FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0045955

Facility Name: Spring Creek Terrace

Address: 3155 East Mount Road (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: 217-877-0671 **Fax #** 217-422-6365

HFS ID Number:

Date of Initial License for Current Owners: 09/16/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeremy Maupin **Telephone Number:** 217-422-6361
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jeremy Maupin
(Title) President

Paid Preparer

(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,754			5,754	13
14	TOTALS	5,754			5,754	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.53%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/16/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/16/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Spring Creek Terrace # 0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	46,480	1,654	1,142	49,276		49,276		49,276			1
2	Food Purchase		27,584		27,584		27,584		27,584			2
3	Housekeeping	30,666	17,411		48,077		48,077		48,077			3
4	Laundry		45		45		45		45			4
5	Heat and Other Utilities			12,924	12,924		12,924		12,924			5
6	Maintenance		9,989	14,282	24,271		24,271	290	24,561			6
7	Other (specify):* **Waste Removal**			1,425	1,425		1,425		1,425			7
8	**TOTAL General Services**	77,146	56,683	29,773	163,602		163,602	290	163,892			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	197,055	9,908	3,278	210,241		210,241		210,241			10
10a	Therapy			2,242	2,242		2,242		2,242			10a
11	Activities	24,074	9,263		33,337		33,337		33,337			11
12	Social Services											12
13	CNA Training	10,965			10,965		10,965		10,965			13
14	Program Transportation			7,818	7,818		7,818		7,818			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	232,094	19,171	20,538	271,803		271,803		271,803			16
	C. General Administration											
17	Administrative	7,510		47,600	55,110		55,110	(24,209)	30,901			17
18	Directors Fees											18
19	Professional Services			7,997	7,997		7,997	532	8,529			19
20	Dues, Fees, Subscriptions & Promotions			1,544	1,544		1,544	29	1,573			20
21	Clerical & General Office Expenses		6,223	8,952	15,175		15,175	123	15,298			21
22	Employee Benefits & Payroll Taxes			80,549	80,549		80,549	2,926	83,475			22
23	Inservice Training & Education			4,277	4,277		4,277		4,277			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			7,497	7,497		7,497		7,497			25
26	Insurance-Prop.Liab.Malpractice			12,398	12,398		12,398		12,398			26
27	Other (specify):*											27
28	**TOTAL General Administration**	7,510	6,223	170,814	184,547		184,547	(20,599)	163,948			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	316,750	82,077	221,125	619,952		619,952	(20,309)	599,643			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 Spring Creek Terrace #0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,295	2,295		2,295	39,142	41,437			30
31	Amortization of Pre-Op. & Org.			19,667	19,667		19,667	(19,667)				31
32	Interest			13,179	13,179		13,179	13,501	26,680			32
33	Real Estate Taxes			3,450	3,450		3,450		3,450			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			3,421	3,421		3,421	101	3,522			35
36	Other (specify):*											36
37	**TOTAL Ownership**			78,216	78,216		78,216	(3,127)	75,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			175,341	175,341		175,341		175,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,912	46,912		46,912		46,912			42
43	Other (specify):* Non-allowable Costs			641	641		641	(641)				43
44	**TOTAL Special Cost Centers**			222,894	222,894		222,894	(641)	222,253			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	316,750	82,077	522,235	921,062		921,062	(24,077)	896,985			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 Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,302	30		9
10	Interest and Other Investment Income				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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(641)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(19,667)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 4,994		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(29,071)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (29,071)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,077)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

