

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0052613</u> Facility Name: <u>Spring Creek Nsg & Rehab Ctr</u> Address: <u>777 Draper Avenue</u> <u>Joliet</u> <u>60432</u> Number City Zip Code County: <u>Will</u> Telephone Number: <u>(815) 727-4794</u> Fax # <u>(815) 727-1026</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>4/1/2014</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____	☐	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 _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 7/1/16

	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	<u>84</u>	Skilled (SNF)	<u>168</u>	<u>46,200</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>84</u>	Intermediate (ICF)		<u>15,288</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>168</u>	TOTALS	<u>168</u>	<u>61,488</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,228</u>	<u>2,263</u>	<u>4,578</u>	<u>16,069</u>	8
9	SNF/PED					9
10	ICF	<u>7,217</u>	<u>1,762</u>		<u>8,979</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,445</u>	<u>4,025</u>	<u>4,578</u>	<u>25,048</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.74%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/2014 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 168 and days of care provided 3,583

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	210,324	43,197	8,633	262,154		262,154	94	262,248			1
2	Food Purchase		156,038		156,038		156,038	(1,192)	154,846			2
3	Housekeeping	145,084	42,543		187,627		187,627	522	188,149			3
4	Laundry	11,772	12,213		23,985		23,985		23,985			4
5	Heat and Other Utilities			81,836	81,836		81,836	729	82,565			5
6	Maintenance	39,829	129	161,494	201,452		201,452	(1,174)	200,278			6
7	Other (specify):*							427	427			7
8	TOTAL General Services	407,009	254,120	251,963	913,092		913,092	(593)	912,499			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,651,002	231,219	44,535	1,926,756		1,926,756		1,926,756			10
10a	Therapy	108,024			108,024		108,024		108,024			10a
11	Activities	123,210	21,385		144,595		144,595		144,595			11
12	Social Services	199,755			199,755		199,755		199,755			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,081,991	252,604	56,535	2,391,130		2,391,130		2,391,130			16
	C. General Administration											
17	Administrative	317,858			317,858		317,858	10,198	328,056			17
18	Directors Fees											18
19	Professional Services			326,037	326,037	(467)	325,570	(143,601)	181,969			19
20	Dues, Fees, Subscriptions & Promotions			99,753	99,753		99,753	(59,089)	40,664			20
21	Clerical & General Office Expenses	79,049	21,357	441,917	542,323		542,323	(378,757)	163,566			21
22	Employee Benefits & Payroll Taxes			518,815	518,815		518,815	(3,190)	515,625			22
23	Inservice Training & Education											23
24	Travel and Seminar			300	300		300	78	378			24
25	Other Admin. Staff Transportation			1,051	1,051		1,051	527	1,578			25
26	Insurance-Prop.Liab.Malpractice			152,081	152,081		152,081	912	152,993			26
27	Other (specify):*							14,114	14,114			27
28	TOTAL General Administration	396,907	21,357	1,539,954	1,958,218	(467)	1,957,751	(558,809)	1,398,942			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,885,907	528,081	1,848,452	5,262,440	(467)	5,261,973	(559,402)	4,702,571			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			17,226	17,226		17,226	302,561	319,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,967	6,967		6,967	4,222	11,189			32
33	Real Estate Taxes			99,081	99,081	467	99,548	2,127	101,675			33
34	Rent-Facility & Grounds			301,367	301,367		301,367	(300,000)	1,367			34
35	Rent-Equipment & Vehicles			811	811		811	498	1,309			35
36	Other (specify):*											36
37	TOTAL Ownership			425,452	425,452	467	425,919	9,408	435,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,748	519,805	657,553		657,553		657,553			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,984	206,984		206,984		206,984			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		137,748	726,789	864,537		864,537		864,537			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,885,907	665,829	3,000,693	6,552,429		6,552,429	(549,994)	6,002,435			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.)

	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	161,627	30		9
10	Interest and Other Investment Income	(193)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(250)	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				18
19	Entertainment				19
20	Contributions	(3,360)	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	(430,202)	21		24
25	Fund Raising, Advertising and Promotional	(52,831)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,438)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (348,647)		\$	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)	(201,347)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (201,347)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (549,994)		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

Report Period Beginning:

Ending:

ID#

0052613

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,423)	21	1
2	Theft Loss	(111)	21	2
3	Collection Expense	(2,665)	21	3
4	Vending Income	(1,145)	02	4
5	PAC Dues	(608)	20	5
6	Annual Report	(250)	20	6
7	Non-allowable Legal	(7,444)	19	7
8	Lobbying	(2,535)	20	8
9	Capitalized R&M	(7,258)	06	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				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	(23,438)		49

ID#

0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

Summary A

12/31/16

[illegible]

Summary B

12/31/16

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ 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	Rental Income	\$ 300,000	Hillcrest Realty, LLC	100.00%	\$	\$(300,000)	1
2	V	30	Depreciation Expense		Hillcrest Realty, LLC	100.00%	139,718	139,718	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			\$ 300,000			\$ 139,718	\$ * (160,282)	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 94	\$	94
16	V	02	Food		Extended Care Consulting, LLC	100.00%	203		203
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	522		522
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	729		729
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,522		1,522
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,524		1,524
21	V	19	Professional Fees	139,200	Extended Care Consulting, LLC	100.00%	3,042		(136,158)
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	495		495
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	3,070		3,070
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	78		78
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	527		527
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	912		912
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,216		1,216
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,415		4,415
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,127		2,127
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	498		498
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 139,200			\$ 20,975	\$ *	(118,225)

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,561	\$	4,561
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	427		427
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			
19	V								
20	V								
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,674		8,674
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	52,566		52,566
23	V	21	Office and Clerical (Direct)	10,626	Extended Care Consulting, LLC	100.00%	10,634		8
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,201		11,201
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,913		2,913
26	V	22	Employee Benefits	3,190	Extended Care Consulting, LLC	100.00%			(3,190)
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 13,816			\$ 90,976	\$ *	77,160

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 151,350	\$ 151,350	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	151,350	CCS Employee Benefits Group	100.00%		(151,350)	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			\$ 151,350			\$ 151,350	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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	Charles Slagle	20.00 %	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		HILLCREST REALTY	CHICAGO	BUILDING COMPANY	1
2	B&Z Grandchildren Trust	47.002%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	Adam Vales Accumulation Trust	4.714%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	Kathryn Vales Accumulation Trust	4.714%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	Kimberly Vales Accumulation Trust	4.714%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	Daniel Rothner Accumulation Trust	4.714%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	Melissa Rothner Accumulation Trust	4.714%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	Rachel Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9	William Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

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	Charles Slagle	Administrator	Owner	20.00%	None	40	100.00%	Salary	\$ 153,533	17-01	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.77	1.92%	Alloc. Salary	1,410	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 154,943		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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$	25,048	\$ 94	1
2	02	Food	Patient Days	1,380,761	34	11,203		25,048	203	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		25,048	522	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		25,048	729	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		25,048	1,522	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		25,048	1,524	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		25,048	3,042	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		25,048	495	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		25,048	3,070	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		25,048	78	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		25,048	527	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		25,048	912	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		25,048	1,216	13
14	32	Interest	Patient Days	1,380,761	34	243,379		25,048	4,415	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		25,048	2,127	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		25,048	498	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,218	\$		\$ 20,974	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	25,048	\$ 4,561	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		25,048	427	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	25,048	8,674	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	25,048	52,566	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		10,634	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		25,048	11,201	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			2,913	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					\$ 5,222,483	\$ 4,461,323		\$ 90,976	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 151,350	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				\$	\$		\$ 151,350	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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 Spring Creek Nsg & Rehab Ctr # 0052613 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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

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	Notes Payable		X	Furniture and Equipment				16,404				6,967	6
7	Hillcrest Realty	X		Notes Payable				36,825					7
8					-								8
9	TOTAL Facility Related						\$	53,229			\$	6,967	9
	B. Non-Facility Related*												
10	Interest Income		X									(193)	10
11	Allocated - Consulting LLC	X										4,415	11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	4,222	14
15	TOTALS (line 9+line14)						\$	53,229			\$	11,189	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Spring Creek Nsg & Rehab Ctr

COUNTY

Will

FACILITY IDPH LICENSE NUMBER

0052613

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(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>30-07-11-101-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>94,326.20</u>	\$ <u>94,326.20</u>
2. <u>See Attached</u>	<u>Allocated - Care Centers Building</u>	\$ <u>167,518.13</u>	\$ <u>2,126.70</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>261,844.33</u>	\$ <u>96,452.90</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? 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

FACILITY NAME Spring Creek Nsg & Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052613

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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?

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.)

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

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

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	132,928	2007	\$ 336,000	1
2	Allocated - Care Centers Building, LLC			10,410	2
3	TOTALS	132,928		\$ 346,410	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	168		2014	1976	\$ 5,288,000	\$ 139,718	27.5	\$ 192,291	\$ 52,573	\$ 1,815,493	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1991	6,230		20				6,230	9
10	Various		1992	46,656		20				46,656	10
11	Various		1993	24,390		20				24,390	11
12	Various		1994	10,172		20				10,172	12
13	Various		1995	5,221		20				5,221	13
14	Various		1996	13,337		20				13,337	14
15	Various		1997	14,039		20	702	702		14,039	15
16	Various		1998	172,840		20	8,642	8,642		164,198	16
17	Various		1999	63,084		20	3,154	3,154		56,776	17
18	Various		2000	11,245		20	562	562		9,558	18
19	Various		2001	86,883		20	4,344	4,344		69,506	19
20	Various		2002	16,919		20	846	846		12,689	20
21	Various		2003	171,488		20	8,574	8,574		120,042	21
22	Various		2004	7,188		20				7,188	22
23	Various		2005	94,154		20	4,708	4,708		56,492	23
24	Various		2006	34,118		20	1,706	1,706		18,765	24
25	Various		2007	48,568		20	2,428	2,428		24,284	25
26	Various		2008	232,319		20	11,616	11,616		104,544	26
27	Various		2009	27,382		20	1,369	1,369		10,953	27
28	Various		2010	80,460		20	4,023	4,023		27,558	28
29	Various		2011	9,101		20	455	455		2,730	29
30	Various		2012	378,759		20	18,938	18,938		95,916	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		50,103	708		708		33,438	68
69	Financial Statement Depreciation			17,226			(17,226)		69
70	TOTAL (lines 4 thru 69)		\$ 6,892,656	\$ 157,652		\$ 265,067	\$ 107,415	\$ 2,750,175	70

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,892,656	\$ 157,652		\$ 265,067	\$ 107,415	\$ 2,750,175	1
2	Installation Of New Emg Panel	2015	4,560		20	228	228	456	2
3	Installed 6 Delayed Egress Magnetic Lock On 2Nd Floor	2016	13,586		20	1,359	1,359	1,359	3
4	Double Face, Pole Illuminated, Pylon Sign	2016	15,400		20	1,540	1,540	1,540	4
5	Floor Covering	2016	11,732		20	587	587	587	5
6	Kimona Silk Mosaic Tile	2016	31,577		20	1,579	1,579	1,579	6
7	New Haven & Oasis Tile	2016	11,289		20	564	564	564	7
8	Installed Self Regulating Roof/Gutter Heating Cable To 25 Down S	2016	11,653		20	583	583	583	8
9	Custom Flooring Materials	2016	59,774		20	2,989	2,989	2,989	9
10	Installed 42 Vanity Tops In Resident Rooms 201-240, Nurse Statio	2016	23,730		20	1,187	1,187	1,187	10
11	Second Floor Sprinkler Renovations	2016	3,395		20	170	170	170	11
12	Counter Tops For 2Nd Floor Nurses Station, Dining Room, & Acti	2016	32,500		20	1,625	1,625	1,625	12
13	2Nd Floor Nw Doors & Installation	2016	3,180		20	159	159	159	13
14	Install 2 Dura Glide Automatic Sliding Door Assemblies	2016	9,500		20	475	475	475	14
15	2Nd Floor Resident Rooms/Corridors/Showers Flooring	2016	119,525		20	5,976	5,976	5,976	15
16	Architect Fees For Facility Remodeling Projects	2016	6,175		20	309	309	309	16
17	Labor For Floor Installation In Resident Rooms And Hallways	2016	32,363		20	1,618	1,618	1,618	17
18	Installed Call Light Switch, New Panels, And 3 Fax Lines	2016	4,149		20	207	207	207	18
19	Installed Wall Air Conditioner	2016	3,109		20	155	155	155	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)		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

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		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	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)		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

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		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

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		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	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)		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Care Centers Building	2002	14,346	368	35	368		5,257	3
4									4
5	Allocated - Extended Care Consulting, LLC	2007	4,354	96	35	96		916	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Extended Care Consulting, LLC	2007	83	4	20	4		42	9
10	Allocated - Extended Care Consulting, LLC	2009	50	2	20	2		20	10
11	Allocated - Extended Care Consulting, LLC	2010	489	24	20	24		171	11
12	Allocated - Extended Care Consulting, LLC	2011	176	9	20	9		53	12
13	Allocated - Extended Care Consulting, LLC	2012	58	3	20	3		15	13
14	Allocated - Extended Care Consulting, LLC	2014	805	40	20	40		121	14
15	Allocated - Extended Care Consulting, LLC	2016	965	48	20	48		48	15
16									16
17	Allocated - Care Centers Building	2002	11,851		20			11,851	17
18	Allocated - Care Centers Building	2003	13,966		20			13,966	18
19	Allocated - Care Centers Building	2005	694	1	20	1		694	19
20	Allocated - Care Centers Building	2009	125	6	20	6		50	20
21	Allocated - Care Centers Building	2014	1,164	58	20	58		175	21
22	Allocated - Care Centers Building	2015	197	10	20	10		20	22
23	Allocated - Care Centers Building	2016	780	39	20	39		39	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)		\$ 50,103	\$ 708		\$ 708	\$	\$ 33,438	34

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

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		\$50,103	\$708		\$708	\$	\$33,438	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)		\$50,103	\$708		\$708	\$	\$33,438	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$86,169	\$413	\$8,616	\$8,203	10	\$35,795	71
72	Current Year Purchases	246,992		24,699	24,699	10	24,699	72
73	Fully Depreciated Assets	391,392				10	391,392	73
74								74
75	TOTALS	\$724,552	\$413	\$33,316	\$32,903		\$451,886	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		Allocated - Consulting LLC	2016	\$3,274	\$92	\$92		5	\$3,089	76
77										77
78										78
79										79
80	TOTALS			\$3,274	\$92	\$92			\$3,089	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)	\$8,364,089	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$158,157	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$319,784	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$161,627	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,226,687	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	Various Improvements	\$319,244	92
93			93
94			94
95		\$319,244	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off Site Storage				1,367			5
6								6
7	TOTAL				\$1,367			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: \$1,309 Description: See Attached Schedule
- ☐ YES☐ NO
- (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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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
		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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 229,511	\$		\$ 229,511	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,406			56,406	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			232,492			232,492	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				114,494		114,494	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,396	23,254		24,650	13
14	TOTAL			\$		\$ 519,805	\$ 137,748		\$ 657,553	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 15,646	\$ 15,646	1
2	Cash-Patient Deposits	10,087	10,087	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,892,050	1,892,050	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	201,014	201,014	6
7	Other Prepaid Expenses	7,667	7,667	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	122,080	122,080	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,248,544	\$ 2,248,544	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		336,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	385,379	5,673,379	15
16	Equipment, at Historical Cost	313,192	649,192	16
17	Accumulated Depreciation (book methods)	(31,857)	(2,087,041)	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): <u>See Attached Schedule</u>	342,301	342,301	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,009,015	\$ 4,913,831	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,257,559	\$ 7,162,375	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,826,428	\$ 3,226,428	26
27	Officer's Accounts Payable	30,000	30,000	27
28	Accounts Payable-Patient Deposits	10,230	10,230	28
29	Short-Term Notes Payable	16,404	53,229	29
30	Accrued Salaries Payable	187,066	187,066	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,874	13,874	31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,873	103,873	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	104,805	5,205,600	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,292,680	\$ 8,830,300	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	<u>See Attached Schedule</u>	3,400,360	3,400,360	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,400,360	\$ 3,400,360	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,693,040	\$ 12,230,660	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,435,481)	\$ (5,068,285)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,257,559	\$ 7,162,375	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,473,312)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,473,312)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(962,169)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (962,169)	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)	\$ (4,435,481)	24 *

* This must agree with page 17, line 47.

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,461,463	1
2	Discounts and Allowances for all Levels	(1,803,421)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,658,042	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,905,600	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,905,600	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	3,705	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,306	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,846	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,857	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	193	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 193	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,568	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,568	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,590,260	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	913,092	31
32	Health Care	2,391,130	32
33	General Administration	1,958,218	33
	B. Capital Expense		
34	Ownership	425,452	34
	C. Ancillary Expense		
35	Special Cost Centers	657,553	35
36	Provider Participation Fee	206,984	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,552,429	40
41	Income before Income Taxes (line 30 minus line 40)**	(962,169)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (962,169)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,359,531	44
45	Private Pay - Net Inpatient Revenue	706,254	45
46	Medicare - Net Inpatient Revenue	456,444	46
47	Other-(specify) Hospice	108,452	47
48	Other-(specify) Insurance	27,361	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,658,042	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,977	2,261	\$ 115,115	\$ 50.91	1
2	Assistant Director of Nursing	17	17	620	36.47	2
3	Registered Nurses	12,119	12,926	460,292	35.61	3
4	Licensed Practical Nurses	21,495	23,038	638,880	27.73	4
5	CNAs & Orderlies	33,369	35,414	404,430	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,079	5,631	108,024	19.18	8
9	Activity Director	2,001	2,213	32,565	14.72	9
10	Activity Assistants	8,297	8,999	90,645	10.07	10
11	Social Service Workers	8,123	9,111	199,755	21.92	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,334	57,802	24.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,156	8,072	99,476	12.32	15
16	Dishwashers	5,344	5,672	53,046	9.35	16
17	Maintenance Workers	2,659	2,914	39,829	13.67	17
18	Housekeepers	13,624	14,635	145,084	9.91	18
19	Laundry	1,243	1,312	11,772	8.97	19
20	Administrator	4,026	4,460	256,363	57.48	20
21	Assistant Administrator	2,019	2,280	61,495	26.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,008	6,545	79,049	12.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,832	2,061	31,665	15.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,381	149,895	\$ 2,885,907 *	\$ 19.25	34

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	154	\$ 8,633	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,710	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 29,343		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	717	\$ 35,825	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	717	\$ 35,825		53

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

** See instructions.

Facility Name & ID Number		Spring Creek Nsg & Rehab Ctr		STATE OF ILLINOIS	#	0052613	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
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? If YES, give association name and amount.			Yes ICLTC \$1,170 and IHCA \$561							
(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.			\$ 95 Line 10							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			Yes							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			No							
	If YES, give effective date of lease.			N/A							
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO X							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			N/A							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.			\$ 206,984							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			No							
	If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			Yes							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			No							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ N/A							
	Has any meal income been offset against related costs?			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?			None							
	d. Have vehicle usage logs been maintained?			N/A							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			N/A							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			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?			Yes							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees										