



Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

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

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 7/1/16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	168	46,200	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)		15,288	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,228	2,263	4,578	16,069	8
9	SNF/PED					9
10	ICF	7,217	1,762		8,979	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,445	4,025	4,578	25,048	14

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

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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

YES  NO

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

Date started 04/01/2014

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

YES  Date 04/01/2014 NO

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

YES  NO  If YES, enter number of beds certified 168 and days of care provided 3,583

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	210,324	43,197	8,633	262,154		262,154	94	262,248		1
2	Food Purchase		156,038		156,038		156,038	(1,192)	154,846		2
3	Housekeeping	145,084	42,543		187,627		187,627	522	188,149		3
4	Laundry	11,772	12,213		23,985		23,985		23,985		4
5	Heat and Other Utilities			81,836	81,836		81,836	729	82,565		5
6	Maintenance	39,829	129	161,494	201,452		201,452	(1,174)	200,278		6
7	Other (specify):*							427	427		7
8	<b>TOTAL General Services</b>	<b>407,009</b>	<b>254,120</b>	<b>251,963</b>	<b>913,092</b>		<b>913,092</b>	<b>(593)</b>	<b>912,499</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,651,002	231,219	44,535	1,926,756		1,926,756		1,926,756		10
10a	Therapy	108,024			108,024		108,024		108,024		10a
11	Activities	123,210	21,385		144,595		144,595		144,595		11
12	Social Services	199,755			199,755		199,755		199,755		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,081,991</b>	<b>252,604</b>	<b>56,535</b>	<b>2,391,130</b>		<b>2,391,130</b>		<b>2,391,130</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	317,858			317,858		317,858	10,198	328,056		17
18	Directors Fees										18
19	Professional Services			326,037	326,037	(467)	325,570	(143,601)	181,969		19
20	Dues, Fees, Subscriptions & Promotions			99,753	99,753		99,753	(59,089)	40,664		20
21	Clerical & General Office Expenses	79,049	21,357	441,917	542,323		542,323	(378,757)	163,566		21
22	Employee Benefits & Payroll Taxes			518,815	518,815		518,815	(3,190)	515,625		22
23	Inservice Training & Education										23
24	Travel and Seminar			300	300		300	78	378		24
25	Other Admin. Staff Transportation			1,051	1,051		1,051	527	1,578		25
26	Insurance-Prop.Liab.Malpractice			152,081	152,081		152,081	912	152,993		26
27	Other (specify):*							14,114	14,114		27
28	<b>TOTAL General Administration</b>	<b>396,907</b>	<b>21,357</b>	<b>1,539,954</b>	<b>1,958,218</b>	<b>(467)</b>	<b>1,957,751</b>	<b>(558,809)</b>	<b>1,398,942</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,885,907</b>	<b>528,081</b>	<b>1,848,452</b>	<b>5,262,440</b>	<b>(467)</b>	<b>5,261,973</b>	<b>(559,402)</b>	<b>4,702,571</b>		<b>29</b>

\*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.

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

#0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	
	<b>D. Ownership</b>											
30	Depreciation			17,226	17,226		17,226	302,561	319,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,967	6,967		6,967	4,222	11,189			32
33	Real Estate Taxes			99,081	99,081	467	99,548	2,127	101,675			33
34	Rent-Facility & Grounds			301,367	301,367		301,367	(300,000)	1,367			34
35	Rent-Equipment & Vehicles			811	811		811	498	1,309			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			425,452	425,452	467	425,919	9,408	435,327			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,748	519,805	657,553		657,553		657,553			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,984	206,984		206,984		206,984			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		137,748	726,789	864,537		864,537		864,537			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,885,907	665,829	3,000,693	6,552,429		6,552,429	(549,994)	6,002,435			45

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	161,627	30		9
10	Interest and Other Investment Income	(193)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(250)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,360)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(430,202)	21		24
25	Fund Raising, Advertising and Promotional	(52,831)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,438)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (348,647)		\$	30

**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)	(201,347)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (201,347)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (549,994)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Spring Creek Nsg & Rehab Ctr