STATE OF ILLINOIS **Page 5A**

Spring Creek Terrace

ID# **0045955**

Report Period Beginning: **1/1/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Amortization	$ (19,667)	31	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(19,667)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Spring Creek Terrace # 0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	290	0	0	0	0	0	0	0	0	0	290	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	290	0	0	0	0	0	0	0	0	0	290	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(24,209)	0	0	0	0	0	0	0	0	0	(24,209)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	532	0	0	0	0	0	0	0	0	0	532	19
20	Fees, Subscriptions & Promotions	0	29	0	0	0	0	0	0	0	0	0	29	20
21	Clerical & General Office Expenses	0	123	0	0	0	0	0	0	0	0	0	123	21
22	Employee Benefits & Payroll Taxes	0	2,926	0	0	0	0	0	0	0	0	0	2,926	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(20,599)	0	0	0	0	0	0	0	0	0	(20,599)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(20,309)	0	0	0	0	0	0	0	0	0	(20,309)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Spring Creek Terrace # 0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	25,302	13,840	0	0	0	0	0	0	0	0	0	39,142	30
31	Amortization of Pre-Op. & Org.	(19,667)	0	0	0	0	0	0	0	0	0	0	(19,667)	31
32	Interest	0	13,501	0	0	0	0	0	0	0	0	0	13,501	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,204)	0	0	0	0	0	0	0	0	0	(36,204)	34
35	Rent-Equipment & Vehicles	0	101	0	0	0	0	0	0	0	0	0	101	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,635	(8,762)	0	0	0	0	0	0	0	0	0	(3,127)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(641)	0	0	0	0	0	0	0	0	0	0	(641)	43
44	**TOTAL Special Cost Centers**	(641)	0	0	0	0	0	0	0	0	0	0	(641)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,994	(29,071)	0	0	0	0	0	0	0	0	0	(24,077)	45

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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
Jeremy Maupin	100	J&J Maupin Homes North Kickapoo	Lincoln	J&J Maupin Enterpris	Decatur, IL	Real Estate
		J&J Maupin Homes Hickory Point Terrace	Forsyth	A Step Forward	Decatur, IL	Day Training &
						3 CILAs

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	J&J Maupin Enterprises	100.00%	$ 290	$ 290	1
2	V	17	Administrative	47,600	J&J Maupin Enterprises	100.00%	23,391	(24,209)	2
3	V	19	Professional Fees		J&J Maupin Enterprises	100.00%	532	532	3
4	V	20	Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	29	29	4
5	V	21	Clerical & General Admin		J&J Maupin Enterprises	100.00%	123	123	5
6	V	22	Employee Benefits		J&J Maupin Enterprises	100.00%	2,926	2,926	6
7	V	30	Depreciation		J&J Maupin Enterprises	100.00%	13,840	13,840	7
8	V	32	Interest		J&J Maupin Enterprises	100.00%	13,501	13,501	8
9	V	35	Rent-Eqipment		J&J Maupin Enterprises	100.00%	101	101	9
10	V	34	Rent	36,204	J&J Maupin Enterprises	100.00%		(36,204)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 83,804			$ 54,733	$ * (29,071)	14

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeremy Maupin	President	Administrative	100.00	72,223	15	25.00	Salary	$ 23,276	L17, C 7	1
2	Jennifer Maupin	Controller	Other Admin	0.00	358	10	33.33	Salary	115	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,391		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 Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

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 [X] NO [ ]

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

Name of Related Organization: J&J Maupin Enterprises
Street Address: 5310 E. William Street Road
City / State / Zip Code: Decatur, IL 62521
Phone Number: (217-422-6361
Fax Number: (217-422-6365

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Revenue	3,944,362	4	$ 1,192	$	961,341	$ 290	1
2	17	Administrative	Revenue	3,944,362	4	95,972	95,972	961,341	23,391	2
3	19	Professional Fees	Revenue	3,944,362	4	2,181		961,341	532	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,944,362	4	118		961,341	29	4
5	21	Clerical & General Admin	Revenue	3,944,362	4	504		961,341	123	5
6	22	Employee Benefits	Revenue	3,944,362	4	12,005		961,341	2,926	6
7	30	Depreciation	Revenue	3,944,362	4	56,784		961,341	13,840	7
8	32	Interest	Revenue	3,944,362	4	55,394		961,341	13,501	8
9	35	Rent-Eqipment	Revenue	3,944,362	4	415		961,341	101	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					$ 224,565	$ 95,972		$ 54,733	25

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Mid IL Bank & Trust		X	Facility	$3,388.74	10/26/05	$ 366,667	$ 67,460	9/26/2015	4.2500	$ 3,713	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09		64,856	11/12/12	6.0000	2,910	6
7	Kim Robinson		X	Working Capital	$1,130.44	9/16/05	170,000	89,763	8/16/2015	6.5000	6,556	7
8												8
9	TOTAL Facility Related				$4,519.18		$ 536,667	$ 222,079			$ 13,179	9
	B. Non-Facility Related*											
10												10
11								Home Office allocation			13,501	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 13,501	14
15	TOTALS (line 9+line14)						$ 536,667	$ 222,079			$ 26,680	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

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

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

Facility Name & ID Number Spring Creek Terrace **#** 0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	2013	$ 3,450	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,450	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 3,450	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	11,651	8
	2010	3,389	9
	2011	3,421	10
	2012	3,430	11
	2013	3,450	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Spring Creek Terrace COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0045955

CONTACT PERSON REGARDING THIS REPORT Jeremy Maupin

TELEPHONE 217-422-6361 FAX #: 217-422-6365

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-30-353-001	Facility	$ 3,450.30	$ 3,450.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 3,450.30	$ 3,450.30

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			2008	5,800	57	7	829	772	4,558	9
10	Roof Repair			2010	5,800	57	7	829	772	2,900	10
11	Parking Lot			2010	1,100	5	15	73	68	257	11
12	Decking			2012	5,190	24	15	346	322	865	12
13	Flooring			2012	2,879	13	15	192	179	480	13
14	Carpet/Flooring-Dining, Kitchen, hallways & 4 bedrooms			2013	8,003	35	15	534	499	800	14
15	New Kitchen Countertops			2014	931	4	15	31	27		15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23	Allocated from J & J Maupin Enterprises							13,840	13,840		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

*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 Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 29,703	$ 195		$ 16,674	$ 16,479	$ 9,860	70

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 239,327	$ 1,881	$ 23,933	$ 22,052	5-10 yrs	$ 222,223	71
72	Current Year Purchases	2,429	121	121		5-10 yrs	121	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 241,756	$ 2,002	$ 24,054	$ 22,052		$ 222,344	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	Program Transportation	2006 Dodge Grand Caravan	2007	$ 12,952	$	$	$	5 yr	$ 12,952	76
77	Administraive Transp.	Passenger Auto	2005	20,000				5 yr	20,000	77
78	Activities	2004 Honda Oddesey	2014	7,093	98	709	611	5 yr	709	78
79										79
80	TOTALS			$ 40,045	$ 98	$ 709	$ 611		$ 33,661	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)	$ 311,504	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,295	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,437	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,142	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 265,865	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:				$	1		3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 101 Description: Allocated from J & J Enterprises
    (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	Administrative	2011 Toyota Prius	$ 178.01	$ 1,246	17
18	Administrative	2014 Honda Civic	234.93	2,175	18
19					19
20					20
21	TOTAL		$ 412.94	$ 3,421	21

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

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		10,965		10,965
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 10,965	$	$ 10,965
10	SUM OF line 9, col. 1 and 2 (e)	$ 10,965			

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	9

(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.

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Day Training	39(3)				175,341			175,341	13
14	TOTAL			$		$ 175,341	$		$ 175,341	14

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (11,517)	$ (11,517)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	134,262	134,262	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	995	995	7
8	Accounts Receivable (owners or related parties)	294,740	294,740	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 418,480	$ 418,480	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	29,703	29,703	15
16	Equipment, at Historical Cost	281,801	281,801	16
17	Accumulated Depreciation (book methods)	(230,650)	(265,865)	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 (spe **Goodwill**	113,078	113,078	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 193,932	$ 158,717	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 612,412	$ 577,197	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,281	$ 15,281	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,383	27,383	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	486	486	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 43,150	$ 43,150	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	154,619	154,619	39
40	Mortgage Payable	67,460	67,460	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)**	$ 222,079	$ 222,079	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 265,229	$ 265,229	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 347,183	$ 311,968	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 612,412	$ 577,197	48

*(See instructions.)

Facility Name & ID Number Spring Creek Terrace **#** 0045955 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 361,404	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 361,404	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	40,279	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	(54,500)	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)**	$ (14,221)	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)**	$ 347,183	24	*

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 781,147	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 781,147	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Workshop Revenue**	180,619	28
28a	**EIC $10, Miscellaneous ($435)**	(425)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 180,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 961,341	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	163,602	31
32	Health Care	271,803	32
33	General Administration	184,547	33
	B. Capital Expense		
34	Ownership	78,216	34
	C. Ancillary Expense		
35	Special Cost Centers	175,982	35
36	Provider Participation Fee	46,912	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 921,062	40
41	**Income before Income Taxes (line 30 minus line 40)****	40,279	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 40,279	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 781,147	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 781,147	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	522	522	15,199	29.12	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	1,192	1,192	10,965	9.20	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,585	1,625	15,789	9.72	9
10	Activity Assistants	880	880	8,285	9.41	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,812	4,012	46,480	11.59	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,033	2,181	30,666	14.06	18
19	Laundry					19
20	Administrator	173	173	7,510	43.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,196	2,332	63,020	27.02	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	12,008	12,252	118,836	9.70	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,401	25,169	$ 316,750 *	$ 12.58	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,142	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,630	L10, C3	38
39	Pharmacist Consultant	Monthly	1,326	L10, C3	39
40	Physical Therapy Consultant	Monthly	390	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	861	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	991	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	280	L10, C3	46
47	Physician	Monthly	42	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 13,862		49

C. CONTRACT NURSES

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristi Nottelmann	Administrator	0	$ 7,510
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 7,510

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 47,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 47,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kelly's Accounting	Accounting	$ 5,932
Templin Healthcare Accounting	Accounting	1,000
Quickbooks	Payroll Service	345
Bolen, Robinson, & Ellis, LLP	Legal Services	450
Duane Morris	Legal Services	270
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 7,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,998
Unemployment Compensation Insurance	20,133
FICA Taxes	19,381
Employee Health Insurance	9,742
Employee Meals	13,295
Illinois Municipal Retirement Fund (IMRF)*	
Allocated from J & J Maupin Enterprises	2,926
TOTAL (agree to Schedule V, line 22, col.8)	$ 83,475

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	257
Health Care Worker Background Check	
(Indicate # of checks performed 30)	390
Patient Background Checks	
Licenses and Fees	897
Allocated from J & J Maupin Enterprises	29
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,573

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
N/A	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

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

Facility Name & ID Number Spring Creek Terrace # 0045955 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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? **No**
If YES, give association name and amount.

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. $ **46,912**
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? **Yes** 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. $ **13,295** Has any meal income been offset against related costs? **No** 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? **33**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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 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.

Spring Creek Terrace

Period Beginning 1/1/2014
Period End 12/31/2014

ATTACHED SCHEDULE I

SCHEDULE I - LINE 23 - IN-SERVICE TRAINING AND EDUCATION

Name	Description	Amount
Shannon Klaska	Behavior Management Specialist Training	2,702
	Crisis Prevention recertification	1,411
	Misc. training materials and expenses	164
	Total In-Service Training and Education	4,277

Spring Creek Terrace

Period Beginning	**1/1/2014**
Period End	**12/31/2014**

ATTACHED SCHEDULE II

SCHEDULE I - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Repairs / Maintenance	**2,033**
Fuel and miscellaneous supplies	**5,464**
	7,497

Spring Creek Terrace

Period Beginning 1/1/2014
Period End 12/31/2014

ATTACHED SCHEDULE III

SCHEDULE XX - (12)

Wage costs are allocated based on scheduled time.