FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0051284

Facility Name: The Springs at Crystal Lake

Address: 1000 East Brighton (Number) | Crystal Lake (City) | 60012 (Zip Code)

County: McHenry

Telephone Number: (815) 477-6400 **Fax #** (815) 477-6569

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2011

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2016 to 12/31/2016 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) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1 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	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	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	1,002	2,362	16,264	19,628	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,002	2,362	16,264	19,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.29%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 14,416

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	368,802	32,500		401,302		401,302		401,302			1
2	Food Purchase		172,770		172,770		172,770	(3,322)	169,448			2
3	Housekeeping	193,839	25,665		219,504		219,504		219,504			3
4	Laundry	52,426	12,731		65,157		65,157		65,157			4
5	Heat and Other Utilities			97,263	97,263		97,263		97,263			5
6	Maintenance	65,203	27,071	97,665	189,939		189,939		189,939			6
7	Other (specify):*											7
8	TOTAL General Services	680,270	270,737	194,928	1,145,935		1,145,935	(3,322)	1,142,613			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	2,330,339	167,845	1,320	2,499,504		2,499,504	24,696	2,524,200			10
10a	Therapy											10a
11	Activities	86,607	3,416	14,603	104,626		104,626		104,626			11
12	Social Services	93,003		576	93,579		93,579		93,579			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,509,949	171,261	27,299	2,708,509		2,708,509	24,696	2,733,205			16
	C. General Administration											
17	Administrative	160,195		502,259	662,454		662,454	76,110	738,564			17
18	Directors Fees											18
19	Professional Services			224,829	224,829		224,829	(91,993)	132,836			19
20	Dues, Fees, Subscriptions & Promotions			31,733	31,733		31,733	(3,361)	28,372			20
21	Clerical & General Office Expenses	224,341	11,697	37,737	273,775		273,775	(2,605)	271,170			21
22	Employee Benefits & Payroll Taxes			559,098	559,098		559,098		559,098			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,311	4,311		4,311		4,311			24
25	Other Admin. Staff Transportation			3,970	3,970		3,970		3,970			25
26	Insurance-Prop.Liab.Malpractice			95,053	95,053		95,053	21,575	116,628			26
27	Other (specify):*											27
28	TOTAL General Administration	384,536	11,697	1,458,990	1,855,223		1,855,223	(274)	1,854,949			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,574,755	453,695	1,681,217	5,709,667		5,709,667	21,100	5,730,767			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Springs at Crystal Lake #0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			96,511	96,511		96,511	293,725	390,236			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145	145		145	316,832	316,977			32
33	Real Estate Taxes							134,718	134,718			33
34	Rent-Facility & Grounds			729,620	729,620		729,620	(729,620)				34
35	Rent-Equipment & Vehicles			53,321	53,321		53,321		53,321			35
36	Other (specify):* **Mortgage Ins**							75,031	75,031			36
37	**TOTAL Ownership**			879,597	879,597		879,597	90,686	970,283			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		828,973	1,572,131	2,401,104		2,401,104		2,401,104			39
40	Barber and Beauty Shops		6,168		6,168		6,168	(3,439)	2,729			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,430	85,430		85,430		85,430			42
43	Other (specify):* **Non-Allowable Cos**	124,594		119,419	244,013		244,013	(244,013)				43
44	**TOTAL Special Cost Centers**	124,594	835,141	1,776,980	2,736,715		2,736,715	(247,452)	2,489,263			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,699,349	1,288,836	4,337,794	9,325,979		9,325,979	(135,666)	9,190,313			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 The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(3,322)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,145)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,851	30		9
10	Interest and Other Investment Income	(434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(50)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(108,588)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(8,116)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(172,455)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (327,259)		$	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)	191,593		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 191,593		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (135,666)		37

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

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

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

The Springs at Crystal Lake

ID# 0051284

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (23,718)	43	1
2	X-Rays - Part A	(14,390)	43	2
3	Misc Income	(2,605)	21	3
4	Chamber of Commerce Dues	(715)	20	4
5	Non Allowable Advertising Costs	(348)	21	5
6	Non Allowable Marketing Salaries	(124,594)	21	6
7	Offset barber/beauty revenue	(3,439)	40	7
8	Non Allowable PAC Contributions	(2,646)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
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27				27
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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**	(172,455)		49