ID# 0052613

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,423)	21	1
2	Theft Loss	(111)	21	2
3	Collection Expense	(2,665)	21	3
4	Vending Income	(1,145)	02	4
5	PAC Dues	(608)	20	5
6	Annual Report	(250)	20	6
7	Non-allowable Legal	(7,444)	19	7
8	Lobbying	(2,535)	20	8
9	Capitalized R&M	(7,258)	06	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(23,438)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			94									94	1
2	Food Purchase	(1,395)		203									(1,192)	2
3	Housekeeping			522									522	3
4	Laundry													4
5	Heat and Other Utilities			729									729	5
6	Maintenance	(7,258)		1,522	4,561								(1,174)	6
7	Other (specify):*				427								427	7
8	<b>TOTAL General Services</b>	<b>(8,653)</b>		<b>3,071</b>	<b>4,989</b>								<b>(593)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,524	8,674								10,198	17
18	Directors Fees													18
19	Professional Services	(7,444)		(136,158)									(143,601)	19
20	Fees, Subscriptions & Promotions	(59,584)		495									(59,089)	20
21	Clerical & General Office Expenses	(434,401)		3,070	52,574								(378,757)	21
22	Employee Benefits & Payroll Taxes				(3,190)								(3,190)	22
23	Inservice Training & Education													23
24	Travel and Seminar			78									78	24
25	Other Admin. Staff Transportation			527									527	25
26	Insurance-Prop.Liab.Malpractice			912									912	26
27	Other (specify):*				14,114								14,114	27
28	<b>TOTAL General Administration</b>	<b>(501,428)</b>		<b>(129,552)</b>	<b>72,172</b>								<b>(558,809)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(510,081)</b>		<b>(126,481)</b>	<b>77,160</b>								<b>(559,402)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	161,627	139,718	1,216									302,561	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(193)		4,415									4,222	32
33	Real Estate Taxes			2,127									2,127	33
34	Rent-Facility & Grounds		(300,000)										(300,000)	34
35	Rent-Equipment & Vehicles			498									498	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>161,434</b>	<b>(160,282)</b>	<b>8,256</b>									<b>9,408</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(348,647)</b>	<b>(160,282)</b>	<b>(118,225)</b>	<b>77,160</b>								<b>(549,994)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 300,000	Hillcrest Realty, LLC	100.00%	\$		\$ (300,000) 1
2	V	30 Depreciation Expense		Hillcrest Realty, LLC	100.00%	139,718		139,718 2
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 300,000			\$ 139,718	\$ *	(160,282) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 94	\$	94	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	203		203	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	522		522	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	729		729	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	1,522		1,522	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,524		1,524	20
21	V	19 Professional Fees	139,200	Extended Care Consulting, LLC	100.00%	3,042		(136,158)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	495		495	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	3,070		3,070	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	78		78	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	527		527	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	912		912	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,216		1,216	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	4,415		4,415	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,127		2,127	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	498		498	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		\$ 139,200			\$ 20,975	\$ *	(118,225)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,561	\$	4,561	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	427		427	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,674		8,674	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	52,566		52,566	22
23	V	21 Office and Clerical (Direct)	10,626	Extended Care Consulting, LLC	100.00%	10,634		8	23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,201		11,201	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,913		2,913	25
26	V	22 Employee Benefits	3,190	Extended Care Consulting, LLC	100.00%			(3,190)	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		\$ 13,816			\$ 90,976	\$ *	77,160	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 151,350	\$ 151,350	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	151,350	CCS Employee Benefits Group	100.00%		(151,350)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 151,350			\$ 151,350	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





Facility Name &amp; ID Number

Spring Creek Nsg &amp; Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Charles Slagle	Administrator	Owner	20.00%	None	40	100.00%	Salary	\$ 153,533	17-01	1	
2	Adam Vales	Relative	Clerical	0%	See Attached	0.77	1.92%	Alloc. Salary	1,410	22-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 154,943		13	

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

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	06	Maintenance (Pooled)	Patient Days	34	251,431	251,431	25,048	\$ 4,561	1
2	06	Maintenance (Direct)	Direct	20	373,682	373,682			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	23,565		25,048	427	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	20	46,748				4
5									5
6									6
7	17	Administrative (Pooled)	Patient Days	34	478,172	478,172	25,048	8,674	7
8	21	Office and Clerical (Pooled)	Patient Days	34	2,897,656	2,897,656	25,048	52,566	8
9	21	Office and Clerical (Direct)	Direct	24	460,382	460,382		10,634	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	617,434		25,048	11,201	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	24	73,413			2,913	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,222,483	\$ 4,461,323		\$ 90,976	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 151,350	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 151,350	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

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

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5				-																
<b>Working Capital</b>																				
6	Notes Payable		X	Furniture and Equipment				16,404		6,967										
7	Hillcrest Realty	X		Notes Payable				36,825												
8					-															
9	<b>TOTAL Facility Related</b>							\$ 53,229		\$ 6,967										
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(193)										
11	Allocated - Consulting LLC	X								4,415										
12																				
13					-															
14	<b>TOTAL Non-Facility Related</b>									\$ 4,222										
15	<b>TOTALS (line 9+line14)</b>							\$ 53,229		\$ 11,189										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

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

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

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

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

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

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





**IMPORTANT NOTICE**

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

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

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

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

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Spring Creek Nsg & Rehab Ctr COUNTY Will  
 FACILITY IDPH LICENSE NUMBER 0052613  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

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

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
<b>TOTALS</b>			\$ <hr/> <hr/>	\$ <hr/> <hr/>

**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            NO

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

**C. Tax Bills**

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

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613 Report Period Beginning:

01/01/16 Ending:

12/31/16

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.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Rows include Facility (132,928 sq ft, 2007, \$336,000), Allocated - Care Centers Building, LLC (10,410), and TOTALS (132,928, \$346,410).

**XI. OWNERSHIP COSTS (continued)**

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

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

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,892,656	\$ 157,652		\$ 265,067	\$ 107,415	\$ 2,750,175	1
2	Installation Of New Emg Panel	2015	4,560		20	228	228	456	2
3	Installed 6 Delayed Egress Magnetic Lock On 2Nd Floor	2016	13,586		20	1,359	1,359	1,359	3
4	Double Face, Pole Illuminated, Pylon Sign	2016	15,400		20	1,540	1,540	1,540	4
5	Floor Covering	2016	11,732		20	587	587	587	5
6	Kimona Silk Mosaic Tile	2016	31,577		20	1,579	1,579	1,579	6
7	New Haven & Oasis Tile	2016	11,289		20	564	564	564	7
8	Installed Self Regulating Roof/Gutter Heating Cable To 25 Down S	2016	11,653		20	583	583	583	8
9	Custom Flooring Materials	2016	59,774		20	2,989	2,989	2,989	9
10	Installed 42 Vanity Tops In Resident Rooms 201-240, Nurse Statio	2016	23,730		20	1,187	1,187	1,187	10
11	Second Floor Sprinkler Renovations	2016	3,395		20	170	170	170	11
12	Counter Tops For 2Nd Floor Nurses Station, Dining Room, & Acti	2016	32,500		20	1,625	1,625	1,625	12
13	2Nd Floor Nw Doors & Installation	2016	3,180		20	159	159	159	13
14	Install 2 Dura Glide Automatic Sliding Door Assemblies	2016	9,500		20	475	475	475	14
15	2Nd Floor Resident Rooms/Corridors/Showers Flooring	2016	119,525		20	5,976	5,976	5,976	15
16	Architect Fees For Facility Remodeling Projects	2016	6,175		20	309	309	309	16
17	Labor For Floor Installation In Resident Rooms And Hallways	2016	32,363		20	1,618	1,618	1,618	17
18	Installed Call Light Switch, New Panels, And 3 Fax Lines	2016	4,149		20	207	207	207	18
19	Installed Wall Air Conditioner	2016	3,109		20	155	155	155	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
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		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,289,853	\$ 157,652		\$ 286,376	\$ 128,725	\$ 2,771,712	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated - Care Centers Building	2002	14,346	368	35	368		5,257	3
4									4
5	Allocated - Extended Care Consulting, LLC	2007	4,354	96	35	96		916	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Extended Care Consulting, LLC	2007	83	4	20	4		42	9
10	Allocated - Extended Care Consulting, LLC	2009	50	2	20	2		20	10
11	Allocated - Extended Care Consulting, LLC	2010	489	24	20	24		171	11
12	Allocated - Extended Care Consulting, LLC	2011	176	9	20	9		53	12
13	Allocated - Extended Care Consulting, LLC	2012	58	3	20	3		15	13
14	Allocated - Extended Care Consulting, LLC	2014	805	40	20	40		121	14
15	Allocated - Extended Care Consulting, LLC	2016	965	48	20	48		48	15
16									16
17	Allocated - Care Centers Building	2002	11,851		20			11,851	17
18	Allocated - Care Centers Building	2003	13,966		20			13,966	18
19	Allocated - Care Centers Building	2005	694	1	20	1		694	19
20	Allocated - Care Centers Building	2009	125	6	20	6		50	20
21	Allocated - Care Centers Building	2014	1,164	58	20	58		175	21
22	Allocated - Care Centers Building	2015	197	10	20	10		20	22
23	Allocated - Care Centers Building	2016	780	39	20	39		39	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 50,103	\$ 708		\$ 708	\$	\$ 33,438	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 50,103	\$ 708		\$ 708	\$	\$ 33,438	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 50,103	\$ 708		\$ 708	\$	\$ 33,438	34

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 86,169	\$ 413	\$ 8,616	\$ 8,203	10	\$ 35,795	71
72	Current Year Purchases	246,992		24,699	24,699	10	24,699	72
73	Fully Depreciated Assets	391,392				10	391,392	73
74								74
75	TOTALS	\$ 724,552	\$ 413	\$ 33,316	\$ 32,903		\$ 451,886	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated - Consulting LLC	2016	\$ 3,274	\$ 92	\$ 92		5	\$ 3,089	76
77										77
78										78
79										79
80	TOTALS			\$ 3,274	\$ 92	\$ 92			\$ 3,089	80

E. Summary of Care-Related Assets

		1 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)	\$ 8,364,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 319,784	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 161,627	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,226,687	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various Improvements	\$ 319,244	92
93			93
94			94
95		\$ 319,244	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off Site Storage				1,367			5
6								6
7	TOTAL				\$ 1,367			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

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: \$ 1,309

Description: See Attached Schedule

(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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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 - 03	hrs					\$ 229,511							\$ 229,511	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					56,406							56,406	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					232,492							232,492	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							114,494					114,494	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): <u>See Supplemental</u>							1,396		23,254					24,650	13
14	<b>TOTAL</b>				\$			\$ 519,805		\$ 137,748				\$	657,553	14

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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 15,646	\$ 15,646	1
2	Cash-Patient Deposits	10,087	10,087	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,892,050	1,892,050	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	201,014	201,014	6
7	Other Prepaid Expenses	7,667	7,667	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	122,080	122,080	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,248,544	\$ 2,248,544	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		336,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	385,379	5,673,379	15
16	Equipment, at Historical Cost	313,192	649,192	16
17	Accumulated Depreciation (book methods)	(31,857)	(2,087,041)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	342,301	342,301	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,009,015	\$ 4,913,831	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,257,559	\$ 7,162,375	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,826,428	\$ 3,226,428	26
27	Officer's Accounts Payable	30,000	30,000	27
28	Accounts Payable-Patient Deposits	10,230	10,230	28
29	Short-Term Notes Payable	16,404	53,229	29
30	Accrued Salaries Payable	187,066	187,066	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,874	13,874	31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,873	103,873	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	104,805	5,205,600	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,292,680	\$ 8,830,300	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	3,400,360	3,400,360	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,400,360	\$ 3,400,360	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,693,040	\$ 12,230,660	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,435,481)	\$ (5,068,285)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,257,559	\$ 7,162,375	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,473,312)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,473,312)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(962,169)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(962,169)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,435,481)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Spring Creek Nsg &amp; Rehab Ctr

# 0052613

Report Period Beginning: 01/01/16

Ending:

12/31/16

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

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,461,463	1
2	Discounts and Allowances for all Levels	(1,803,421)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,658,042	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,905,600	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,905,600	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,705	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,306	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,846	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,857	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	193	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 193	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	2,568	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,568	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,590,260	30

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

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

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Spring Creek Nsg & Rehab Ctr**

# **0052613**

Report Period Beginning:

**01/01/16**

Ending:

**12/31/16**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

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

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

**C. CONTRACT NURSES**

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

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr

# 0052613

Report Period Beginning: 01/01/16

Ending: 12/31/16

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Tasha Mitchell	Administrator		\$ 102,830	Workers' Compensation Insurance	\$ 30,835	IDPH License Fee	\$		
Charles Slagle	Administrator	20	153,533	Unemployment Compensation Insurance	63,235	Advertising: Employee Recruitment	29,758		
Jesse Contreras	Assistant Admin		61,495	FICA Taxes	220,772	Health Care Worker Background Check	1,893		
				Employee Health Insurance	112,359	(Indicate # of checks performed <u>82</u> )			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	3,044		
				Pension Expense	77,690	Licenses and Fees	5,475		
				Other Employee Welfare	3,307	Allocated - Extended Care Consulting	495		
				Holiday Expense	7,426				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 317,858	TOTAL (agree to Schedule V, line 22, col.8)		\$ 515,625	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 40,665
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	300	
C. Professional Services									
Vendor/Payee	Type	Amount							
Matrixcare	E.H.R.	\$ 43,104					Allocated - Extended Care Consulting		78
Legat Architects	Architecture Consultant	3,729					Entertainment Expense		( )
Pinnacle Quality Insight	Customer Satisfaction	975					(agree to Sch. V, line 24, col. 8)		
Ron Cournaya	Accounting Fees	2,500					TOTAL		\$ 378
Personnel Planners	Unemployment Consultant	1,143							
Legal	See Attached	89,709							
Marcum	Accounting Fees	19,500							
ECC Consulting	Bookkeeping Fees	139,200							
Paycor	Payroll Services	17,979							
Ability Network	Medicare Billing	6,248							
National Datacare Corp	Resident Fund Processing	1,948							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 326,035						

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Spring Creek Nsg & Rehab Ctr# 0052613

Report Period Beginning:

01/01/16

Ending:

12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$1,170 and IHCA \$561
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 95 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 206,984  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees