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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052613

Facility Name: Spring Creek Nursing & Rehab Ctr, Llc

Address: 777 Draper Avenue (Number) Joliet (City) 60432 (Zip Code)

County: Will

Telephone Number: (815) 727-4794 **Fax #** (815) 727-1026

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
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 01/01/15 to 12/31/15 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	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			1,921	1,921	8
9	SNF/PED					9
10	ICF	9,328	2,738		12,066	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,328	2,738	1,921	13,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 22.81%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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 04/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 1,830

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,774	25,393	5,259	193,426		193,426	46	193,472			1
2	Food Purchase		101,026		101,026		101,026	(1,010)	100,016			2
3	Housekeeping	55,037	16,805		71,842		71,842	325	72,167			3
4	Laundry	18,090	4,711		22,801		22,801		22,801			4
5	Heat and Other Utilities			82,421	82,421		82,421	493	82,914			5
6	Maintenance	128,584		112,297	240,881		240,881	4,245	245,126			6
7	Other (specify):*							243	243			7
8	**TOTAL General Services**	364,485	147,935	199,977	712,397		712,397	4,342	716,739			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,071,160	187,530	3,250	1,261,940		1,261,940		1,261,940			10
10a	Therapy	46,394			46,394		46,394		46,394			10a
11	Activities	93,670	12,083		105,753		105,753		105,753			11
12	Social Services	179,386		709	180,095		180,095		180,095			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,390,610	199,613	13,959	1,604,182		1,604,182		1,604,182			16
	C. General Administration											
17	Administrative	302,713			302,713		302,713	5,843	308,556			17
18	Directors Fees											18
19	Professional Services			233,699	233,699		233,699	(137,770)	95,929			19
20	Dues, Fees, Subscriptions & Promotions			48,805	48,805		48,805	(29,759)	19,046			20
21	Clerical & General Office Expenses	50,287	10,758	435,690	496,735		496,735	(379,088)	117,647			21
22	Employee Benefits & Payroll Taxes			293,423	293,423		293,423	(1,684)	291,739			22
23	Inservice Training & Education											23
24	Travel and Seminar			169	169		169	100	269			24
25	Other Admin. Staff Transportation			1,013	1,013		1,013	397	1,410			25
26	Insurance-Prop.Liab.Malpractice			152,458	152,458		152,458	405	152,863			26
27	Other (specify):*							7,452	7,452			27
28	**TOTAL General Administration**	353,000	10,758	1,165,257	1,529,015		1,529,015	(534,104)	994,911			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,108,095	358,306	1,379,193	3,845,594		3,845,594	(529,762)	3,315,832			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 Nursing & Rehab Ctr, Llc #0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			14,160	14,160		14,160	264,242	278,402			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			460	460		460	195,836	196,296			32
33	Real Estate Taxes			99,118	99,118		99,118	(19,876)	79,242			33
34	Rent-Facility & Grounds			301,321	301,321		301,321	(300,000)	1,321			34
35	Rent-Equipment & Vehicles			2,109	2,109		2,109	237	2,346			35
36	Other (specify):*											36
37	TOTAL Ownership			417,168	417,168		417,168	140,439	557,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,037	267,382	308,419		308,419		308,419			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,316	151,316		151,316		151,316			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		41,037	418,698	459,735		459,735		459,735			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,108,095	399,343	2,215,059	4,722,497		4,722,497	(389,323)	4,333,174			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 Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	67,780	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	(198)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(32,810)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(379,057)	21		24
25	Fund Raising, Advertising and Promotional	(28,568)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,344)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (387,197)		$	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)	(2,126)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,126)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (389,323)		37

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

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

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

Spring Creek Nursing & Rehab Ctr, Llc

ID# 0052613

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (935)	02	1
2	Other Income	(746)	21	2
3	Non-Allowable Legal	(136)	19	3
4	PAC Dues	(1,481)	20	4
5				5
6				6
7	Building Co.			7
8	Legal Fees	(10,877)	19	8
9	Bank Service Charges	(169)	21	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**	(14,344)		49

Spring Creek Nursing & Rehab Ctr, Llc

ID# 0052613

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc **#** 0052613 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			46									46	1
2	Food Purchase	(1,133)		123									(1,010)	2
3	Housekeeping			325									325	3
4	Laundry													4
5	Heat and Other Utilities			493									493	5
6	Maintenance			1,418	2,827								4,245	6
7	Other (specify):*				243								243	7
8	**TOTAL General Services**	(1,133)		2,405	3,070								4,342	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			886	4,957								5,843	17
18	Directors Fees													18
19	Professional Services	(11,013)	10,877	(137,634)									(137,770)	19
20	Fees, Subscriptions & Promotions	(30,049)		290									(29,759)	20
21	Clerical & General Office Expenses	(412,782)	376	3,627	29,691								(379,088)	21
22	Employee Benefits & Payroll Taxes				(1,684)								(1,684)	22
23	Inservice Training & Education													23
24	Travel and Seminar			100									100	24
25	Other Admin. Staff Transportation			397									397	25
26	Insurance-Prop.Liab.Malpractice			405									405	26
27	Other (specify):*				7,452								7,452	27
28	**TOTAL General Administration**	(453,844)	11,253	(131,929)	40,416								(534,104)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(454,977)	11,253	(129,524)	43,486								(529,762)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc **#** 0052613 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	67,780	195,820	642									264,242	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		193,252	2,584									195,836	32
33	Real Estate Taxes		(21,171)	1,295									(19,876)	33
34	Rent-Facility & Grounds		(300,000)										(300,000)	34
35	Rent-Equipment & Vehicles			237									237	35
36	Other (specify):*													36
37	**TOTAL Ownership**	67,780	67,901	4,758									140,439	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(387,197)	79,154	(124,766)	43,486								(389,323)	45

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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	34	Rental Income - Base	$ 300,000	Hillcrest Realty, LLC	100.00%	$	$ (300,000)	1
2	V	33	Rental Income - Property Tax	99,118	Hillcrest Realty, LLC	100.00%		(99,118)	2
3	V	19	Legal Expenses		Hillcrest Realty, LLC	100.00%	10,877	10,877	3
4	V	21	Misc. Admin Expenses		Hillcrest Realty, LLC	100.00%	207	207	4
5	V	21	Bank Service Charge		Hillcrest Realty, LLC	100.00%	169	169	5
6	V	30	Depreciation Expense		Hillcrest Realty, LLC	100.00%	195,820	195,820	6
7	V	33	Real Estate Tax Expenses		Hillcrest Realty, LLC	100.00%	77,947	77,947	7
8	V	32	Interest Expense - Lake Forest Interest		Hillcrest Realty, LLC	100.00%	193,252	193,252	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 399,118			$ 478,272	$ * 79,154	14

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 46	$ 46	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	123	123	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	325	325	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	493	493	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,418	1,418	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	886	886	20
21	V	19	Professional Fees	139,200	Extended Care Consulting, LLC	100.00%	1,566	(137,634)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	290	290	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	3,627	3,627	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	100	100	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	397	397	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	405	405	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	642	642	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	2,584	2,584	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,295	1,295	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	237	237	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 139,200			$ 14,434	$ * (124,766)	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	2,827	$ 2,827	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	243	243	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	4,957	4,957	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	29,691	29,691	22
23	V	21	Office and Clerical (Direct)	5,615	Extended Care Consulting, LLC	100.00%	5,615		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	5,948	5,948	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,504	1,504	25
26	V	22	Employee Benefits	1,684	Extended Care Consulting, LLC	100.00%		(1,684)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,299			$ 50,785	$ * 43,486	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 60,631	$ 60,631	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	60,631	CCS Employee Benefits Group	100.00%		(60,631)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,631			$ 60,631	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Charles Slagle	20.00 %	Parc of Joliet	Joliet, IL	Extended Care Consulting	Evanston	Mgmt / Bookkeeping	1
2	B&Z Grandchildren Trust	47.002%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	Extended Care Clinical	Evanston	Clinical	2
3	Adam Vales Accumulation Trust	4.714%	BRIAR PLACE LTD.	INDIAN HEAD PARK	Care Centers Building	Evanston	Building Company	3
4	Kathryn Vales Accumulation Trust	4.714%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	Vent Lease LLC	Evanston	Ventilator Equipment	4
5	Kimberly Vales Accumulation Trust	4.714%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	Tri Care Rehab	Hillside	Therapy	5
6	Daniel Rothner Accumulation Trust	4.714%	GRASMERE PLACE, LLC	CHICAGO	C.C.S. Veba	Evanston	Health Insurance	6
7	Melissa Rothner Accumulation Trust	4.714%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	Des Plaines	Pharmacy	7
8	Rachel Rothner Accumulation Trust	4.714%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	Reliable Medical Supply	Des Plaines	Medical Supplies	8
9	William Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL DYER	DYER, IN	Hillcrest Realty, LLC	Chicago	Building Company	9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Charles Slagle	Administrator	Owner	20.00%	none	40.00	100.00%	Salary	$ 149,999	17-01	1
2	Adam Vales	Relative	Clerical	N/A	See Attached	0.38	0.95%	Alloc. Salary	650	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 150,649		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 Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1 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	01	Dietary	Patient Days	1,326,152	31	$ 4,390	$	13,987	$ 46	1
2	02	Food	Patient Days	1,326,152	31	11,689		13,987	123	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		13,987	325	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		13,987	493	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		13,987	1,418	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		13,987	886	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		13,987	1,566	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		13,987	290	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		13,987	3,627	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		13,987	100	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		13,987	397	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		13,987	405	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		13,987	642	13
14	32	Interest	Patient Days	1,326,152	31	244,990		13,987	2,584	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		13,987	1,295	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		13,987	237	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 14,434	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1 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	06	Maintenance (Pooled)	Patient Days	1,326,152	31	268,019	268,019	13,987	2,827	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		13,987	243	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	13,987	4,957	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	13,987	29,691	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		5,615	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		13,987	5,948	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			1,504	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					$ 4,964,932	$ 4,280,758		$ 50,785	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 60,631	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 60,631	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Notes Payable		X	Furniture & Equipment				10,908			460	6
7	Allocated from Hillcrest Realty,	X		Notes Payable				36,825				7
8												8
9	TOTAL Facility Related						$	$ 47,733			$ 460	9
	B. Non-Facility Related*											
10	Allocated from Extended Care Consulting, LLC										2,584	10
11	Allocated from Hillcrest Realty, LLC										193,252	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 195,836	14
15	TOTALS (line 9+line14)						$	$ 47,733			$ 196,296	15

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 115,565	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.)		$ 95,691	2
3. Under or (over) accrual (line 2 minus line 1).		$ (19,874)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 99,116	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.		$ 79,242	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	81,402	8
	2011	88,684	9
	2012	100,004	10
	2013	110,062	11
	2014	94,396	12

2015 Accrual = $94,396 x 1.05 = $ 99,116 (Rounding)

Allocated from Extended Care Consulting LLC: $1,295

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Spring Creek Nursing & Rehab Ctr, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052613

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-11-101-003-0000	Long Term Care Facility	$ 94,395.90	$ 94,395.90
2.	See Attached	Allocated from Care Centers Building	$ 165,913.23	$ 1,224.62
3.	45-10-01-202-001.000-034	Allocated from Extended Care Consul	$ 3,814.66	$ 40.23
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 264,123.79	$ 95,660.75

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Spring Creek Nursing & Rehab Ctr, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052613

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,039 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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).

N/A

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: 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	Facility			$ 336,000	1
2	Allocated from Care Centers Building, LLC			6,053	2
3	TOTALS			$ 342,053	3

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	168		2014	1976	$ 5,288,000	$ 195,820	27.5	$ 192,291	$ (3,529)	$ 1,623,202	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1991	6,230		20			6,230	9
10	Various			1992	46,656		20			46,656	10
11	Various			1993	24,390		20			24,390	11
12	Various			1994	10,172		20			10,172	12
13	Various			1995	5,221		20			5,221	13
14	Various			1996	13,337		20	667	667	13,337	14
15	Various			1997	14,039		20	702	702	13,337	15
16	Various			1998	172,840		20	8,642	8,642	155,556	16
17	Various			1999	63,084		20	3,154	3,154	53,621	17
18	Various			2000	11,245		20	562	562	8,996	18
19	Various			2001	86,883		20	4,344	4,344	65,162	19
20	Various			2002	16,919		20	846	846	11,843	20
21	Various			2003	171,488		20	8,574	8,574	111,467	21
22	Various			2004	53,623		20	2,681	2,681	32,174	22
23	Various			2005	94,154		20	4,708	4,708	51,785	23
24	Various			2006	34,118		20	1,706	1,706	17,059	24
25	Various			2007	48,568		20	2,428	2,428	21,856	25
26	Various			2008	232,319		20	11,616	11,616	92,928	26
27	Various			2009	27,382		20	1,369	1,369	9,584	27
28	Various			2010	78,450		20	3,923	3,923	23,535	28
29	Various			2011	9,101		20	455	455	2,275	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 Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		25,586	348		348		18,552	68
69	Financial Statement Depreciation			14,160			(14,160)		69
70	TOTAL (lines 4 thru 69)		$ 6,533,805	$ 210,328		$ 249,017	$ 38,689	$ 2,418,938	70

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,533,805	$ 210,328		$ 249,017	$ 38,689	$ 2,418,938	1
2	1St Floor Dining & Resident Rooms - Plaster, Prime, Paint	2012	17,430		20	872	872	3,486	2
3	3Rd Floor Resident Rooms, Hallways - Plaster, Prime, Paint	2012	169,706		20	8,485	8,485	33,941	3
4	2Nd Floor Resident Rooms, Hallways - Plaster, Prime, Paint, Wallp	2012	181,630		20	9,082	9,082	36,326	4
5	Water Heater	2012	2,568		20	128	128	514	5
6	3Rd Floor Resident Rooms - Overbed Light Fixtures	2012	10,184		20	509	509	2,037	6
7	3Rd Floor - Entrance Keypads, Sirens & Door Monitor	2012	3,372		20	169	169	674	7
8	Double Face Sign	2015	27,600		20	1,380	1,380	1,380	8
9	Delayed Egress/Fire Alarm/Door Monitor Panel/Install Magnetic Lo	2015	13,586		20	679	679	679	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,959,881	$ 210,328		$ 270,320	$ 59,992	$ 2,497,975	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Care Centers Building LLC	2002	8,341	214	35	214		2,843	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Care Centers Building LLC	2002	6,890		20			6,890	9
10	Allocated from Care Centers Building LLC	2003	8,120		20			8,120	10
11	Allocated from Care Centers Building LLC	2005	403	43	20	43		403	11
12	Allocated from Care Centers Building LLC	2009	73	4	20	4		25	12
13	Allocated from Care Centers Building LLC	2014	677	34	20	34		68	13
14	Allocated from Care Centers Building LLC	2015	115	6	20	6		6	14
15									15
16	Allocated from Extended Care Consulting, LLC	2007	49	2	20	2		22	16
17	Allocated from Extended Care Consulting, LLC	2009	29	1	20	1		10	17
18	Allocated from Extended Care Consulting, LLC	2010	285	14	20	14		85	18
19	Allocated from Extended Care Consulting, LLC	2011	102	5	20	5		26	19
20	Allocated from Extended Care Consulting, LLC	2012	34	2	20	2		7	20
21	Allocated from Extended Care Consulting, LLC	2014	468	23	20	23		47	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 25,586	$ 348		$ 348	$	$ 18,552	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 25,586	$ 348		$ 348	$	$ 18,552	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 25,586	$ 348		$ 348	$	$ 18,552	34

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 50,051	$ 208	$ 5,005	$ 4,797	10	$ 21,776	71
72	Current Year Purchases	30,229	33	3,023	2,990	10	3,023	72
73	Fully Depreciated Assets	368,205				10	368,205	73
74								74
75	TOTALS	$ 448,486	$ 241	$ 8,029	$ 7,788		$ 393,005	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Cc	2015	$ 1,903	$ 54	$ 54	$	5	$ 1,742	76
77										77
78										78
79										79
80	TOTALS			$ 1,903	$ 54	$ 54	$		$ 1,742	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)	$ 7,752,323	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,623	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,403	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 67,780	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,892,722	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off Site Storage				1,321			5
6								6
7	TOTAL				$ 1,321 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,109 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Extended Care Consulting, LLC		$	$ 237	17
18					18
19					19
20					20
21	TOTAL		$	$ 237	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 Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 101,298	$		$ 101,298	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,005			14,005	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			149,091			149,091	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				36,475		36,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					2,988	4,562		7,550	13
14	TOTAL			$		$ 267,382	$ 41,037		$ 308,419	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.

STATE OF ILLINOIS

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc **#** 0052613 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 156,348	$ 156,348	1
2	Cash-Patient Deposits	3,625	3,625	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,147,111	1,147,111	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,975	161,975	6
7	Other Prepaid Expenses	11,479	11,479	7
8	Accounts Receivable (owners or related parties)		300,000	8
9	Other(specify):	23,478	23,478	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,504,016	$ 1,804,016	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		336,000	13
14	Buildings, at Historical Cost		5,288,000	14
15	Leasehold Improvements, at Historical Cost	27,600	27,600	15
16	Equipment, at Historical Cost	66,200	402,200	16
17	Accumulated Depreciation (book methods)	(14,632)	(1,991,479)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,669	1,669	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 80,837	$ 4,063,990	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,584,853	$ 5,868,006	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,584,011	$ 1,584,011	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,221	11,221	28
29	Short-Term Notes Payable	10,908	47,733	29
30	Accrued Salaries Payable	129,209	129,209	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,780	9,780	31
32	Accrued Real Estate Taxes(Sch.IX-B)	99,118	99,116	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	128,550	5,229,345	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,972,797	$ 7,110,415	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,085,368	3,085,368	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,085,368	$ 3,085,368	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,058,165	$ 10,195,783	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,473,312)	$ (4,327,777)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,584,853	$ 5,868,006	48

***(See instructions.)**

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,911,920)	1
2	Restatements (describe):		2
3	**Rent Adjustment**	245,454	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,666,466)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,806,846)	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	( )	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)**	$ (1,806,846)	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)**	$ (3,473,312)	24 *

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 2,847,180	1
2	Discounts and Allowances for all Levels	(950,399)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,896,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,008,647	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,008,647	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	7,493	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	742	19
20	Radiology and X-Ray		20
21	Other Medical Services	307	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,542	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	See Supplemental Schedule	1,681	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,915,651	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	712,397	31
32	Health Care	1,604,182	32
33	General Administration	1,529,015	33
	B. Capital Expense		
34	Ownership	417,168	34
	C. Ancillary Expense		
35	Special Cost Centers	308,419	35
36	Provider Participation Fee	151,316	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,722,497	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,806,846)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,806,846)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,240,058	44
45	Private Pay - Net Inpatient Revenue	490,140	45
46	Medicare - Net Inpatient Revenue	98,695	46
47	Other-(specify) Hospice	50,320	47
48	Other-(specify) Insurance	17,568	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,896,781	49

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

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,620	1,813	$ 86,732	$ 47.84	1
2	Assistant Director of Nursing	142	142	5,415	38.13	2
3	Registered Nurses	6,374	6,805	255,765	37.58	3
4	Licensed Practical Nurses	13,133	13,816	375,146	27.15	4
5	CNAs & Orderlies	23,816	24,962	285,202	11.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,877	3,073	46,394	15.10	8
9	Activity Director	3,972	4,318	62,242	14.41	9
10	Activity Assistants	2,499	2,646	31,428	11.88	10
11	Social Service Workers	6,238	6,983	179,386	25.69	11
12	Dietician					12
13	Food Service Supervisor	2,193	2,349	55,134	23.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,648	9,280	107,640	11.60	15
16	Dishwashers					16
17	Maintenance Workers	6,736	7,277	128,584	17.67	17
18	Housekeepers	5,272	5,549	55,037	9.92	18
19	Laundry	1,757	1,850	18,090	9.78	19
20	Administrator	4,076	4,493	250,462	55.74	20
21	Assistant Administrator	2,028	2,232	52,251	23.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,186	4,456	50,287	11.29	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	3,177	3,648	62,900	17.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,744	105,692	$ 2,108,095 *	$ 19.95	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	116	$ 5,259	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,250	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	11	709	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	127	$ 19,218		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tasha Mitchell	Administrator	0%	$ 100,463
Jesse Contreras	Asst. Admin	0%	52,251
Charles Slagle	Administrator	20%	149,999
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 302,713

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ECC Consulting	Bookkeeping Fees	$ 139,200
See Attached	Legal Fees	25,135
FRR/Marcum LLP	Accounting	19,500
Personnel Planners	Unemployment Tax Consult	2,099
Legat Architects	Architectural Services	250
National Datacare Corp	Resident Fund Processing	2,043
Matrixcare	Computer Services	22,490
Ability Network	Computer Services	1,547
American Data	Computer Services	5,643
E-Health Data	Computer Services	2,646
Paycor Payroll Services	Payroll	10,211
See Supplemental Schedule		2,935
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 233,699

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,038
Unemployment Compensation Insurance	49,057
FICA Taxes	156,271
Employee Health Insurance	43,558
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,352
Pension Expense	3,812
Other Employee Welfare	1,929
Holiday Expense	2,722
TOTAL (agree to Schedule V, line 22, col.8)	$ 291,739

* Attach copy of IMRF notifications

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,842
Health Care Worker Background Check	
(Indicate # of checks performed 272.9)	2,729
Patient Background Checks	
Dues & Subscriptions	3,263
Licenses & Fees	3,922
Allocated from Extended Care Consulting LI	290
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,046

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	169
Allocated from Extended Care Consulting LI	100
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 269

**See instructions.

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
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 Nursing & Rehab Ctr, Llc # 0052613 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $3,931**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

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

(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. $ **151,316**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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. **No**
Attach invoices and a summary of services for all architect and appraisal fees.