	Control System - Elevator #2	2016	3,875		20	194	194	452	8
9	Asphalt Work	2016	13,954		20	698	698	1,861	9
10	Fire Alarm System	2016	8,972		20	449	449	1,010	10
11	Water Heater	2016	6,545		20	327	327	982	11
12	Replace DGC- Remote Annunciator	2016	2,606		20	130	130	369	12
13	Install 2 Exhaust Fans	2016	3,850		20	193	193	466	13
14	Replace Exf Motors For Heating/Cooling System	2016	2,819		20	141	141	411	14
15	1 4 Ton RTU- Laundry Area wit New Condensate Connections	2017	6,250		20	313	313	469	15
16	Rodding & Replacement of Iron Piping and Drains in Kitchen	2018	8,535		20	427	427	427	16
17	Replacement of Copper Supply Line & Valve- Ciculating Pump	2018	2,900		20	145	145	145	17
18	2 Hot Water Tanks- Mechanic Room with Piping and Ducts	2018	13,913		20	696	696	696	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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	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
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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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	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
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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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	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
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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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	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
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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)		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,092,853	$		$ 54,643	$ 54,643	$ 471,257	1
2	Buildings								2
3	Allocated From Premier Realty	2011	54,047		35	1,544	1,544	12,354	3
4	Allocated From Premier Realty	2012	6,881		35	197	197	1,376	4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10	Allocated From Premier HC & Financal Services	2012	1,226		20	61	61	429	10
11	Allocated From Premier HC & Financal Services	2016	2,874		20	144	144	431	11
12									12
13	Allocated From Premier Realty	2011	96,125		20	4,806	4,806	38,450	13
14	Allocated From Premier Realty	2012	2,786		20	139	139	975	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)		$ 1,256,792	$		$ 61,534	$ 61,534	$ 525,272	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,256,792	$		$ 61,534	$ 61,534	$ 525,272	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
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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)		$ 1,256,792	$		$ 61,534	$ 61,534	$ 525,272	34

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 254,619	$	$ 25,461	$ 25,461		$ 174,444	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	32,923					32,923	73
74								74
75	TOTALS	$ 287,542	$	$ 25,461	$ 25,461		$ 207,367	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	Facility	McCormick Auto- Trans	2012	$ 9,504	$	$ 1,158	$ 1,158	5	$ 8,491	76
77										77
78										78
79										79
80	TOTALS			$ 9,504	$	$ 1,158	$ 1,158		$ 8,491	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)	$ 1,556,595	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,153	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 88,153	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 741,130	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.

Pine Crest Healthcare
12/31/2018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pine Crest Healthcare	212,203	-	21,220	21,220	144,994
Premier Healthcare & Financial	10,673	-	1,067	1,067	7,002
Premier Real Estate	31,743	-	3,174	3,174	22,448
				-	
Total	254,619	-	25,461	25,461	174,444

Current Year Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pine Crest Healthcare					
Premier Healthcare & Financial					
Premier Real Estate					
Total	-	-	-	-	-

Fully Depreciated Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pine Crest Healthcare	32,923				32,923
Premier Healthcare & Financial					
Premier Real Estate					
Total	32,923	-	-	-	32,923

Total Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pine Crest Healthcare	245,126	-	21,220	21,220	177,917
Premier Healthcare & Financial	10,673	-	1,067	1,067	7,002
Premier Real Estate	31,743	-	3,174	3,174	22,448
	-	-	-	-	-
Total	287,542	-	25,461	25,461	207,367

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,293,743			3
4	Additions							4
5								5
6	Allocated From Premier HC & Financial				22,495			6
7	TOTAL		199		$ 1,316,238 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 4,876 Description: ____
(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	**Pine Crest Health Care**
FACILITY NUMBER	**0051318**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

DESCRIPTION	AMOUNT
COPIER	3,098
DISHMACHINE	1,777
TOTAL	4,876

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		hrs	$		$ 221,212	$		$ 221,212	1
2	Licensed Speech and Language Development Therapist		hrs			65,978			65,978	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			221,746			221,746	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				25,093		25,093	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					29,210	69,826		99,036	13
14	TOTAL			$		$ 538,145	$ 94,919		$ 633,064	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	**Pine Crest Health Care, LLC**
FACILITY NUMBER	**0051318**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING SPECIAL SERVICES

SUPPLIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 6)

DESCRIPTION	AMOUNT
OXGEN SUPPLY	2,503
NRS SUPLY N-CHRGE	61,904
GLOVES	5,418
	-
	-
	-
	-
	-
	-
	-
	69,826

OTHER- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 5)

DESCRIPTION	AMOUNT
G TUBE	20,151
X-RAYS	1,216
LABORATORY	7,843
	-
	-
	-
	-
	-
	-
	-
	29,210

SALARIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 3)

DESCRIPTION	AMOUNT
	-
	-
	-
	-
	-
	-
	-
	-

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 30,677	$	1
2	Cash-Patient Deposits	1,542		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,427,620		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,485		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	17,591		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,524,915	$	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	1,003,422		15
16	Equipment, at Historical Cost	303,529		16
17	Accumulated Depreciation (book methods)	(744,857)		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	1,046,797		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,608,890	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,133,805	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 446,394	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	55,000		29
30	Accrued Salaries Payable	366,750		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,633		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	30,530		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 919,308	$	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	See Attached	2,660		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,660	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 921,968	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,211,837	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,133,805	$	48

***(See instructions.)**

FACILITY NAME	**Pine Crest Health Care, LLC**
FACILITY NUMBER	**0051318**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM COST REPOR	15,427	
DUE TO MEDICAID	2,165	
	17,591	

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM PRIOR OWNEF	315	
ACCRUED BED TAX	29,939	
DUE TO PRIOR OWNER	277	
	30,530	

OTHER NON-CURRENT ASSETS (PAGE 17, LINE 23)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
ORGANIZATION COST	8,300	
A/A ORG COSTS	(6,503)	
SECURITY DEPOSITS	1,020,000	
DUE FROM OTHERS	25,000	
	1,046,797	

OTHER NON-CURRENT LIABILITIES (PAGE 17, LINE 43)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO AFFILIATE	2,660	
	2,660	

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,477,269	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt/Journal Entries**	(59,159)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,418,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,727	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	(306,000)	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)**	$ (206,273)	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)**	$ 3,211,837	24 *

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 10,366,379	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,366,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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***	12,406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,406	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	151,600	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 151,600	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,530,384	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,520,058	31
32	Health Care	3,449,325	32
33	General Administration	2,390,221	33
	B. Capital Expense		
34	Ownership	1,941,399	34
	C. Ancillary Expense		
35	Special Cost Centers	660,842	35
36	Provider Participation Fee	468,812	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,430,657	40
41	**Income before Income Taxes (line 30 minus line 40)****	99,727	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 99,727	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,043,299	44
45	Private Pay - Net Inpatient Revenue	110,016	45
46	Medicare - Net Inpatient Revenue	1,041,778	46
47	Other-(specify) Hospice	90,979	47
48	Other-(specify) Veterans	1,080,307	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,366,379	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	**Pine Crest Health Care, LLC**
FACILITY NUMBER	**0051318**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

DESCRIPTION	AMOUNT
MEDICAID W/O CO-INSURANCE	140,860
VENDING INCOME (ADJ PG 5A)	6,360
MISC INC (ADJ PG 5A)	4,237
MEDICAL RECORD INCOME(ADJ PG 5A)	143
Total	151,600

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	1,896	1,952	$ 94,370	$ 48.35	1
2	Assistant Director of Nursing	1,848	1,976	79,401	40.18	2
3	Registered Nurses	16,574	18,355	570,846	31.10	3
4	Licensed Practical Nurses	29,567	32,589	930,455	28.55	4
5	CNAs & Orderlies	58,890	64,814	847,141	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,108	5,908	84,249	14.26	8
9	Activity Director	1,844	2,080	47,304	22.74	9
10	Activity Assistants	8,455	9,403	108,222	11.51	10
11	Social Service Workers	13,327	14,275	283,854	19.88	11
12	Dietician					12
13	Food Service Supervisor	3,150	3,375	64,213	19.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,582	21,877	259,810	11.88	15
16	Dishwashers					16
17	Maintenance Workers	3,801	4,096	72,636	17.73	17
18	Housekeepers	19,994	22,320	266,347	11.93	18
19	Laundry	7,319	8,264	100,232	12.13	19
20	Administrator	1,944	2,080	110,697	53.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,260	6,773	136,124	20.10	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	2,424	2,600	39,923	15.36	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached					33
34	TOTAL (lines 1 - 33)	201,983	222,737	$ 4,095,823 *	$ 18.39	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	278	$ 13,083	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	161,600	10-03	38
39	Pharmacist Consultant	Monthly	13,670	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant			11-03	44
45	Social Service Consultant	34	2,082	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	312	$ 222,035		49

C. CONTRACT NURSES

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

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Zina Ward	Administrator	0.00%	$ 110,697
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,697

B. Administrative - Other

Description	Amount
Consulting Fees- Premier HC & Financial Services	$ 617,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 617,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 10,832
Marcum	Accounting	15,858
Prospect Resources	Energy Consulting	1,300
Mowery & Schoenfeld	Accounting	2,026
Reliable Health Systems	Data Processing	18,120
Creative Technology	IT Support	9,104
Point Click Care	Data Processing	33,746
Galaxy	Data Processing	1,200
Zirmed	Data Processing-Claims Mgmt	575
Experian	Claims Management	127
OnShift	HR Consulting	13,824
See Attached		8,008
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 114,720

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,845
Unemployment Compensation Insurance	27,937
FICA Taxes	291,129
Employee Health Insurance	181,348
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	31,920
Other Employe Expense	14,611
Holiday Expense	2,909
TOTAL (agree to Schedule V, line 22, col.8)	$ 643,699

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	$
Advertising: Employee Recruitment	37,098
Health Care Worker Background Check	3,374
(Indicate # of checks performed 337)	
Patient Background Checks	
Dues	16,109
License & Fees	4,257
Allocated From Premier HC & Financial	414
Allocated From Premier RE	11
Allocated From iCare Consulting	55
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,318

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	699
Allocated From Premier HC & Financial	920
Allocated From iCare Consulting	645
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,264

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pine Crest Health Care, LLC # 0051318 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Data Process-Claims Mgmt	$ 1,767
EON Applications	Computer Services	382
Survey Monkey	Survey Platform	5
Aatrix	Tax Consulting	104
Assurance	Safety Consulting	5,500
Skidesky & Associates	Real Estate Appeal	250
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,008

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

Pine Crest Healthcare
Detail of Legal Expense
12/31/2018

GL Account	Date	Vendor	Description of Service	Amount	Adjustment	Allowable
8380.6	7/25/2018	Field & Goldberg	Loan Modification	647.00	(647.00)	-
8380.6	5/10/2017	Neal Gerber Eisenberg	Prior Year Legal Services	65.40	(65.40)	-
8380.6	6/16/2017	Neal Gerber Eisenberg	Prior Year Legal Services	81.75	(81.75)	-
8380.6	11/13/2017	Neal Gerber Eisenberg	Prior Year Legal Services	196.20	(196.20)	-
8380.6	12/19/2017	Neal Gerber Eisenberg	Prior Year Legal Services	45.24	(45.24)	-
8380.6	7/30/2018	Neal Gerber Eisenberg	General Employment Matters	1,078.12		1,078.12
8380.6	11/21/2017	Meyer Magence	Prior Year Legal Services	375.00	(375.00)	-
8380.6	2/28/2018	Meyer Magence	Conference with AG Office	300.00	-	300.00
8380.6	2/21/2018	SB2	Monthly PA Review	550.00		550.00
8380.6	3/23/2018	SB2	Prior Year Legal Services	1,577.78	(1,577.78)	-
8380.6	3/12/2018	SB2	Monthly PA Review	192.36		192.36
8380.6	3/21/2018	SB2	Monthly PA Review	506.25		506.25
8380.6	4/12/2018	SB2	Monthly PA Review	187.50		187.50
8380.6	7/31/2018	Polsinelli	Managed Care Contracting	3,821.94	(508.32)	3,313.62
8380.6	10/31/2018	Polsinelli	Managed Care Contracting	1,207.60		1,207.60
				10,832.14	(3,496.69)	7,335.45

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. **ILCLTC- $32,218**

(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. $ **16,601** Line **10-02**

(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. $ **468,812**
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? **No** Indicate the amount. $ **N/A**

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