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$	TS Realty, LLC	100	$ 76,110	$ 76,110	1
2	V	26	Insurance		TS Realty, LLC	100	96,606	96,606	2
3	V	30	Depreciation		TS Realty, LLC	100	254,874	254,874	3
4	V	32	Interest	55	TS Realty, LLC	100	317,321	317,266	4
5	V	33	Real Estate Taxes		TS Realty, LLC	100	134,718	134,718	5
6	V	34	Rent Expense	729,620	TS Realty, LLC	100		(729,620)	6
7	V	19	Professional Services		TS Realty, LLC	100	41,639	41,639	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 729,675			$ 921,268	$ * 191,593	14

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Weldler	35	Community Nursing & Rehabilitation Center, L	Naperville	Pine Acres Realty,	DeKalb	Real Estate	1
2	The Gershon Bassman Gift Trust	20.1	Pine Acres Living & Rehab Center, LLC	DeKalb	LLC			2
3	The Todd Andrew Stern 2001 Trust	7.5			Community Nursing	Naperville	Real Estate	3
4	The Evan Michael Stern 2005 Trust	7.5			and Rehab Realty,			4
5	Abraham J. Stern	4.95			LLC			5
6	Susan L. Stern	4.95			TS Realty, LLC	Crystal Lake	Real Estate	6
7	Judith Rajchenbach	2						7
8	Yosef & Naomi Rajchenbach,	2						8
9	Avrum & Chana Rajchenbach	2						9
10	Shlomo & Chaya Busel	2						10
11	Pinchas & Nahma Schwartz	2						11
12	Chaim & Rivka Rajchenbach	2						12
13	Moshe & Aliza Weiss	2						13
14	Moshe & Sara Rajchenbach	2						14
15	Esther & Yehonotan Olstein	2						15
16	Leah Rajchenbach	2						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Mark Weldler	Manager	Finance	35.00	See Schedule 7A	5	10.00	Guar Payment	$ 578,369	L17, C3 & 7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 578,369		13

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First American Capital Group		X	Building	Varies	2/1/2016	$ 8,091,100	$ 8,007,757	3/1/2051	0.0385	$ 317,321	1
2	GMC		X	Vehicle	809.00	2/15/2011	40,906		3/15/2016	0.0720	117	2
3	Ford		X	Vehicle	720.23	9/15/2011	39,812		9/15/2016	0.0324	28	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,529.23		$ 8,171,818	$ 8,007,757			$ 317,466	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(489)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (489)	14
15	TOTALS (line 9+line14)						$ 8,171,818	$ 8,007,757			$ 316,977	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 75031 Line # 36

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 141,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	$ 135,718	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,282)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Alloc. Fr. Mgmt Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 134,718	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	120,315	8
	2012	129,981	9
	2013	134,314	10
	2014	136,636	11
	2015	135,718	12

FY15 RE Taxes X 103% = 2016 RE Tax Accrual 135,718 X 103% = 139,789

Use 140,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Springs at Crystal Lake, LLC COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051284

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-27-201-007	Nursing Home	$ 135,717.70	$ 135,717.70
2.	14-27-201-008	Land	$ 12,255.22	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 147,972.92	$ 135,717.70

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	172,933	2011	$ 225,000	1
2					2
3	TOTALS	172,933		$ 225,000	3

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	97		2011	1989	$ 5,730,339	$	40	$ 143,258	$ 143,258	$ 781,949	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Telephone and Computer Wiring			2011	43,312	4,331	10	4,331		23,821	9
10	Furnace			2011	4,900	490	10	490		2,695	10
11	Water Heater			2011	6,950	695	10	695		3,823	11
12											12
13	Sprinkler system valve			2012	6,579	658	10	658		2,961	13
14	Replaced compressor			2013	3,474	347	10	347		1,216	14
15	Install fire alarm system			2013	4,665	467	10	467		1,633	15
16	Install 5 ton AC unit			2013	4,136	414	10	414		1,448	16
17	Break tank system			2013	15,990	1,599	10	1,599		5,597	17
18	Ejector pump			2013	3,596	360	10	360		1,259	18
19	Galvanized Steel Door			2013	2,902	290	10	290		1,015	19
20											20
21	Compressor Replacement for walk in Freezer - Kitchen			2014	5,853	585	10	585		1,464	21
22	Remove and replace thermostats - Resident Rooms			2014	3,311	331	10	331		828	22
23	Replaced leaking RPZ valve - Mechanical room			2014	3,116	312	10	312		779	23
24	Replaced evaporator for walk in freezer - Kitchen			2014	4,764	476	10	476		1,191	24
25	Exterior Paint - Building Exterior			2014	4,614	461	10	461		1,154	25
26	Dialysis Project-Concrete, Carpentry, Millwork, Doors,			2014	170,539	17,054	10	17,054		42,635	26
27	Frames, Painting, Roofing, Flooring, Fire Protection,										27
28	Plumbing, HVAC, Electrical & Labor										28
29	Mass Grading-Permits, Tree Removal, Silt Fencing, Blueprints,			2014	161,393	16,139	10	16,139		40,349	29
30	Engineering, Dewatering, Discing, Earthwork Labor,										30
31	Storm Sewer Material & Labor										31
32	Corridor/Nurse Station/Room Remodel-Handrails, Wood			2014	904,043	90,404	10	90,404		226,011	32
33	Trim, Acoustic Ceiling, Toilet Acc., Marble Sills, Doors,										33
34	Blinds, Lights, Cabinetry, Solid Surface Tops, Flooring										34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Sealcoat and hot crack filler for main roadway,	2015	$ 5,170	$ 517	10	$ 517	$	$ 776	37
38	front parking lot, fire lane, and walkway								38
39	Sprinkler repair/replace parts (Total)	2015	24,574	2,457	10	2,457		3,686	39
40	Demo, drywall, carpentry, doors, flooring, paint - Library	2015	79,397	7,940	10	7,940		11,910	40
41	Demo, carpeting, trim & stain-Dir/HR/MR Offices & Reception	2015	15,200	1,520	10	1,520		2,280	41
42	New light pole in parking lot	2015	2,517	252	10	252		378	42
43	Hot water heater	2015	3,586	359	10	359		538	43
44	Replaced ejector pit pump	2015	4,471	447	10	447		671	44
45									45
46	Installed handrails on handicap ramp in outdoor entrance and	2016	5,475	274	10	274		274	46
47	striping handicap stalls in bathroom								47
48	Furnished and installed doors throughout facility	2016	3,436	172	10	172		172	48
49	Furnished corian solid surface counter tops in kitchen	2016	2,599	130	10	130		130	49
50	Replaced fuel priming pump in basement	2016	6,719	336	10	336		336	50
51	Installed outdoor lighting at the front of the building	2016	3,000	150	10	150		150	51
52	Fire sprinkler repair/replace parts in shower room of E wing,	2016	15,843	792	10	792		792	52
53	D wing, C wing, 1st floor, & basement								53
54	Backflow repair of fireline in basement	2016	7,443	372	10	372		372	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Reconcile to Financials			(93,732)			93,732		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,263,906	$ 57,399		$ 294,389	$ 236,990	$ 1,164,290	70

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 795,734	$ 30,195	$ 86,930	$ 56,735	5-10	$ 397,806	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 795,734	$ 30,195	$ 86,930	$ 56,735		$ 397,806	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	Ford E250 2009	2011	$ 41,990	$ 4,548	$ 4,548	$ -	5	$ 41,990	76
77	Facility Use	GMC Truck 2011	2011	40,312	4,369	4,369	-	5	40,312	77
78							-			78
79							-			79
80	TOTALS			$ 82,302	$ 8,917	$ 8,917	$ -		$ 82,302	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,366,943	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,511	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 390,236	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 293,725	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,644,398	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 284,681	92
93			93
94			94
95		$ 284,681	95

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] 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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 53,321 Description: Nursing & Medical Eq $26,339; Dietary Eq $1,440; Maintenance Equipment $1,995; Copier Equip. $23,547
(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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

It is the policy of this facility to only hire certified nurses aides.

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

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	8,629	$ 621,273	$	8,629	$ 621,273	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,229	160,456		2,229	160,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,424	750,492		10,424	750,492	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				813,322		813,322	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					15,651		15,651	12
13	Other (specify): Dialysis	39(3)				39,910			39,910	13
14	TOTAL			$	21,282	$ 1,572,131	$ 828,973	21,282	$ 2,401,104	14

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

Facility Name & ID Number The Springs at Crystal Lake **#** 0051284 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ 1,891,846	$ 1,892,937	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (18,058))	1,852,631	1,852,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,672	79,639	6
7	Other Prepaid Expenses	23,107	23,107	7
8	Accounts Receivable (owners or related parties)	329,547	551,500	8
9	Other(specify): Rent Receivable		49,970	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,159,803	$ 4,449,784	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		225,000	13
14	Buildings, at Historical Cost		5,730,339	14
15	Leasehold Improvements, at Historical Cost	561,477	1,533,567	15
16	Equipment, at Historical Cost	347,819	878,036	16
17	Accumulated Depreciation (book methods)	(328,539)	(1,644,398)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		132,780	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Sch 17A	284,681	322,037	22
23	Other(specify): Escrow		344,287	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 865,438	$ 7,521,648	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,025,241	$ 11,971,432	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 914,021	$ 937,559	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		114,927	29
30	Accrued Salaries Payable	153,823	153,823	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,755	6,755	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,000	32
33	Accrued Interest Payable		25,692	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	146,930	149,280	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,221,529	$ 1,528,036	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,892,830	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,892,830	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,221,529	$ 9,420,866	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,803,712	$ 2,550,566	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,025,241	$ 11,971,432	48

***(See instructions.)**

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/2016**

Schedule 17A

XV. Balance Sheet
Line 22 Other Long-Term Assets (specify):

Description	Operating	After Consolidation
Construction in Progress	284,681	322,037
Organizational Fees	-	-
Accum Amort-Org Fees	-	-
Total - Line 22	**284,681**	**322,037**
	-	-

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
	Accrued Management Fees	209,494	209,494
20215.000	Loans - Members	-	2,350
20220.000	Loans - Members	28,000	28,000
	Accrued Rent	49,970	49,970
	Accrued Assessment Fee #2	5,263	5,263
	Insurance Payable	12,955	12,955
	Due to State	505	505
	Due To/from AdminStar	(18,873)	(18,873)
	Resident Credit Balances	28,882	28,882
	Due To / from Primary Insurance	11,564	11,564
	Due to/from BC-BS	36,779	36,779
	Due To/From CNRC	(217,609)	(217,609)
	Current Portion Debt - TCF	-	-
	Current Portion Notes Payable - Truck	-	-
	Total - Line 36	**146,930**	**149,280**
		-	-

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,444,512	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	14,108	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,458,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	706,802	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,121,521	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(483,231)	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)**	$ 1,345,092	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)**	$ 3,803,712	24 *

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 6,794,645	1
2	Discounts and Allowances for all Levels	(1,215,816)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,578,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,264,801	6
7	Oxygen	31,631	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,296,432	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	438	12
13	Barber and Beauty Care	3,439	13
14	Non-Patient Meals	2,884	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	775,598	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	119,207	19
20	Radiology and X-Ray	14,550	20
21	Other Medical Services	231,667	21
22	Laundry	5,614	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,153,397	23
	D. Non-Operating Revenue		
24	Contributions	75	24
25	Interest and Other Investment Income***	434	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 509	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	3,614	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,614	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,032,781	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,145,935	31
32	Health Care	2,708,509	32
33	General Administration	1,855,223	33
	B. Capital Expense		
34	Ownership	879,597	34
	C. Ancillary Expense		
35	Special Cost Centers	2,651,285	35
36	Provider Participation Fee	85,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,325,979	40
41	**Income before Income Taxes (line 30 minus line 40)****	706,802	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 706,802	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 152,070	44
45	Private Pay - Net Inpatient Revenue	4,363,410	45
46	Medicare - Net Inpatient Revenue	1,063,349	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,578,829	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No^ **If not, please attach a reconciliation.**

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

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

^ - This entity is a cash basis taxpayer

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/2016**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Equipment Rental	564
Equipment Rental	445
Misc Income	2,605
Total - Line 28	**3,614**

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1,722	1,817	$ 86,383	$ 47.54	1
2	Assistant Director of Nursing	2,002	2,058	69,492	33.77	2
3	Registered Nurses	22,817	24,215	757,410	31.28	3
4	Licensed Practical Nurses	11,549	12,185	446,724	36.66	4
5	CNAs & Orderlies	43,861	46,015	658,435	14.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,080	45,306	21.78	9
10	Activity Assistants	3,293	3,659	41,301	11.29	10
11	Social Service Workers	3,585	3,895	93,003	23.88	11
12	Dietician	1,928	2,160	61,947	28.68	12
13	Food Service Supervisor	2,016	2,180	56,968	26.13	13
14	Head Cook	6,908	7,283	99,086	13.61	14
15	Cook Helpers/Assistants	15,309	15,428	150,801	9.77	15
16	Dishwashers					16
17	Maintenance Workers	2,587	2,887	65,203	22.59	17
18	Housekeepers	16,114	17,650	193,839	10.98	18
19	Laundry	3,676	3,986	52,426	13.15	19
20	Administrator	2,297	2,652	160,195	60.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,514	2,813	36,680	13.04	23
24	Clerical	9,696	10,366	187,661	18.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,831	2,076	26,051	12.55	31
32	Other Health C See Sch 20A	7,905	8,620	285,844	33.16	32
33	Other(specify) See Sch 20A	3,904	4,300	124,594	28.98	33
34	TOTAL (lines 1 - 33)	167,423	178,325	$ 3,699,349 *	$ 20.74	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		$		35
36	Medical Director	Monthly	10,800	9(3)	36
37	Medical Records Consultant	21	1,320	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,340	11(3)	44
45	Social Service Consultant	8	576	12(3)	45
46	Other(specify) Administrative Consu	Monthly	10,668	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	$ 24,704		49

C. CONTRACT NURSES

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

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/2016**

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS	3,540	3,866	148,045	$ 38.30
Restorative Aide	2,457	2,628	71,619	$ 27.25
Transitional Care Coordinator	1,908	2,126	66,180	$ 31.13
Total - Line 32 Other Health Care (specify):	**7,905**	**8,620**	**285,844**	**$ 33.16**

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Sales & Marketing / Admissions	1,936	2,160	62,587	$ 28.98
Dir of Admissions	1,968	2,140	62,007	$ 28.98
Total - Line 33 Other (specify):	**3,904**	**4,300**	**124,594**	**$ 28.98**

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephanie Demitrinko	Administrator	0	$ 160,195
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,195

B. Administrative - Other

Description	Amount
Mark Weldler - Guar. Pmts.	$ 502,259
TOTAL (agree to Schedule V, line 17, col. 3)	$ 502,259
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 47,671
Polsinelli	Legal	19,629
Meyers & Flowers	Collections	1,676
Much Shelist Attorneys At Law	Legal	1,000
Vanek, Larson & Kolb LLC	Legal	3,991
McDermott Will & Emory	Legal	15,080
Legal Accrual	Legal	30,000
RSM US LLP	Accounting	47,396
Paylocity	Payroll Fees	9,888
Ability Network, Inc.	Computer Services	4,002
Propel Marketing	Computer Advertising	348
See Sch 21C	Various	44,148
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 224,829

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,264
Unemployment Compensation Insurance	0
FICA Taxes	320,547
Employee Health Insurance	132,213
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	336
Other Employee Benefits	0
Employee Life Insurance	16,738
TOTAL (agree to Schedule V, line 22, col.8)	$ 559,098

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	334
Health Care Worker Background Check	
(Indicate # of checks performed 2)	28
Patient Background Checks 733	9,918
Miscellaneous Licenses & Fees	3,895
Miscellaneous Dues & Subscriptions	5,559
Allocated from RE Entity	0
ILCLTC less Lobbying	5,373
Less: Chamber of Commerce Dues	(715)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,372

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,311
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,311

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Information Controls, Inc.	Computer Services	1,542
CDW Direct	Computer Services	1,083
Singer Networks LLC	Computer Services	4,437
Telemedicine Solutions	Health Information Technology Services	6,000
Allscripts	EHR Services	3,105
CMS Application	Professional Fees	554
Loan Renewal Fees	Professional Fees	1,036
Personnel Planners, Inc.	Human Resources Services	1,695
MDI Achieve	EHR Solutions Services	24,696
	Subtotal	44,148
	Total (agree to Schedule V, line 19, column 3)	224,829
Less : Non-Allowable Advertising		(348) Propel Marketing
Less: Non-Allowable Legal Fees and Other Professional Fees		(108,588)
Less: Reclassifications to Purchased Services		(24,696)
Add: Professional Fees from Real Estate Entiity		41,639
	Total (agree to Schedule V, line 19, column 8)	132,836

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $8019**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,327** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **85,430**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,322**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees