

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: <u>0051052</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Crystal Pines Rehab HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>335 N Illinois St</u> <u>Crystal Lake</u> <u>60014</u> Number City Zip Code																											
County: <u>McHenry</u>																											
Telephone Number: <u>(815) 459-7791</u> Fax # <u>(815) 459-7680</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>10/28/2010</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avem Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
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	☐ "Sub-S" Corp.	_____																									
	☒ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																									

STATE OF ILLINOIS

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Facility Name & ID NumberCrystal Pines Rehab HCC# 0051052Report Period Beginning: 1/1/2025Ending: 12/31/2025

III. STATISTICAL DATA

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

N/A

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

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9
Level of Care	Patient Days by Level of Care and Primary Source of Payment							
	Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total
8	4,293	7,189	8,829		2,834	2,259	3,049	28,453
9								
10								
11								
12								
13								
14	4,293	7,189	8,829		2,834	2,259	3,049	28,453

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

68.38%

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?

YESNO

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

YESNO

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

Date started10/28/2010

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

YESDate10/28/2010NO

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

YESNO

If YES, enter certified beds.

number of certified beds114

Medicare IntermediaryWisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUALMODIFIEDCASH*

Is your fiscal year identical to your tax year?

YESNO

Tax Year:12/31/2025Fiscal Year:12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	390,183	30,068	36,413	456,664		456,664	(225)	456,439		1
2	Food Purchase		282,728		282,728		282,728		282,728		2
3	Housekeeping		20,162	149,412	169,574		169,574		169,574		3
4	Laundry		8,952	134,112	143,064		143,064		143,064		4
5	Heat and Other Utilities			174,985	174,985		174,985		174,985		5
6	Maintenance	64,545	18,224	149,720	232,489		232,489		232,489		6
7	Other (specify):*										7
8	TOTAL General Services	454,728	360,134	644,642	1,459,504		1,459,504	(225)	1,459,279		8
	B. Health Care and Programs										
9	Medical Director			27,500	27,500		27,500		27,500		9
10	Nursing and Medical Records	2,912,442	132,849	739,964	3,785,255		3,785,255		3,785,255		10
10a	Therapy										10a
11	Activities	121,100	7,968	5,341	134,409		134,409		134,409		11
12	Social Services	69,256	22	3,413	72,691		72,691		72,691		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,102,798	140,839	776,218	4,019,855		4,019,855		4,019,855		16
	C. General Administration										
17	Administrative	115,792		444,814	560,606		560,606	(20,322)	540,284		17
18	Directors Fees										18
19	Professional Services			213,988	213,988		213,988	(50,488)	163,500		19
20	Dues, Fees, Subscriptions & Promotions			11,770	11,770		11,770	(4,056)	7,714		20
21	Clerical & General Office Expenses	214,954	22,864	348,816	586,634		586,634	(78,724)	507,910		21
22	Employee Benefits & Payroll Taxes			416,113	416,113		416,113		416,113		22
23	Inservice Training & Education			4,206	4,206		4,206		4,206		23
24	Travel and Seminar			25,642	25,642		25,642		25,642		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,593	108,593		108,593		108,593		26
27	Other (specify):*										27
28	TOTAL General Administration	330,746	22,864	1,573,942	1,927,552		1,927,552	(153,590)	1,773,962		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,888,272	523,837	2,994,802	7,406,911		7,406,911	(153,815)	7,253,096		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			65,020	65,020		65,020	160,170	225,190		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			22,334	22,334		22,334	111,626	133,960		32
33	Real Estate Taxes			85,542	85,542		85,542		85,542		33
34	Rent-Facility & Grounds			420,063	420,063		420,063	(420,063)			34
35	Rent-Equipment & Vehicles			12,225	12,225		12,225		12,225		35
36	Other (specify):*							19,138	19,138		36
37	TOTAL Ownership			605,184	605,184		605,184	(129,129)	476,055		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		178,798	655,583	834,381		834,381		834,381		39
40	Barber and Beauty Shops			180	180		180		180		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			587,889	587,889		587,889		587,889		42
43	Other (specify):* Marketing			98,445	98,445		98,445	(98,445)			43
44	TOTAL Special Cost Centers		178,798	1,342,097	1,520,895		1,520,895	(98,445)	1,422,450		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,888,272	702,635	4,942,083	9,532,990		9,532,990	(381,389)	9,151,601		45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(225)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(45,722)	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	(77,582)	21		24
25	Fund Raising, Advertising and Promotional	(37,371)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	34,662			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,979)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(254,410)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (254,410)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (381,389)		37

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

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

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

Report Period Beginning:

Ending:

ID#0051052

1/1/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ (3,706)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	38,872	21	3
4	Chamber of Commerce	(350)	20	4
5	Gifts	(154)	21	5
6				6
7				7
8				8
9				9
10				10
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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	34,662		49

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 Owership-1		See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 420,063	TI Crystal lake LLC	100.00%	\$	(420,063)	1
2	V	32	Interest		TI Crystal lake LLC	100.00%	110,970	110,970	2
3	V	19	Accounting/Legal/Other Taxes		TI Crystal lake LLC	100.00%	12,131	12,131	3
4	V	36	Mortgage Insurance		TI Crystal lake LLC	100.00%	19,138	19,138	4
5	V	30	Depreciation		TI Crystal lake LLC	100.00%	146,939	146,939	5
6	V	32	Amorization of Financing Costs		TI Crystal lake LLC	100.00%	23,731	23,731	6
7	V	33	Real Estate Taxes	85,542	TI Crystal lake LLC	100.00%	85,542		7
8	V	26	Property Insurance	14,645	TI Crystal lake LLC	100.00%	14,645		8
9	V	21	Other Licenses/Taxes		TI Crystal lake LLC	100.00%	5,862	5,862	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 520,250			\$ 418,958	\$ * (101,292)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 Management-Operating	\$ 444,814	Tutera Health Care Service		\$ 424,492	\$ (20,322)	15
16	V	19 Management-Data Processing	62,619	Tutera Health Care Service			(62,619)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		13,231	13,231	17
18	V	43 Management-Marketing	61,074	Tutera Health Care Service			(61,074)	18
19	V	32 Interest	22,334	Tutera Investments			(22,334)	19
20	V	26 Insurance	89,336	LTC Plus Insurance, Inc.		89,336		20
21	V	10 Pharmacy Consultant	6,834	Critical Care Rx, LLC		6,834		21
22	V	39 Drugs	97,793	Critical Care Rx, LLC		97,793		22
23	V	39 Physical Therapy	37,855	Critical Care Rx, LLC		37,855		23
24	V	10 OTC Drugs	4	Critical Care Rx, LLC		4		24
25	V	10 Medical Supplies	150	Critical Care Rx, LLC		150		25
26	V	10 Contracted Nursing	14,701	Teamworkers		14,701		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		\$ 837,514			\$ 684,396	\$ * (153,118)	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Bethany Rehab & Health Care Center	Dekalb, IL			Antioch Valley	Overland Park, KS	AL	1
2	Carlinsville Rehab & Health Care Center	Carlinsville, IL			Carnegie Village Senior	Belton, MO	IL/AL	2
3	Carnegie Village Rehab & Health Care Center	Belton, MO			Country Gardens Assisted	Muskogee, OK	AL	3
4	Charlton Place Rehab & Health Care Center	Deatsville, AL			Laurel Assisted Living	Liberty, MO	AL	4
5	Coulterville Rehab & Health Care Center	Coulterville, IL			Missiona Chateau Senior	Prairie Village, KS	AL/IL	5
6	Dixon Rehab & Health Care Center	Dixon, IL			Oakley Court Assisted	Freeport, IL	AL	6
7	Estoria Rehabilitation	Liberty, MO			Town Center	Overland Park, KS	AL	7
8	Fair Oaks Rehab & Health Care Center	South Beloit, IL			Stratford Commons Memory	Overland Park, KS	Memory Care	8
9	Grand Meadows Senior Living	Asbury, IA			The Lodge at Manito	Manito, IL	AL	9
10	Highland Rehab & Health Care Center	Kansas City, MO			Tiffany Springs SLC	Kansas City, MO	AL/IL	10
11	Hillsboro Rehab & Health Care Center	Hillsboro, IL			Wesley Court Assisted	Boling Springs, SC	AL	11
12	Lakeland Rehab & Health Care Center	Effingham, IL						12
13	Matton Rehab & Health Care Center	Mattoon II						13
14	Meridian Rehab & Health Care Center	Wichita, KS						14
15	Metropolis Rehab & Health Care Center	Metropolis, IL			LTC Plus Insurance LLC	Kansas City, MO	Insurance Company	15
16	Monterey Park Rehab & Health Care Center	Independence, MO			JCT Capital, Inc.	Kansas City, MO	Mgmt Company	16
17	Montgomery Children's Specialty Center	Montgomery, AL			Tutera Group, Inc.	Kansas City, MO	Mgmt Company	17
18	Moweaqua Rehab & Health Care Center	Moweaqua, IL			Tutera Health Care Services	Kansas City, MO	Mgmt Company	18
19	Northland Rehab & Health Care Center	Kansas City, MO			Tutera Investments, LLC	Kansas City, MO	Mgmt Company	19
20	St. Paul's Senior Community	Belleville, IL			Walnut Creek Mgmt Co	Kansas City, MO	Mgmt Company	20
21	Stratford Rehab & Health Care Center	Overland Park, KS			Walnut Creek New Enterprises	Kansas City, MO	Mgmt Company	21
22	The Village at Mission	Prairie Village, KS			IPM, Inc.	Kansas City, MO	Property Mgt	22
23	Tiffany Springs Rehab & Health Care Center	Kansas City, MO			Columbia 7611 LLC	Kansas City, MO	Building Company	23
24	Westview of Derby Rehab & Health Care Center	Derby, KS			JCT FLP Auburn LLC	Aurora, IL	Building Company	24
25	Windsor Estates of St. Charles	St. Charles, MO			TeamWorkers LLC	Kansas City, MO	Agency Nursing	25
26	Holly Hill Rehab & Health Care Center	Sulphur, LA			Critical Care Rx, LLC	Kansas City, MO	Pharmacy Company	26
27	Rosewood Rehab & Health Care Center	Lake Charles, LA						27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

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☒XNO☐

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

Name of Related OrganizationTutera Health Care Services

Street Address7611 State Line Road

City / State / Zip CodeKansas City, Missouri 64114

Phone Number(816) 444-0900

Fax Number(816) 822-0081

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Management Fee-Operating	Direct Cost	512,439,158	114	\$ 24,349,098	\$ 16,637,381	8,933,763	424,497	1
2	30	Management Fee-Depreciation	Direct Cost	512,439,158	114	758,922		8,933,763	13,231	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					\$ 25,108,020	\$ 16,637,381		\$ 437,728	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HUD Landlord WTB	x		Mortgage			\$				\$	110,970	1
2	Amortized Financing Costs-HUD	x										23,731	2
3	Interest Income Offset											(741)	3
4													4
5													5
	Working Capital												
6	JCT Capital/Tutera Investment	x		Note Payable				3,021,367				22,334	6
7	Related Party Offset											(22,334)	7
8													8
9	TOTAL Facility Related						\$	\$ 3,021,367			\$	133,960	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
15	TOTALS (line 9+line14)						\$	\$ 3,021,367			\$	133,960	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,138 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.		\$	92,524	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.)		\$	89,033	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,491)	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	89,033	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	85,542	7	
Assessed Value from Real Estate Tax Bill:	2024	86,311	8		
Real Estate Tax Bill for Calendar Year:	2020	99,646	9		
	2021	92,783	10		
	2022	98,737	11		
	2023	92,524	12		
	2024	89,033	13		
				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION\$

- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crystal Pines Rehab HCC COUNTY McHenry
FACILITY IDPH LICENSE NUMBER 0051052
CONTACT PERSON REGARDING THIS REPORT Kiley Brooks
TELEPHONE (816) 444-0900 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>14-33-151-007</u>	<u>Long-Term Care</u>	\$ <u>89,032.90</u>	\$ <u>89,032.90</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>89,032.90</u>	\$ <u>89,032.90</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

14,571

B. General Construction Type:

Exterior

Brick

Frame

Brick

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	114		2010	1972	\$ 4,697,000	\$ 120,436	39	\$ 120,436		\$ 1,826,611	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2023 Improvements		2013		158,903	7,793	20	7,793		99,358	9
10	Furnace Heater Exchange		2017		8,488	566	15	566		4,574	10
11	Hot Water Heater Repair		2020		3,589	513	7	513		2,777	11
12	3ct Oak Doors - Dining Room		2021		7,999	1,143	7	1,143		4,666	12
13	Dining Room Renovation - fix drywall, ceiling tiles, & painting		2023		25,000	1,667	15	1,667		3,473	13
14	Break Room Renovation - fix drywall, ceiling tiles, & painting		2023		9,007	300	30	300		725	14
15	Facility Electric and Lights Update		2024		16,570	3,314	5	3,314		3,866	15
16	hemodialysis den center (first down payments)		2024		64,016	2,134	30	2,134		2,490	16
17	Dialysis Den Build-out - parts 2,3,4, and final		2024		215,607	10,780	20	10,780		17,068	17
18	Remodeling of two 300 wing shower rooms		2024		49,622	2,481	20	2,481		2,894	18
19	Doors Installment		2024		12,458	1,246	10	1,246		1,038	19
20	Roof Repair		2024		12,735	1,273	10	1,273		848	20
21	Facility Wiring Repair		2024		18,148	3,630	5	3,630		2,420	21
22	Dining and Hallway Flooring Project		2024		20,393	2,039	10	2,039		340	22
23	New Salon Project		2025		10,931	1,002	10	1,002		1,002	23
24	2013 Improvements (H Crystal Lake)		2013		189,822	4,867	39	4,867		63,274	24
25	2014 Improvements (H Crystal Lake)		2014		13,058	871	15	871		10,012	25
26	2016 Improvements (H Crystal Lake)		2016		166,727	9,776	Various	9,776		110,156	26
27	2017 Improvements (H Crystal Lake)		2017		7,000	700	Various	700		6,300	27
28											28
29	Home Office Allocation					13,231		13,231			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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	N/A		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$5,707,072	\$189,762		\$189,762	\$	\$2,163,892	70

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

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	\$250,364	\$28,351	\$28,351	\$	Various	\$113,955	71
72	Current Year Purchases	28,516	3,370	3,370		Various	3,370	72
73	Fully Depreciated Assets	1,096,623				Various	1,096,623	73
74								74
75	TOTALS	\$1,375,503	\$31,721	\$31,721	\$		\$1,213,948	75

D. Vehicle Costs. (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Van	2017	\$ 48,609	\$ 3,707	\$ 3,707	\$	5	\$ 48,609	76
77										77
78										78
79										79
80	TOTALS			\$ 48,609	\$ 3,707	\$ 3,707	\$		\$ 48,609	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,619,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,190	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 225,190	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,426,449	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	WIP	\$94,215
93		
94		
95		\$94,215

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$20,233Description: Dietary, Laundry, Copier, Nursing (See WTB)
- ☐ YES☒ NO
- (Attach a schedule detailing the breakdown of movable equipment)

	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

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. /2026\$
13. /2027\$
14. /2028\$

* 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.

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

☒ 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)	\$					

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	V39-02,03	hrs	\$	2,150	\$ 214,890	\$	2,150	\$ 214,890	1	
2	Licensed Speech and Language Development Therapist	V39-03	hrs		504	50,273		504	50,273	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	V39-02,03	hrs		3,188	303,291	124	3,188	303,415	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	V39-02	# of prescripts							9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Respiratory Therapy</u>	V39-03					32,843		32,843	12	
13	Other (specify): <u>See WTB</u>	V39-02,03				87,129	145,831		232,960	13	
14	TOTAL			\$	5,842	\$ 655,583	\$ 178,798	5,842	\$ 834,381	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,289	\$ 44,561	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	562,021	562,021	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,015	90,586	6
7	Other Prepaid Expenses	263,959	280,661	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	33,562	522,731	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 955,846	\$ 1,500,560	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		488,000	13
14	Buildings, at Historical Cost		5,073,607	14
15	Leasehold Improvements, at Historical Cost	633,465	633,465	15
16	Equipment, at Historical Cost	244,655	1,424,112	16
17	Accumulated Depreciation (book methods)	(269,981)	(3,426,449)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		289,160	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(220,818)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(31,727)	(31,727)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 576,412	\$ 4,229,350	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,532,258	\$ 5,729,910	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 402,806	\$ 402,806	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,211	20,211	28
29	Short-Term Notes Payable	3,021,367	3,021,367	29
30	Accrued Salaries Payable			30
	Accrued Taxes Payable (excluding real estate taxes)	480,375	480,375	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,033	32
33	Accrued Interest Payable		9,031	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(5,749)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,919,010	\$ 4,022,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,736,811	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)	\$	\$ 3,736,811	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,919,010	\$ 7,759,634	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,386,752)	\$ (2,029,724)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,532,258	\$ 5,729,910	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,753,552)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,753,552)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(594,079)	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)	(39,121)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (633,200)	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)	\$ (2,386,752)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,330,123	1
2	Discounts and Allowances for all Levels	(2,776,990)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,553,133	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,057,000	6
7	Oxygen	6,581	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,063,581	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	225	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	276,029	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,517	19
20	Radiology and X-Ray	8,815	20
21	Other Medical Services	28,607	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 338,193	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	741	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 741	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	(16,737)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (16,737)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,938,911	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,459,504	31
32	Health Care	4,019,855	32
33	General Administration	1,927,552	33
B. Capital Expense			
34	Ownership	605,184	34
C. Ancillary Expense			
35	Special Cost Centers	933,006	35
36	Provider Participation Fee	587,889	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,532,990	40
41	Income before Income Taxes (line 30 minus line 40)**	(594,079)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (594,079)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,145,957.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,919,004.00	45
46	MMAI-Medicaid is the Primary Payer	2,356,779.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	238,582.00	48
49	Medicare Part A	773,256.00	49
50	Other-(specify) Managed Care	119,555.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,553,133	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,080	\$ 115,528	\$ 55.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,700	19,904	951,374	47.80	3
4	Licensed Practical Nurses	8,137	8,617	357,552	41.49	4
5	CNAs & Orderlies	50,429	52,655	1,465,426	27.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,839	1,983	53,399	26.93	9
10	Activity Assistants	3,147	3,406	67,701	19.88	10
11	Social Service Workers	2,415	2,673	69,256	25.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,580	17,327	390,183	22.52	15
16	Dishwashers					16
17	Maintenance Workers	2,019	2,109	64,545	30.60	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,256	2,359	115,792	49.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,289	7,758	214,954	27.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	947	1,011	22,562	22.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,790	121,882	\$ 3,888,272 *	\$ 31.90	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	372	\$ 21,456	1-3	35
36	Medical Director	Monthly	27,500	9-3	36
37	Medical Records Consultant	Monthly	1,664	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,326	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,126	11-3	44
45	Social Service Consultant	53	3,413	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	473	\$ 66,485		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,988	\$ 231,559	10-3	50
51	Licensed Practical Nurses	5,447	308,646	10-3	51
52	Certified Nurse Assistants/Aides	6,685	215,340	10-3	52
53	TOTAL (lines 50 - 52)	15,120	\$ 755,545		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Jeremy Kanter	Administrator		\$ 64,203	Workers' Compensation Insurance	\$	67,932	IDPH License Fee	\$
Owen Bookman	Interim Admin		21,592	Unemployment Compensation Insurance			Advertising: Employee Recruitment	
Lori Schlais	Administrator		29,997	FICA Taxes		319,403	Health Care Worker Background Check (Indicate # of checks performed 90)	
				Employee Health Insurance		35,470	Patient Background Checks 113	1,109
				Employee Meals			Association Dues (total from pg 22, #4)	10,563
				Illinois Municipal Retirement Fund (IMRF)*			McHenry County Health Dept	
				Other Benefits		(6,692)	Other Licenses	
TOTAL (agree to Schedule V, line 17, col. 1)							Other Dues and Subscriptions	(252)
(List each licensed administrator separately.)							Crystal Lake Chamber of Commerce	350
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				PAC and Lobbying payments	(3,706)
Tutera Health Care Services - Management Fee			\$ 444,814				All non-allowable advertising	(350)
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal		\$ 76,650	N/A		\$	Out-of-State Travel	\$
Scyferth, Blumenthal, & Harris LL	Legal		2,790					
Clifton Larson Allen LLP	Cost Reports/Taxes		5,297					
Payroll	Payroll Processing		19,111				In-State Travel	25,642
Walnut Creek Mgt Company	CBO, IT & DP Mgt Fee		62,619					
Pointclickcare Technologies	Medical Records Software		31,768					
Newsmart Technologies	E.H.R.		2,156					
Proclaim Partners, LLC	Claims Mgt		6,260				Seminar Expense	
Aline OPS LLC	CRM Software		2,905					
Various	Data Processing		4,432					
TOTAL (agree to Schedule V, line 19, column 3)							Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 25,642

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training?** No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm
Firm Name: N/A No
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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: