

Facility Name & ID Number The Springs at Crystal Lake

0051284 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,405</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>97</u>	TOTALS	<u>97</u>	<u>35,405</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>276</u>	<u>3,270</u>	<u>17,972</u>	<u>21,518</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>276</u>	<u>3,270</u>	<u>17,972</u>	<u>21,518</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.78%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 2/1/2011

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

YES Date 2/1/2011 NO

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

YES NO If YES, enter number of beds certified 97 and days of care provided 15,732

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

The Springs at Crystal Lake

0051284

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	348,034	26,696		374,730		374,730		374,730		1
2	Food Purchase		198,840		198,840		198,840	(3,304)	195,536		2
3	Housekeeping	181,296	32,217		213,513		213,513		213,513		3
4	Laundry	52,247	8,976		61,223		61,223		61,223		4
5	Heat and Other Utilities			97,519	97,519		97,519		97,519		5
6	Maintenance	59,699	38,037	84,788	182,524		182,524		182,524		6
7	Other (specify):*										7
8	TOTAL General Services	641,276	304,766	182,307	1,128,349		1,128,349	(3,304)	1,125,045		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	2,487,252	198,948	15,500	2,701,700		2,701,700	21,820	2,723,520		10
10a	Therapy										10a
11	Activities	86,033	3,921	11,326	101,280		101,280	1,092	102,372		11
12	Social Services	88,491		512	89,003		89,003	288	89,291		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,661,776	202,869	38,138	2,902,783		2,902,783	23,200	2,925,983		16
	C. General Administration										
17	Administrative	156,820		548,309	705,129		705,129		705,129		17
18	Directors Fees										18
19	Professional Services			175,812	175,812		175,812	(66,448)	109,364		19
20	Dues, Fees, Subscriptions & Promotions			41,735	41,735		41,735	(1,199)	40,536		20
21	Clerical & General Office Expenses	358,943	14,361	39,376	412,680		412,680	(127,965)	284,715		21
22	Employee Benefits & Payroll Taxes			565,443	565,443		565,443		565,443		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,319	3,319		3,319		3,319		24
25	Other Admin. Staff Transportation			7,791	7,791		7,791		7,791		25
26	Insurance-Prop.Liab.Malpractice			88,521	88,521		88,521		88,521		26
27	Other (specify):*										27
28	TOTAL General Administration	515,763	14,361	1,470,306	2,000,430		2,000,430	(195,611)	1,804,819		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,818,815	521,996	1,690,751	6,031,562		6,031,562	(175,715)	5,855,847		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.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			91,018	91,018	91,018	290,399	381,417				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			864	864	864	427,301	428,165				32
33	Real Estate Taxes						139,636	139,636				33
34	Rent-Facility & Grounds			840,000	840,000	840,000	(840,000)					34
35	Rent-Equipment & Vehicles			44,876	44,876	44,876		44,876				35
36	Other (specify):*											36
37	TOTAL Ownership			976,758	976,758	976,758	17,336	994,094				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		817,010	1,728,372	2,545,382	2,545,382		2,545,382				39
40	Barber and Beauty Shops		7,878		7,878	7,878		7,878				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,284	88,284	88,284		88,284				42
43	Other (specify):* Non-Allowable Co			131,194	131,194	131,194	(131,194)					43
44	TOTAL Special Cost Centers		824,888	1,947,850	2,772,738	2,772,738	(131,194)	2,641,544				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,818,815	1,346,884	4,615,359	9,781,058	9,781,058	(289,573)	9,491,485				45

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

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,304)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,495)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	65,639	30		9
10	Interest and Other Investment Income	(210)	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	(72)	43		18
19	Entertainment				19
20	Contributions	(13,519)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(41,473)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,018)	43		24
25	Fund Raising, Advertising and Promotional	(8,532)	43		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 See Page 5A	(182,496)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,480)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,093)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,093)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (289,573)		37

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

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

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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Labs - Part A	\$ (27,122)	43	1
2	X-Rays - Part A	(24,955)	43	2
3	Misc Income	(8,712)	21	3
4	Chamber of Commerce Dues	(680)	20	4
5	Non Allowable Advertising Costs	(2,614)	21	5
6	Non Allowable Marketing Salaries	(118,413)	21	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		(182,496)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Jeremias	10	Community Nursing & Rehabilitation Center, LLC	Naperville	Pine Acres Realty,	DeKalb	Real Estate
Mark Weldler	35	Pine Acres Living & Rehab Center, LLC	DeKalb	LLC		
				Community Nursing and Rehab Realty,	Naperville	Real Estate
				LLC		
				TS Realty, LLC	Crystal Lake	Real Estate

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	20 Licenses	\$	TS Realty, LLC		\$ 13,000	\$ 13,000	1
2	V	30 Depreciation		TS Realty, LLC		224,760	224,760	2
3	V	32 Interest	2,953	TS Realty, LLC		430,464	427,511	3
4	V	33 Real Estate Taxes		TS Realty, LLC		139,636	139,636	4
5	V	34 Rent Expense	840,000	TS Realty, LLC			(840,000)	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		\$ 842,953			\$ 807,860	\$ * (35,093)	14

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Mark Weldler	Manager	Finance	35.00	See Sch 7A	5	10.00	Guar Payment	\$ 548,309	L17, C3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 548,309		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 The Springs at Crystal Lake

0051284 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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 N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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		N/A							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

The Springs at Crystal Lake

0051284

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Lake Forest Bank		X	Building	Varies	2/1/2011	\$ 5,340,000	\$ 5,340,000	6/1/15	0.0625	\$ 338,385	1						
2	Lake Forest Bank		X	Bridge Loan	Varies	2/1/2011	1,335,000	1,335,000	6/1/15	0.0237	32,079	2						
3	GMC		X	Vehicle	\$720.23	9/15/2011	39,812	6,357	9/15/16	0.0324	355	3						
4	Ford		X	Vehicle	\$809.00	2/15/2011	40,906	1,949	3/15/16	0.0720	509	4						
5												5						
Working Capital																		
6	Bassman Trust		X	Working Capital	Varies	2/1/2011	1,500,000		6/1/15	0.0800	60,000	6						
7												7						
8												8						
9	TOTAL Facility Related				\$1,529.23		\$ 8,255,718	\$ 6,683,306			\$ 431,328	9						
B. Non-Facility Related*																		
10											Disallow Nonallowable Interest Expense	(3,163)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$ (3,163)	14						
15	TOTALS (line 9+line14)						\$ 8,255,718	\$ 6,683,306			\$ 428,165	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2014 report.		\$ 138,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2014	\$ 136,636	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,364)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 141,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 139,636	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	<u>87,310</u>	8
	2011	<u>120,315</u>	9
	2012	<u>129,981</u>	10
	2013	<u>134,314</u>	11
	2014	<u>136,636</u>	12
FY14 RE Taxes X 103% = 136,636 X 103% = 140,735			
Use 141,000			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Springs at Crystal Lake, LLC COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051284

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (815) 477-6400 FAX #: (815) 477-6569

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>14-27-201-007</u>	<u>Nursing Home</u>	\$ <u>136,635.90</u>	\$ <u>136,635.90</u>
2.	<u>14-27-201-008</u>	<u>Land</u>	\$ <u>12,338.18</u>	\$ _____
3.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
4.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
5.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
6.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
7.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
8.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
9.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
10.	<u>_____</u>	<u>_____</u>	\$ _____	\$ _____
		TOTALS	\$ <u><u>148,974.08</u></u>	\$ <u><u>136,635.90</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 33,873 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Use</u>	<u>172,933</u>	<u>2011</u>	<u>\$ 225,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	172,933		\$ 225,000	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	97	2011	1989	\$ 5,730,339	\$	40	\$ 143,258	\$ 143,258	\$ 638,691	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Telephone and Computer Wiring	2011		43,312	4,331	10	4,331		19,490	9
10	Furnace	2011		4,900	490	10	490		2,205	10
11	Water Heater	2011		6,950	695	10	695		3,128	11
12										12
13	Sprinkler system valve	2012		6,579	658	10	658		2,303	13
14	Replaced compressor	2013		3,474	347	10	347		868	14
15	Install fire alarm system	2013		4,665	467	10	467		1,167	15
16	Install 5 ton AC unit	2013		4,136	414	10	414		1,035	16
17	Break tank system	2013		15,990	1,599	10	1,599		3,998	17
18	Ejector pump	2013		3,596	360	10	360		900	18
19	Galvanized Steel Door	2013		2,902	290	10	290		725	19
20										20
21	Compressor Replacement for walk in Freezer - Kitchen	2014		5,853	585	10	585		878	21
22	Remove and replace thermostats - Resident Room:	2014		3,311	331	10	331		497	22
23	Replaced leaking RPZ valve - Mechanical room	2014		3,116	312	10	312		468	23
24	Replaced evaporator for walk in freezer - Kitchen	2014		4,764	476	10	476		714	24
25	Exterior Paint - Building Exterior	2014		4,614	461	10	461		692	25
26	Dialysis Project-Concrete, Carpentry, Millwork, Doors,	2014		170,539	17,054	10	17,054		25,581	26
27	Frames, Painting, Roofing, Flooring, Fire Protection,									27
28	Plumbing, HVAC, Electrical & Labor									28
29	Mass Grading-Permits, Tree Removal, Silt Fencing, Blueprints,	2014		161,393	16,139	10	16,139		24,209	29
30	Engineering, Dewatering, Discing, Earthwork Labor,									30
31	Storm Sewer Material & Labor									31
32	Corridor/Nurse Station/Room Remodel-Handrails, Wood	2014		904,043	90,404	10	90,404		135,606	32
33	Trim, Acoustic Ceiling, Toilet Acc., Marble Sills, Doors,									33
34	Blinds, Lights, Cabinetry, Solid Surface Tops, Flooring									34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Springs at Crystal Lake

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	
37	Sealcoat and hot crack filler for main roadway, front parking lot, f	2015	\$ 5,170	\$ 259	10	\$ 259	\$	\$ 259	37
38	Sprinkler repair/replace parts (Total)	2015	24,574	1,229	10	1,229		1,229	38
39	Demo, drywall, carpentry, doors, flooring, paint - Library	2015	79,397	3,970	10	3,970		3,970	39
40	Demo, carpeting, trim & stain-Dir/HR/MR Offices & Reception	2015	15,200	760	10	760		760	40
41	New light pole in parking lot	2015	2,517	126	10	126		126	41
42	Hot water heater	2015	3,586	179	10	179		179	42
43	Replaced ejector pit pump	2015	4,471	224	10	224		224	43
44									44
45									45
46									46
47									47
48	Reconcile to Financials			(92,675)			92,675		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)		\$ 7,219,391	\$ 49,484		\$ 285,417	\$ 235,933	\$ 869,901	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	\$ 739,729	\$ 21,011	\$ 75,477	\$ 54,466	5-10	\$ 306,813	71
72	Current Year Purchases	56,005	4,063	4,063		5-10	4,063	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 795,734	\$ 25,074	\$ 79,540	\$ 54,466		\$ 310,876	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	Ford E250 2009	2011	\$ 41,990	\$ 8,398	\$ 8,398		5	\$ 37,442	76
77	Facility Use	GMC Truck 2011	2011	40,312	8,062	8,062		5	35,943	77
78										78
79										79
80	TOTALS			\$ 82,302	\$ 16,460	\$ 16,460			\$ 73,385	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,322,428	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,018	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 381,417	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 290,399	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,254,162	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 322,037	92
93			93
94			94
95		\$ 322,037	95

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

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

Facility Name & ID Number The Springs at Crystal Lake

0051284

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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 _____.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 44,876 Description: Nursing & Medical Eq \$20,698; Dietary Eq \$1,440; Maintenance Equipment \$3,372; Copier Equip. \$19,366

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	9,117	\$ 656,407	\$	9,117	\$ 656,407	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,718	195,695		2,718	195,695	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(3)	hrs		11,581	833,825		11,581	833,825	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				800,026		800,026	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Oxygen</u>	39(2)					16,984		16,984	12	
13	Other (specify): <u>Dialysis</u>	39(3)				42,445			42,445	13	
14	TOTAL			\$	23,416	\$ 1,728,372	\$ 817,010	23,416	\$ 2,545,382	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Springs at Crystal Lake

0051284

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 581,482	\$ 582,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>82,666</u>)	1,828,092	1,828,092	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,825	54,825	6
7	Other Prepaid Expenses	74,465	168,753	7
8	Accounts Receivable (owners or related parties)	260,000	481,953	8
9	Other(specify): <u>Prepaid Deposits</u>		40,874	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,798,864	\$ 3,156,947	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		225,000	13
14	Buildings, at Historical Cost		5,730,339	14
15	Leasehold Improvements, at Historical Cost	516,961	1,489,052	15
16	Equipment, at Historical Cost	347,820	878,036	16
17	Accumulated Depreciation (book methods)	(232,028)	(1,254,162)	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) <u>See Sch 17A</u>	284,681	363,676	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 917,434	\$ 7,431,941	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,716,298	\$ 10,588,888	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 660,675	\$ 660,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,404	87,404	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,072	4,072	31
32	Accrued Real Estate Taxes(Sch.IX-B)		141,000	32
33	Accrued Interest Payable		31,464	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	483,329	610,226	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,235,480	\$ 1,534,841	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	36,306	6,711,306	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 36,306	\$ 6,711,306	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,271,786	\$ 8,246,147	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,444,512	\$ 2,342,741	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,716,298	\$ 10,588,888	48

*(See instructions.)

Facility Name: The Springs at Crystal Lake, LLC
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/2015

Schedule 17A

XV. Balance Sheet

Line 22 Other Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
Construction in Progress	284,681	322,037
Organizational Fees	-	62,674
Accum Amort-Org Fees	-	(21,035)
Total - Line 22	284,681	363,676

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Accrued Management Fees	437,235	437,235
Loans - Members	-	2,350
Accrued Assessment Fee #2	6,562	6,562
Insurance Payable	22,434	22,434
Due To/from AdminStar	(12,961)	(12,961)
Resident Credit Balances	54,858	54,858
Due To / from Primary Insurance	-	-
Due to/from BC-BS	75,229	75,229
Due to/from Hospice	-	-
Due To/From CNRC	24,519	24,519
Due To/from TS Realty	(124,547)	-
Total - Line 36	483,329	610,226

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,721,122	1
2	Restatements (describe):		2
3	Prior Period Adjustments	9,982	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,731,104	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,194,242	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	(480,834)	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)	\$ 713,408	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,444,512	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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,277,729	1
2	Discounts and Allowances for all Levels	(1,426,056)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,851,673	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,875,779	6
7	Oxygen	28,233	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,904,012	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	187	12
13	Barber and Beauty Care	3,931	13
14	Non-Patient Meals	3,304	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	783,418	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	137,724	19
20	Radiology and X-Ray	26,314	20
21	Other Medical Services	246,042	21
22	Laundry	8,558	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,209,478	23
D. Non-Operating Revenue			
24	Contributions	206	24
25	Interest and Other Investment Income***	210	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 416	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	9,721	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,721	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,975,300	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,128,349	31
32	Health Care	2,902,783	32
33	General Administration	2,000,430	33
B. Capital Expense			
34	Ownership	976,758	34
C. Ancillary Expense			
35	Special Cost Centers	2,684,454	35
36	Provider Participation Fee	88,284	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,781,058	40
41	Income before Income Taxes (line 30 minus line 40)**	1,194,242	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,194,242	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 53,779	44
45	Private Pay - Net Inpatient Revenue	4,484,397	45
46	Medicare - Net Inpatient Revenue	1,322,834	46
47	Other-(specify) <u>Managed Care</u>	(9,337)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,851,673	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^ - This entity is a cash basis taxpayer

Facility Name: The Springs at Crystal Lake
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/2015

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Equipment Rental	350
Equipment Rental	659
Misc Income	8,712
Total - Line 28	<u><u>9,721</u></u>

Facility Name & ID Number The Springs at Crystal Lake

0051284

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	1,596	1,727	\$ 75,971	\$ 43.99	1
2	Assistant Director of Nursing	655	728	27,158	37.30	2
3	Registered Nurses	25,942	27,811	805,328	28.96	3
4	Licensed Practical Nurses	15,976	17,188	540,912	31.47	4
5	CNAs & Orderlies	52,291	55,753	719,881	12.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,984	2,180	44,368	20.35	9
10	Activity Assistants	3,632	3,941	41,665	10.57	10
11	Social Service Workers	3,648	3,999	88,491	22.13	11
12	Dietician	1,952	2,160	57,923	26.82	12
13	Food Service Supervisor	2,084	2,190	53,682	24.51	13
14	Head Cook	8,037	9,501	116,862	12.30	14
15	Cook Helpers/Assistants	13,020	13,412	119,567	8.91	15
16	Dishwashers					16
17	Maintenance Workers	2,645	2,797	59,699	21.34	17
18	Housekeepers	16,163	17,643	181,296	10.28	18
19	Laundry	3,721	4,169	52,247	12.53	19
20	Administrator	2,344	2,672	156,820	58.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,717	3,130	43,861	14.01	23
24	Clerical	8,758	9,227	129,328	14.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,003	2,261	25,134	11.12	31
32	Other Health C: See Sch 20A	8,332	9,309	292,868	31.46	32
33	Other(specify) See Sch 20A	6,431	7,053	185,754	26.34	33
34	TOTAL (lines 1 - 33)	183,931	198,851	\$ 3,818,815 *	\$ 19.20	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			35
36	Medical Director	Monthly	10,800	9(3) 36
37	Medical Records Consultant	13	840	10(3) 37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	24	1,628	11(3) 44
45	Social Service Consultant	11	800	12(3) 45
46	Other(specify) <u>MDS Consultant</u>	310	15,500	10(3) 46
47				47
48				48
49	TOTAL (lines 35 - 48)	358	\$ 29,568	49

C. CONTRACT NURSES

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

Facility Name: The Springs at Crystal Lake
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS	3,738	4,219	146,695	\$ 34.77
Restorative Aide	2,528	2,865	71,083	\$ 24.81
Transitional Care Coordinator	2,065	2,225	75,090	\$ 33.74
Total - Line 32 Other Health Care (specify):	8,332	9,309	292,868	\$ 31.46

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Sales & Marketing / Admissions	2,000	2,247	118,413	\$ 52.70
Ancillary/Purchasing	2,561	2,834	39,710	\$ 14.01
AH Coor & AP/HR Coor	1,870	1,972	27,631	\$ 14.01
Total - Line 33 Other (specify):	6,431	7,053	185,754	\$ 26.34

Facility Name: The Springs at Crystal Lake
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Singer Networks LLC	Computer Services	23,930
Telemedicine Solutions	Health Information Technology Services	6,000
Allscripts	EHR Services	3,210
JCAHO Survey	Accreditation/Survey Services	6,410
ICHA	Illinois Catholic Health Association Fees	125
Personnel Planners, Inc.	Human Resources Services	1,908
MDI Achieve	EHR Solutions Services	20,980
HealthPRO Rehabilitation	Activities and Social Services Consultation	1,380
SAS Architects	Architecture and Planning Services	(1,032)
		<u>62,911</u>
	Total (agree to Schedule V, line 19, column 3)	<u>175,812</u>
		(2,614)
Less : Nonallowable Advertising		(41,473)
Less: Non-Allowable Legal Fees and Other Professional Fees		(22,361)
Less: Reclassifications to Purchased Services		<u>109,364</u>
	Total (agree to Schedule V, line 19, column 8)	<u>109,364</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number The Springs at Crystal Lake# 0051284Report Period Beginning: 01/01/2015Ending: 12/31/2015**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. IL Council on LTC - \$20,662
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,443 Line 10(2)
- (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. \$ 88,284
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? Yes Indicate the amount. \$ 3,304
- (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? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.