

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0055608</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																			
Facility Name: <u>Spring Creek</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																			
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>05/01/2019</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td colspan="2">(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Print Name and Title) <u>See Accountant's Report Attached</u></td></tr><tr><td colspan="2">(Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard rd, Skokie, IL 60076</u></td></tr><tr><td colspan="2">(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>See Accountant's Report Attached</u>		(Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard rd, Skokie, IL 60076</u>		(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>		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) _____				(Date) _____																
	(Type or Print Name) _____																				
	(Title) _____																				
Paid Preparer	(Signed) _____			(Date) _____																	
	(Print Name and Title) <u>See Accountant's Report Attached</u>																				
	(Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard rd, Skokie, IL 60076</u>																				
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	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																				
Type of Ownership:																					
☐ 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 _____																				
In the event there are further questions about this report, please contact:																					
Name: <u>Mendel Schneider</u>																					
Telephone Number: <u>(847)933-1274</u>																					
Email Address: _____																					

Facility Name & ID Number Spring Creek

0055608 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>168</u>	Skilled (SNF)	<u>168</u>	<u>61,488</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>168</u>	TOTALS	<u>168</u>	<u>61,488</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,409</u>	<u>815</u>	<u>3,869</u>	<u>31,093</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,409</u>	<u>815</u>	<u>3,869</u>	<u>31,093</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.57%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/2019

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/2019 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 3,868

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Spring Creek # 0055608 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	221,692	20,411	10,769	252,872		252,872		252,872			1
2	Food Purchase		162,915		162,915		162,915		162,915			2
3	Housekeeping	138,946	16,724	11,363	167,033		167,033		167,033			3
4	Laundry	42,701	8,282		50,983		50,983		50,983			4
5	Heat and Other Utilities			127,179	127,179		127,179		127,179			5
6	Maintenance	113,963		38,661	152,624		152,624	176	152,800			6
7	Other (specify):*											7
8	TOTAL General Services	517,302	208,332	187,972	913,606		913,606	176	913,782			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,194,369	187,374	125,333	2,507,076		2,507,076	(24,510)	2,482,566			10
10a	Therapy											10a
11	Activities	88,276	890		89,166		89,166		89,166			11
12	Social Services	50,798		2,600	53,398		53,398		53,398			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benifets							7,028	7,028			15
16	TOTAL Health Care and Programs	2,333,443	188,264	139,933	2,661,640		2,661,640	(17,482)	2,644,158			16
	C. General Administration											
17	Administrative	97,175		473,549	570,724		570,724	(395,627)	175,097			17
18	Directors Fees											18
19	Professional Services			49,162	49,162		49,162	15,096	64,258			19
20	Dues, Fees, Subscriptions & Promotions			38,062	38,062		38,062	(4,377)	33,685			20
21	Clerical & General Office Expenses	191,294	38,253	131,113	360,660		360,660	139,780	500,440			21
22	Employee Benefits & Payroll Taxes			392,318	392,318		392,318		392,318			22
23	Inservice Training & Education											23
24	Travel and Seminar			408	408		408		408			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			307,342	307,342		307,342		307,342			26
27	Other (specify):* Allocated Benifets							25,028	25,028			27
28	TOTAL General Administration	288,469	38,253	1,391,954	1,718,676		1,718,676	(220,100)	1,498,576			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,139,214	434,849	1,719,859	5,293,922		5,293,922	(237,406)	5,056,516			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			3,001	3,001		3,001	302,940	305,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,217	7,217		7,217	(2,318)	4,899			32
33	Real Estate Taxes			68,732	68,732		68,732		68,732			33
34	Rent-Facility & Grounds			584,000	584,000		584,000	8,413	592,413			34
35	Rent-Equipment & Vehicles			826	826		826		826			35
36	Other (specify):*											36
37	TOTAL Ownership			663,776	663,776		663,776	309,035	972,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,294	342,656	419,950		419,950		419,950			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			260,766	260,766		260,766		260,766			42
43	Other (specify):* Bad debt			68,316	68,316		68,316	(68,316)				43
44	TOTAL Special Cost Centers		77,294	671,738	749,032		749,032	(68,316)	680,716			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,139,214	512,143	3,055,373	6,706,730		6,706,730	3,313	6,710,043			45

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

	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	(1,344,516)	30		9
10	Interest and Other Investment Income	(5,497)	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	(28,828)	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	(68,316)	43		24
25	Fund Raising, Advertising and Promotional	(4,432)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,552)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,463,141)		\$	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)	1,466,454		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,466,454		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 3,313		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

Spring Creek

ID#

0055608

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Spring Creek# 0055608

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	176	0	0	0	0	0	0	0	0	0	176	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	176	0	0	0	0	0	0	0	0	0	176	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	91,873	(116,383)	0	0	0	0	0	0	0	0	(24,510)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	7,028	0	0	0	0	0	0	0	0	0	7,028	15
16	TOTAL Health Care and Programs	0	98,901	(116,383)	0	0	0	0	0	0	0	0	(17,482)	16
	C. General Administration													
17	Administrative	0	77,922	(473,549)	0	0	0	0	0	0	0	0	(395,627)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,096	0	0	0	0	0	0	0	0	0	15,096	19
20	Fees, Subscriptions & Promotions	(4,432)	55	0	0	0	0	0	0	0	0	0	(4,377)	20
21	Clerical & General Office Expenses	(40,380)	180,160	0	0	0	0	0	0	0	0	0	139,780	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	25,028	0	0	0	0	0	0	0	0	0	25,028	27
28	TOTAL General Administration	(44,812)	298,261	(473,549)	0	0	0	0	0	0	0	0	(220,100)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,812)	397,338	(589,932)	0	0	0	0	0	0	0	0	(237,406)	29

STATE OF ILLINOIS

Facility Name & ID Number

Spring Creek

#

0055608

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

Summary B

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,344,516)	0	0	1,647,456	0	0	0	0	0	0	0	302,940	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,497)	0	0	3,179	0	0	0	0	0	0	0	(2,318)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,592	0	(3,179)	0	0	0	0	0	0	0	8,413	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,350,013)	11,592	0	1,647,456	0	0	0	0	0	0	0	309,035	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(68,316)	0	0	0	0	0	0	0	0	0	0	(68,316)	43
44	TOTAL Special Cost Centers	(68,316)	0	0	0	0	0	0	0	0	0	0	(68,316)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,463,141)	408,930	(589,932)	1,647,456	0	0	0	0	0	0	0	3,313	45

Facility Name & ID Number Spring Creek# 0055608Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
Moshe Blonder	33.33	Arista Healthcare	Naperville	Saba Healthcare	Skokie	Mgmt
Aaron Singer	33.34	Forest City Nursing & Rehab	Rockford	Saba Financial	Skokie	Mgmt
SC Holdco	33.33	Rock River Healthcare	Rockford			
		Pearl Pavillion	Freeport			
		Briar Place Nursing	Indian Head Park			
		Parc Joliet Nursing	Joliet			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical Salaries	\$	Saba Healthcare		\$ 153,451	\$ 153,451	1
2	V	27	Payroll Taxes		Saba Healthcare		10,485	10,485	2
3	V	27	Employee Benifets		Saba Healthcare		14,543	14,543	3
4	V	10	Nursing salary		Saba Healthcare		91,873	91,873	4
5	V	20	Dues & Subs		Saba Healthcare		55	55	5
6	V	19	Professional Fees		Saba Healthcare		15,096	15,096	6
7	V	34	Rent		Saba Healthcare		11,592	11,592	7
8	V	6	Repairs & Maintenance		Saba Healthcare		176	176	8
9	V	21	Telephone		Saba Healthcare		1,229	1,229	9
10	V	17	Salary Blonder		Saba Healthcare		38,961	38,961	10
11	V	17	Salary Singer		Saba Healthcare		38,961	38,961	11
12	V	21	Admin & General Expenses		Saba Healthcare		25,480	25,480	12
13	V	15	Nursing Benifets		Saba Healthcare		7,028	7,028	13
14	Total			\$			\$ 408,930	\$ *	408,930 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 473,549	Saba Healthcare		\$	\$ (473,549)	15
16	V	10 Nurse Consultant	116,383	Saba Healthcare			(116,383)	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		\$ 589,932			\$ 0	\$ * (589,932)	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	34	Rent	\$ 3,179	Spring Creek SNF Land		\$	(3,179)	15
16	V	32	Interest		Spring Creek SNF Land		3,179	3,179	16
17	V	30	Depreciation		Spring Creek SNF Land		1,647,456	1,647,456	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			\$ 3,179			\$ 1,650,635	\$ * 1,647,456	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								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	Aaron Singer	Owner	Administrative	33.34	211,039	6.66	16.67	Mgmt Fee	\$ 38,961	17-7	1
2	Moshe Blonder	Owner	Administrative	33.33	211,039	6.66	16.67	Mgmt Fee	38,961	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 77,922		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# 0055608 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

SABA HEALTHCARE

Street Address

3515 w Howard

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847)383-9104

Fax Number

()

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

	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	21	Clerical Salaries	Number of Beds	1,078	6	\$ 984,647	\$ 984,647	168	\$ 153,451	1
2	27	Payroll Taxes	Number of Beds	1,078	6	67,280		168	10,485	2
3	27	Employee Benifets	Number of Beds	1,078	6	93,316		168	14,543	3
4	10	Nursing salary	Number of Beds	1,078	6	589,519	589,519	168	91,873	4
5	20	Dues & Subs	Number of Beds	1,078	6	356		168	55	5
6	19	Professional Fees	Number of Beds	1,078	6	96,869		168	15,096	6
7	34	Rent	Number of Beds	1,078	6	74,385		168	11,592	7
8	6	Repairs & Maintenance	Number of Beds	1,078	6	1,130		168	176	8
9	21	Telephone	Number of Beds	1,078	6	7,884		168	1,229	9
10	17	Salary Blonder	Number of Beds	1,078	6	250,000	250,000	168	38,961	10
11	17	Salary Singer	Number of Beds	1,078	6	250,000	250,000	168	38,961	11
12	21	Admin & General Expenses	Number of Beds	1,078	6	163,497		168	25,480	12
13	15	Nursing Benifets	Number of Beds	1,078	6	45,098		168	7,028	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,623,981	\$ 2,074,166		\$ 408,930	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	Due to Prior Owner		X	Mortgage			\$ 6,350,000	\$ 6,350,000			\$ 3,179	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First midwest		X	Working Capital							7,217	6
7												7
8												8
9	TOTAL Facility Related						\$ 6,350,000	\$ 6,350,000			\$ 10,396	9
	B. Non-Facility Related*											
10	Interest income										(5,497)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (5,497)	14
15	TOTALS (line 9+line14)						\$ 6,350,000	\$ 6,350,000			\$ 4,899	15

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

* 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

[illegible]

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Spring Creek COUNTY Will

FACILITY IDPH LICENSE NUMBER 0055608

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 30-07-11-101-003-0000	Nursing Home	\$ 76,875.20	\$ 76,875.20
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 76,875.20	\$ 76,875.20

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,039

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>23,039</u>	<u>2020</u>	<u>\$ 660,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>23,039</u>		<u>\$ 660,000</u>	<u>3</u>

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	168		2020		\$ 4,586,132	\$ 293,588	27.5	\$ 166,768	\$ (126,820)	\$ 166,768	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Resurface			2019	15,000	317	10	1,500	1,183	1,683	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

See Page 12A, Line 70 for total

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$4,601,132	\$293,905		\$168,268	\$(125,637)	\$168,451	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	1,376,723	1,356,551	137,672	(1,218,879)	10	137,672	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,376,723	\$ 1,356,551	\$ 137,672	\$ (1,218,879)		\$ 137,672	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,637,855	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,650,456	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,940	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,344,516)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 306,123	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$580,821			3
4	Additions							4
5	Allocated from Saba				11,592			5
6								6
7	TOTAL				\$592,413			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?☐ YES☐ NO
16. Rental Amount for movable equipment: \$826 Description: Medical Equipment Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 140,564	\$		\$ 140,564	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,943			25,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			176,149			176,149	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				63,863		63,863	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					13,431		13,431	12
13	Other (specify):									13
14	TOTAL			\$		\$ 342,656	\$ 77,294		\$ 419,950	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,297,067	\$ 1,297,067	1
2	Cash-Patient Deposits	58,020	58,020	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,502,204	1,502,204	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,530	84,530	6
7	Other Prepaid Expenses	74,062	74,062	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related	276,214	26,214	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,292,097	\$ 3,042,097	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		660,000	13
14	Buildings, at Historical Cost		4,586,132	14
15	Leasehold Improvements, at Historical Cost	15,000	15,000	15
16	Equipment, at Historical Cost	22,855	1,376,723	16
17	Accumulated Depreciation (book methods)	(3,184)	(1,650,640)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 34,671	\$ 4,987,215	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,326,768	\$ 8,029,312	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 79,939	\$ 79,939	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,020	58,020	28
29	Short-Term Notes Payable	949,359	949,359	29
30	Accrued Salaries Payable	213,769	213,769	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,037	20,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,112	75,112	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	116,152	116,152	35
	Other Current Liabilities(specify):			
36	Defered Provider Relief Funds	798,569	798,569	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,310,957	\$ 2,310,957	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,350,000	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)	\$	\$ 6,350,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,310,957	\$ 8,660,957	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,015,811	\$ (631,645)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,326,768	\$ 8,029,312	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 274,761	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 274,761	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,401,050	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	(660,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 741,050	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)	\$ 1,015,811	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Spring Creek

0055608

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,772,955	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,772,955	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,497	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,497	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Stimulus Income</u>	329,328	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 329,328	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,107,780	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	913,606	31
32	Health Care	2,661,640	32
33	General Administration	1,718,676	33
	B. Capital Expense		
34	Ownership	663,776	34
	C. Ancillary Expense		
35	Special Cost Centers	488,266	35
36	Provider Participation Fee	260,766	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,706,730	40
41	Income before Income Taxes (line 30 minus line 40)**	1,401,050	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,401,050	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,016,030	44
45	Private Pay - Net Inpatient Revenue	166,660	45
46	Medicare - Net Inpatient Revenue	2,504,641	46
47	Other-(specify) <u>Insurance</u>	350	47
48	Other-(specify) <u>Med B</u>	85,274	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,772,955	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash basis 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	2,035	2,083	\$ 114,983	\$ 55.20	1
2	Assistant Director of Nursing	2,808	2,995	80,160	26.76	2
3	Registered Nurses	13,059	13,527	525,128	38.82	3
4	Licensed Practical Nurses	24,368	25,154	756,775	30.09	4
5	CNAs & Orderlies	43,510	44,785	679,692	15.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,134	1,154	29,510	25.57	8
9	Activity Director	1,664	1,760	34,233	19.45	9
10	Activity Assistants	4,115	4,315	54,043	12.52	10
11	Social Service Workers	2,372	2,492	50,798	20.38	11
12	Dietician					12
13	Food Service Supervisor	2,200	2,248	47,692	21.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,003	12,389	174,000	14.04	15
16	Dishwashers					16
17	Maintenance Workers	7,244	7,563	113,963	15.07	17
18	Housekeepers	8,229	8,420	138,946	16.50	18
19	Laundry	3,090	3,222	42,701	13.25	19
20	Administrator	2,051	2,083	97,175	46.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,494	10,005	191,294	19.12	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	498	498	8,121	16.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,874	144,693	\$ 3,139,214 *	\$ 21.70	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,769	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	116,383	10-3	38
39	Pharmacist Consultant	Monthly	8,950	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				44
45	Social Service Consultant	52	2,600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	52	\$ 150,702		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of Illinois 23,280

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(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? _____

(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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,908 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. _____

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 260,766
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
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. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.