

Facility Name & ID Number The Springs at Crystal Lake, LLC

0051284 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	97	Skilled (SNF)	97	35,405	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	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,072	2,419	14,792	18,283	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	1,072	2,419	14,792	18,283	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.64%

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

0 (Do not include bed reserve days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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 12,587

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: 12/31/2017 Fiscal Year: 12/31/2017

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

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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	368,089	19,868	-	387,957		387,957	-	387,957		1
2	Food Purchase		165,832		165,832		165,832	(605)	165,227		2
3	Housekeeping	198,705	26,572	-	225,277		225,277	-	225,277		3
4	Laundry	42,573	8,866	-	51,439	-	51,439	-	51,439		4
5	Heat and Other Utilities			99,808	99,808		99,808	-	99,808		5
6	Maintenance	62,548	30,880	91,029	184,457		184,457	-	184,457		6
7	Other (specify):*	-	-	-	-		-	-	-		7
8	TOTAL General Services	671,915	252,018	190,837	1,114,770	-	1,114,770	(605)	1,114,165		8
	B. Health Care and Programs										
9	Medical Director	-	-	10,800	10,800		10,800	-	10,800		9
10	Nursing and Medical Records	2,297,378	119,504	450	2,417,332		2,417,332	27,216	2,444,548		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	90,530	2,972	12,573	106,075		106,075	-	106,075		11
12	Social Services	95,674	-	864	96,538		96,538	-	96,538		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):*	-	-	-	-		-	-	-		15
16	TOTAL Health Care and Programs	2,483,582	122,476	24,687	2,630,745	-	2,630,745	27,216	2,657,961		16
	C. General Administration										
17	Administrative	150,931	-	464,907	615,838		615,838	(416,275)	199,563		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			132,901	132,901		132,901	(32,072)	100,829		19
20	Dues, Fees, Subscriptions & Promotions			28,333	28,333		28,333	(4,698)	23,635		20
21	Clerical & General Office Expenses	236,045	13,234	41,766	291,045		291,045	(6,361)	284,684		21
22	Employee Benefits & Payroll Taxes			584,669	584,669		584,669	-	584,669		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			4,770	4,770		4,770	-	4,770		24
25	Other Admin. Staff Transportation		-	8,813	8,813		8,813	-	8,813		25
26	Insurance-Prop.Liab.Malpractice			112,624	112,624		112,624	18,847	131,471		26
27	Other (specify):*	-	-	-	-		-	-	-		27
28	TOTAL General Administration	386,976	13,234	1,378,783	1,778,993	-	1,778,993	(440,559)	1,338,434		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,542,473	387,728	1,594,307	5,524,508	-	5,524,508	(413,948)	5,110,560		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.

Facility Name & ID Number The Springs at Crystal Lake, LLC

#0051284

Report Period Beginning:

1/1/17

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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			90,967	90,967		90,967	293,726	384,693			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			-	-		-	305,234	305,234			32
33	Real Estate Taxes			-	-		-	135,844	135,844			33
34	Rent-Facility & Grounds			707,544	707,544		707,544	(707,544)	-			34
35	Rent-Equipment & Vehicles			40,100	40,100		40,100	-	40,100			35
36	Other (specify):* Mortgage Ins			-	-		-	53,601	53,601			36
37	TOTAL Ownership			838,611	838,611	-	838,611	80,861	919,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	674,485	1,463,490	2,137,975		2,137,975	-	2,137,975			39
40	Barber and Beauty Shops	-	6,612	-	6,612		6,612	(3,273)	3,339			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			87,719	87,719		87,719	-	87,719			42
43	Other (specify):* Non-Allowable Cos	170,646	-	190,106	360,752		360,752	(360,752)	-			43
44	TOTAL Special Cost Centers	170,646	681,097	1,741,315	2,593,058	-	2,593,058	(364,025)	2,229,033			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,713,119	1,068,825	4,174,233	8,956,177	-	8,956,177	(697,112)	8,259,065			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(605)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,815)	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	46,442	30		9
10	Interest and Other Investment Income	(602)	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				18
19	Entertainment	(188)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,856)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(16,576)	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	(696,780)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (750,980)		\$	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)	53,868		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 53,868		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (697,112)		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

The Springs at Crystal Lake, LLC

ID# 0051284

Report Period Beginning: 1/1/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (27,625)	43	1
2	X-Rays - Part A	(19,415)	43	2
3	Misc Income	(6,361)	21	3
4	Chamber of Commerce Dues	(745)	20	4
5	Non Allowable Marketing Salaries	(170,646)	43	5
6	Offset barber/beauty revenue	(3,273)	40	6
7	Non Allowable PAC Contributions	(3,953)	20	7
8	Medicare Consolidated Billing Expense	(48,487)	43	8
9	Reclass Mort Ins out of Ins line	(53,601)	26	9
10	Reclass Mort Ins into Mort Ins line	53,601	36	10
11	Adjust Owner Compensation	(416,275)	17	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(696,780)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	26 Insurance	\$	TS Realty, LLC	100.00%	\$ 72,448	\$ 72,448	1
2	V	30 Depreciation		TS Realty, LLC	100.00%	247,284	247,284	2
3	V	32 Interest	80	TS Realty, LLC	100.00%	305,916	305,836	3
4	V	33 Real Estate Taxes		TS Realty, LLC	100.00%	135,844	135,844	4
5	V	34 Rent Expense	707,544	TS Realty, LLC	100.00%		(707,544)	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		\$ 707,624			\$ 761,492	\$ * 53,868	14

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

Facility Name & ID Number

The Springs at Crystal Lake, LLC

0051284

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1/1/17

Ending:

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Weldler	35	Community Nursing & Rehabilitation Center, L	Naperville	Pine Acres Realty,	DeKalb	Real Estate	1
2	The Gershon Bassman Gift Trust	20.1	Pine Acres Living & Rehab Center, LLC	DeKalb	LLC			2
3	The Todd Andrew Stern 2001 Trust	7.5			Community Nursing	Naperville	Real Estate	3
4	The Evan Michael Stern 2005 Trust	7.5			and Rehab Realty,			4
5	Abraham J. Stern	4.95			LLC			5
6	Susan L. Stern	4.95			TS Realty, LLC	Crystal Lake	Real Estate	6
7	Judith Rajchenbach	2						7
8	Yosef & Naomi Rajchenbach,	2						8
9	Avrum & Chana Rajchenbach	2						9
10	Shlomo & Chaya Busel	2						10
11	Pinchas & Nahma Schwartz	2						11
12	Chaim & Rivka Rajchenbach	2						12
13	Moshe & Aliza Weiss	2						13
14	Moshe & Sara Rajchenbach	2						14
15	Esther & Yehonotan Olstein	2						15
16	Leah Levin	2						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

Facility Name & ID Number The Springs at Crystal Lake, LLC # 0051284 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Att Sch 7A	5	10.00	Guar Payment	\$ 48,632	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	\$ 48,632		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

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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 N/A

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		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, LLC

0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17

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		7	8	9	10					
		Related**					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	First American Capital Group		X	Building	Varies	2/1/2016	\$ 8,091,100	\$ 7,892,830	3/1/2051	0.0385	\$ 305,916	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 8,091,100	\$ 7,892,830			\$ 305,916	9					
B. Non-Facility Related*																	
10												10					
11												11					
12										Interest Income		(682)					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (682)	14					
15	TOTALS (line 9+line14)						\$ 8,091,100	\$ 7,892,830			\$ 305,234	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 53,601 Line # 36

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

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

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1/1/17

Ending:

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.			\$	140,000	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.)	2016		\$	137,245	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,755)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	138,600	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.)			\$	(1)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	135,844	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	129,981	8	FOR BHF USE ONLY	
	2013	134,314	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	136,636	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	135,718	11	15	LESS REFUND FROM LINE 6 \$
	2016	137,245	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
FY16 RE Taxes X 101% = 2016 RE Tax Accrual 137,245 X 101% = 138,617					
Use 138,600					

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-27-201-007</u>	<u>Nursing home</u>	\$ <u>137,245.06</u>	\$ <u>137,245.06</u>
2. <u>14-27-201-008</u>	<u>Land</u>	\$ <u>12,393.14</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>149,638.20</u></u>	\$ <u><u>137,245.06</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 The Springs at Crystal Lake, LLC

0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	2	3	4	
	Use	Square Feet	Year Acquired	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	\$ 925,207
5					-		-		
6					-		-		
7					-		-		
8					-		-		
Improvement Type**									
9	Telephone and Computer Wiring		2011	43,312	4,331	10	4,331		28,152
10	Furnace		2011	4,900	490	10	490		3,185
11	Water Heater		2011	6,950	695	10	695		4,518
12									
13	Sprinkler system valve		2012	6,579	658	10	658		3,619
14	Replaced compressor		2013	3,474	695	10	347	(347)	1,563
15	Install fire alarm system		2013	4,665	933	10	467	(467)	2,100
16	Install 5 ton AC unit		2013	4,136	827	10	414	(414)	1,862
17	Break tank system		2013	15,990	3,198	10	1,599	(1,599)	7,196
18	Ejector pump		2013	3,596	719	10	360	(360)	1,619
19	Galvanized Steel Door		2013	2,902	580	10	290	(290)	1,306
20									
21	Compressor Replacement for walk in Freezer - Kitchen		2014	5,853	585	10	585		2,049
22	Remove and replace thermostats - Resident Room:		2014	3,311	331	10	331		1,159
23	Replaced leaking RPZ valve - Mechanical room		2014	3,116	312	10	312		1,091
24	Replaced evaporator for walk in freezer - Kitchen		2014	4,764	476	10	476		1,667
25	Exterior Paint - Building Exterior		2014	4,614	461	10	461		1,615
26	Dialysis Project-Concrete, Carpentry, Millwork, Doors,		2014	170,539	17,054	10	17,054		59,689
27	Frames, Painting, Roofing, Flooring, Fire Protection,								
28	Plumbing, HVAC, Electrical & Labor								
29	Mass Grading-Permits, Tree Removal, Silt Fencing, Blueprints,		2014	161,393	10,392	10	16,139	5,747	56,488
30	Engineering, Dewatering, Discing, Earthwork Labor,								
31	Storm Sewer Material & Labor								
32	Corridor/Nurse Station/Room Remodel-Handrails, Wood		2014	904,043		10	90,404	90,404	316,415
33	Trim, Acoustic Ceiling, Toilet Acc., Marble Sills, Doors,								
34	Blinds, Lights, Cabinetry, Solid Surface Tops, Flooring								
35									
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, LLC

0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17

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,	2015	\$ 5,170	\$ 517	10	\$ 517	\$	\$ 1,293	37
38	front parking lot, fire lane, and walkway								38
39	Sprinkler repair/replace parts (Total)	2015	24,574	2,457	10	2,457		6,143	39
40	Demo, drywall, carpentry, doors, flooring, paint - Library	2015	79,397	7,940	10	7,940		19,849	40
41	Demo, carpeting, trim & stain-Dir/HR/MR Offices & Reception	2015	15,200	1,520	10	1,520		3,800	41
42	New light pole in parking lot	2015	2,517		10	252	252	629	42
43	Hot water heater	2015	3,586		10	359	359	897	43
44	Replaced ejector pit pump	2015	4,471		10	447	447	1,118	44
45									45
46	Installed handrails on handicap ramp in outdoor entrance and	2016	5,475	548	10	548		822	46
47	striping handicap stalls in bathroom								47
48	Furnished and installed doors throughout facility	2016	3,436	344	10	344		516	48
49	Furnished corian solid surface counter tops in kitchen	2016	2,599	260	10	260		390	49
50	Replaced fuel priming pump in basement	2016	6,719	672	10	672		1,008	50
51	Installed outdoor lighting at the front of the building	2016	3,000	300	10	300		450	51
52	Fire sprinkler repair/replace parts in shower room of E wing,	2016	15,843	1,584	10	1,584		2,376	52
53	D wing, C wing, 1st floor, & basement								53
54	Backflow repair of fireline in basement	2016	7,443	744	10	744		1,116	54
55	Replaced evaporator coil for walk-in cooler	2017	4,000	200	10	200		200	55
56	Parking lot patching - multiple areas of lot	2017	5,986	299	10	299		299	56
57	Water heater- Boiler Room	2017	6,635	332	10	332		332	57
58	Lavoatories on 1st floor plugged, rodded drain, found leak on dom	2017	6,328	316	10	316		316	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)		\$ 7,286,855	\$ 60,772		\$ 297,763	\$ 236,990	\$ 1,462,053	70

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

Facility Name & ID Number The Springs at Crystal Lake, LLC

0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	\$ 795,734	\$ 30,195	\$ 86,930	\$ 56,735	5-10	\$ 484,736	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 795,734	\$ 30,195	\$ 86,930	\$ 56,735		\$ 484,736	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	\$	\$	\$	5	\$ 41,990	76
77	Facility Use	GMC Truck 2011	2011	40,312				5	40,312	77
78										78
79										79
80	TOTALS			\$ 82,302	\$	\$	\$		\$ 82,302	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)	\$ 8,389,892	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 90,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,693	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 293,725	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,029,091	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, LLC

0051284

Report Period Beginning: 1/1/17

Ending: 12/31/17

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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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 N/A 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: \$ 40,100 Description: See Sch 14A

(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: The Springs at Crystal Lake, LLC
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing & Medical Equipment	14,147
Dietary Equipment	1,554
Maintenance Equipment	2,726
Copier Equipment	20,899
Other Equipment	774
Total - Line 16	<u>40,100</u>

Facility Name & ID Number The Springs at Crystal Lake, LLC # 0051284 Report Period Beginning: 1/1/17 Ending: 12/31/17

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>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. <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	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	\$	7,914	\$ 569,797	\$	7,914	\$ 569,797							1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,138	153,929		2,138	153,929							2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		9,690	697,644		9,690	697,644							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						658,706						658,706	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Oxygen</u>	39(2)							15,779						15,779	12
13	Other (specify): <u>Dialysis</u>	39(3)							42,120						42,120	13
14	TOTAL			\$	19,742	\$ 1,463,490	\$	19,742	\$ 674,485	\$		19,742	\$	2,137,975		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 **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,535,510	\$ 1,815,354	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>4,685</u>)	1,903,112	1,903,112	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,356	79,756	6
7	Other Prepaid Expenses	28,536	28,536	7
8	Accounts Receivable (owners or related parties)	650,677	650,677	8
9	Other(specify): <u>Rent Receivable</u>		26,866	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,183,191	\$ 4,504,301	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	584,427	1,556,516	15
16	Equipment, at Historical Cost	347,818	878,036	16
17	Accumulated Depreciation (book methods)	(419,506)	(2,029,091)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		128,892	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>CIP</u>)	284,681	322,037	22
23	Other(specify): <u>Escrow</u>		389,877	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 797,420	\$ 7,201,606	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,980,611	\$ 11,705,907	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,076,692	\$ 1,100,228	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		119,431	29
30	Accrued Salaries Payable	198,963	198,963	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,279	7,279	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,600	32
33	Accrued Interest Payable		25,323	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	369,685	372,035	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,652,619	\$ 1,961,859	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,773,399	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)	\$	\$ 7,773,399	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,652,619	\$ 9,735,258	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,327,992	\$ 1,970,649	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,980,611	\$ 11,705,907	48

*(See instructions.)

Facility Name: The Springs at Crystal Lake, LLC
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued Management Fees	154,401	154,401
Loans - Members	-	2,350
Loans - Members	14,000	14,000
Accrued Rent	26,866	26,866
Accrued Assessment Fee #2	5,331	5,331
Insurance Payable	-	-
Due to State	57,581	57,581
Due To/from AdminStar	6,797	6,797
Resident Credit Balances	65,531	65,531
Due To / from Primary Insurance	-	-
Due to/from BC-BS	39,178	39,178
Total - Line 36	369,685	372,035

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,803,712	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(106,606)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,697,106	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	336,541	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	(705,655)	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)	\$ (369,114)	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)	\$ 3,327,992	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Springs at Crystal Lake, LLC

0051284

Report Period Beginning: 1/1/17

Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,541,600	1
2	Discounts and Allowances for all Levels	(1,671,860)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,869,740	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,991,242	6
7	Oxygen	21,971	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,013,213	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,273	13
14	Non-Patient Meals	605	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,019,399	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	141,034	19
20	Radiology and X-Ray	19,415	20
21	Other Medical Services	211,446	21
22	Laundry	7,248	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,402,420	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	602	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 602	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	6,743	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,743	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,292,718	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,114,770	31
32	Health Care	2,630,745	32
33	General Administration	1,778,993	33
B. Capital Expense			
34	Ownership	838,611	34
C. Ancillary Expense			
35	Special Cost Centers	2,505,339	35
36	Provider Participation Fee	87,719	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,956,177	40
41	Income before Income Taxes (line 30 minus line 40)**	336,541	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 336,541	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 156,203	44
45	Private Pay - Net Inpatient Revenue	3,866,415	45
46	Medicare - Net Inpatient Revenue	543,393	46
47	Other-(specify) <u>Managed care</u>	301,879	47
48	Other-(specify) <u>Hospice</u>	1,850	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,869,740	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.

Facility Name: The Springs at Crystal Lake, LLC
IDPH License ID Number: 0051284
Fiscal Year End: 12/31/17

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Account	Description	Amount
41350	Equipment Rental	(247)
45350	Equipment Rental	(135)
59911	Miscellaneous income	(6,361)
	Total - Line 28	<u>(6,743)</u>

Facility Name & ID Number The Springs at Crystal Lake, LLC

0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	1,968	2,086	\$ 102,064	\$ 48.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,080	24,085	762,532	31.66	3
4	Licensed Practical Nurses	11,843	12,449	463,313	37.22	4
5	CNAs & Orderlies	42,301	43,526	627,220	14.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	49,429	23.76	9
10	Activity Assistants	3,437	3,621	41,101	11.35	10
11	Social Service Workers	3,598	3,989	95,674	23.98	11
12	Dietician	1,823	2,080	61,983	29.80	12
13	Food Service Supervisor	1,952	2,120	56,526	26.66	13
14	Head Cook	6,626	7,052	100,758	14.29	14
15	Cook Helpers/Assistants	14,402	14,756	148,822	10.09	15
16	Dishwashers					16
17	Maintenance Workers	2,259	2,641	62,548	23.68	17
18	Housekeepers	16,082	17,440	198,705	11.39	18
19	Laundry	2,877	3,446	42,573	12.35	19
20	Administrator	2,292	2,634	150,931	57.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,807	1,975	27,638	13.99	23
24	Clerical	10,913	11,639	208,407	17.91	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	1,940	2,090	28,420	13.60	31
32	Other Health C: See Sch 20A	8,263	9,066	313,829	34.62	32
33	Other(specify) See Sch 20A	3,920	4,324	170,646	39.46	33
34	TOTAL (lines 1 - 33)	163,319	173,099	\$ 3,713,119 *	\$ 21.45	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	7 450	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	16 1,072	11(3)	44
45	Social Service Consultant	12 864	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	35 \$ 13,186		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, LLC
IDPH License ID Number: 0051284
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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	3,881	4,079	161,186	39.52
Restorative Aide	2,526	2,867	78,517	27.39
Transitional Care Coordinator	1,856	2,120	74,126	34.97
Total - Line 32 Other Health Care (specify):	8,263	9,066	313,829	

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	1,928	2,180	86,028	39.46
Dir of Admissions	1,992	2,144	84,618	39.47
Total - Line 33 Other (specify):	3,920	4,324	170,646	

Facility Name: The Springs at Crystal Lake, LLC
IDPH License ID Number: 0051284
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Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Chase card services	Computer Services	116
Singer Networks LLC	Computer Services	8,680
Stephanie Dimitrenko	Computer Services	50
Telemedicine Solutions	Computer Services	6,000
Allscripts	Professional Fees	3,000
Personnel Planners, Inc.	Professional Fees	1,140
MDI Achieve	Professional Fees	27,216
Joint Commission	Professional Fees	4,640
	Total	50,842
Total (agree to Schedule V, line 19, column 3)		132,901
Less: Non-Allowable Legal Fees and Other Professional Fees		(4,856)
Less: Reclassifications to Purchased Services		(27,216)
Total (agree to Schedule V, line 19, column 8)		100,829

Facility Name & ID Number The Springs at Crystal Lake, LLC# 0051284

Report Period Beginning:

1/1/17

Ending:

12/31/17**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 - \$11979
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,773 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. \$ 87,719
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 605
- (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