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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: Steven N. 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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: 01/01/18 Ending: 12/31/18

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	168	Skilled (SNF)	168	61,320	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	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	24,053	3,552	5,615	33,220	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,053	3,552	5,615	33,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.17%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 4/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 168 and days of care provided 5,224

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: 12/31/18 Fiscal Year: 12/31/18

* 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: 01/01/18 Ending: 12/31/18

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	218,910	54,992	17,057	290,959		290,959	129	291,088			1
2	Food Purchase		292,373		292,373		292,373	(1,737)	290,636			2
3	Housekeeping	172,050	61,633		233,683		233,683	700	234,383			3
4	Laundry	24,584	16,774		41,358		41,358		41,358			4
5	Heat and Other Utilities			126,715	126,715		126,715	1,047	127,762			5
6	Maintenance	353,335	778	198,762	552,875		552,875	(684)	552,191			6
7	Other (specify):*							513	513			7
8	**TOTAL General Services**	768,879	426,550	342,534	1,537,963		1,537,963	(32)	1,537,931			8
	B. Health Care and Programs											
9	Medical Director			28,500	28,500		28,500		28,500			9
10	Nursing and Medical Records	2,623,137	386,309	403,835	3,413,281		3,413,281	(4,514)	3,408,767			10
10a	Therapy	37,699			37,699		37,699		37,699			10a
11	Activities	179,029	27,231		206,260		206,260		206,260			11
12	Social Services	262,121			262,121		262,121		262,121			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,101,986	413,540	432,335	3,947,861		3,947,861	(4,514)	3,943,347			16
	C. General Administration											
17	Administrative	219,144			219,144		219,144	12,533	231,677			17
18	Directors Fees											18
19	Professional Services			233,457	233,457	(1,306)	232,151	(135,538)	96,613			19
20	Dues, Fees, Subscriptions & Promotions			156,374	156,374		156,374	(82,474)	73,900			20
21	Clerical & General Office Expenses	43,962	54,831	343,801	442,594		442,594	(233,235)	209,359			21
22	Employee Benefits & Payroll Taxes			794,832	794,832		794,832	(4,810)	790,022			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,827	1,827		1,827	244	2,071			24
25	Other Admin. Staff Transportation			651	651		651	647	1,298			25
26	Insurance-Prop.Liab.Malpractice			322,115	322,115		322,115	1,176	323,291			26
27	Other (specify):*							21,654	21,654			27
28	**TOTAL General Administration**	263,106	54,831	1,853,057	2,170,994	(1,306)	2,169,688	(419,803)	1,749,885			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,133,971	894,921	2,627,926	7,656,818	(1,306)	7,655,512	(424,349)	7,231,163			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: 01/01/18 Ending: 12/31/18

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			116,815	116,815		116,815	225,125	341,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,956	35,956		35,956	3,178	39,134			32
33	Real Estate Taxes			79,122	79,122	1,306	80,428	3,095	83,523			33
34	Rent-Facility & Grounds			300,110	300,110		300,110	(300,000)	110			34
35	Rent-Equipment & Vehicles			3,491	3,491		3,491	322	3,813			35
36	Other (specify):*			5,989	5,989		5,989	(5,989)				36
37	**TOTAL Ownership**			541,483	541,483	1,306	542,789	(74,269)	468,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,766	707,203	884,969		884,969	(12,059)	872,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,123	248,123		248,123		248,123			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		177,766	955,326	1,133,092		1,133,092	(12,059)	1,121,033			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,133,971	1,072,687	4,124,735	9,331,393		9,331,393	(510,677)	8,820,716			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: 01/01/18 Ending: 12/31/18

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	153,563	30		9
10	Interest and Other Investment Income	(11,483)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(312)	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	(13,500)	21		18
19	Entertainment				19
20	Contributions	(3,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(287,725)	21		24
25	Fund Raising, Advertising and Promotional	(74,801)	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	(39,230)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (276,988)		$	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)	(233,689)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (233,689)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (510,677)		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: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,687)	02	1
2	Other Income	(8,540)	21	2
3	Patient Clothing	(2,577)	10	3
4	Collection Expense	(5,310)	21	4
5	Amortization	(5,989)	36	5
6	Rental Income	(50)	21	6
7	Capitalized R&M	(9,406)	06	7
8	PAC Dues	(5,460)	20	8
9	Non Allowable Expense	(211)	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**	(39,230)		49

Spring Creek Nursing & Rehab Ctr, Llc

ID# 0052613

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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:** 01/01/18 **Ending:** 12/31/18

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			129									129	1
2	Food Purchase	(1,999)		262									(1,737)	2
3	Housekeeping			700									700	3
4	Laundry													4
5	Heat and Other Utilities			1,047									1,047	5
6	Maintenance	(9,406)		2,802	5,920								(684)	6
7	Other (specify):*				513								513	7
8	**TOTAL General Services**	(11,405)		4,940	6,433								(32)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,577)				(1,937)							(4,514)	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**	(2,577)				(1,937)							(4,514)	16
	C. General Administration													
17	Administrative			1,004	11,529								12,533	17
18	Directors Fees													18
19	Professional Services			(135,538)									(135,538)	19
20	Fees, Subscriptions & Promotions	(83,761)		1,287									(82,474)	20
21	Clerical & General Office Expenses	(315,336)		6,605	75,496								(233,235)	21
22	Employee Benefits & Payroll Taxes				(4,810)								(4,810)	22
23	Inservice Training & Education													23
24	Travel and Seminar			244									244	24
25	Other Admin. Staff Transportation			647									647	25
26	Insurance-Prop.Liab.Malpractice			1,176									1,176	26
27	Other (specify):*				21,654								21,654	27
28	**TOTAL General Administration**	(399,097)		(124,575)	103,869								(419,803)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(413,079)		(119,635)	110,302	(1,937)							(424,349)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	153,563	69,853	1,709									225,125	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,483)		14,661									3,178	32
33	Real Estate Taxes			3,095									3,095	33
34	Rent-Facility & Grounds		(300,000)										(300,000)	34
35	Rent-Equipment & Vehicles			322									322	35
36	Other (specify):*	(5,989)											(5,989)	36
37	**TOTAL Ownership**	136,091	(230,147)	19,787									(74,269)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(12,059)							(12,059)	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**					(12,059)							(12,059)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(276,988)	(230,147)	(99,848)	110,302	(13,996)							(510,677)	45

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 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. [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	34	Rent	$ 300,000	Hillcrest Realty, LLC		$	$ (300,000)	1
2	V	33	Real Estate Taxes	79,122	Hillcrest Realty, LLC		79,122		2
3	V	30	Depreciation		Hillcrest Realty, LLC		69,853	69,853	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 379,122			$ 148,975	$ * (230,147)	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: 01/01/18 Ending: 12/31/18

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%	$ 129	$ 129	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	262	262	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	700	700	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,047	1,047	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,802	2,802	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,004	1,004	20
21	V	19	Professional Fees	139,200	Extended Care Consulting, LLC	100.00%	3,662	(135,538)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,287	1,287	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,605	6,605	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	244	244	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	647	647	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,176	1,176	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,709	1,709	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	14,661	14,661	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,095	3,095	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	322	322	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			$ 39,352	$ * (99,848)	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: 01/01/18 Ending: 12/31/18

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%	5,920	$ 5,920	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%	513	513	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%	11,529	11,529	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	75,496	75,496	22
23	V	21	Office and Clerical (Direct)	16,033	Extended Care Consulting, LLC	100.00%	16,033		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,403	17,403	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,251	4,251	25
26	V	22	Employee Benefits	4,815	Extended Care Consulting, LLC	100.00%		(4,810)	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			$ 20,848			$ 131,145	$ * 110,302	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: 01/01/18 Ending: 12/31/18

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	10	Nursing and Medical Records	22,471	MAC Rx, LLC		20,534	(1,937)	15
16	V	39	Ancillary	139,922	MAC Rx, LLC		127,862	(12,059)	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			$ 162,393			$ 148,397	$ * (13,996)	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: 01/01/18 Ending: 12/31/18

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%	$ 339,784	$ 339,784	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	339,784	CCS Employee Benefits Group	100.00%		(339,784)	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			$ 339,784			$ 339,784	$ *	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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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 %	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	HILLCREST REALTY	CHICAGO	BUILDING COMPANY	1
2	B&Z Grandchildren Trust	47.002%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	Adam Vales Accumulation Trust	4.714%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	3
4	Kathryn Vales Accumulation Trust	4.714%	GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	Kimberly Vales Accumulation Trust	4.714%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	5
6	Daniel Rothner Accumulation Trust	4.714%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				6
7	Melissa Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL DYER	DYER, IN				7
8	Rachel Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9	William Rothner Accumulation Trust	4.714%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			NAPERVILLE MANOR HEALTH & REHAB CENTER	NAPERVILLE				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			THE PARC AT JOLIET	JOLIET				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				27
28								28
29								29
30								30

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	100.00%	Salary	$ 150,434	17-1	1
2	Adam Vales	Relative	Clerical	0%	See Attached	1.61	4.03%	Alloc. Salary	3,056	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	$ 153,490		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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1,389,746	40	$ 5,386	$	33,220	$ 129	1
2	02	Food	Patient Days	1,389,746	40	10,961		33,220	262	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		33,220	700	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		33,220	1,047	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		33,220	2,802	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		33,220	1,004	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		33,220	3,662	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		33,220	1,287	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		33,220	6,605	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		33,220	244	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		33,220	647	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		33,220	1,176	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		33,220	1,709	13
14	32	Interest	Patient Days	1,389,746	40	613,328		33,220	14,661	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		33,220	3,095	15
16	35	Rent - Equipment & Auto	Patient Days	1,389,746	40	13,470		33,220	322	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 39,352	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	247,664	247,664	33,220	5,920	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		33,220	513	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	33,220	11,529	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	33,220	75,496	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		16,033	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		33,220	17,403	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			4,251	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,599,498	$ 4,730,091		$ 131,145	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation						20,534	1
2	39	Ancillary	Direct Allocation						127,862	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					$	$		$ 148,397	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 339,784	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					$	$		$ 339,784	25

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	Bank Leumi		X	Line of Credit				717,965			35,956	6
7	Notes Payable		X	Furniture and Equipment				2,652				7
8	See Supplemental Schedule							36,825				8
9	TOTAL Facility Related						$	$ 757,442			$ 35,956	9
	B. Non-Facility Related*											
10	Alloc.- Extended Care Consultin	X									14,661	10
11	Interest Income		X								(11,483)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,178	14
15	TOTALS (line 9+line14)						$	$ 757,442			$ 39,134	15

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 90,282	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.)		$ 85,731	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,551)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 86,768	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.)		$ 1,306	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.		$ 83,523	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	110,062	8
	2014	94,396	9
	2015	94,326	10
	2016	85,983	11
	2017	82,636	12

2018 Accrual = $82,636 x 1.05 = $86,768

Allocated from Extended Care Consulting $3,095

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 Property	$ 82,636.00	$ 82,636.00
2.	See Attached	Allocated from Care Centers Bldg	$ 190,923.89	$ 3,094.82
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 273,559.89	$ 85,730.82

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? X YES NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 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

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [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 [X] (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: 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	132,928	2007	$ 336,000	1
2	Allocated from Care Centers Building			13,292	2
3	TOTALS			$ 349,292	3

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 69,853	27.5	$ 192,291	$ 122,438	$ 2,200,075	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			13,337	14
15	Various			1997	14,039		20			14,039	15
16	Various			1998	172,840		20	8,642	8,642	172,840	16
17	Various			1999	63,084		20	3,154	3,154	59,930	17
18	Various			2000	11,245		20	562	562	10,121	18
19	Various			2001	86,883		20	4,344	4,344	73,851	19
20	Various			2002	16,919		20	846	846	13,535	20
21	Various			2003	171,488		20	8,574	8,574	128,616	21
22	Various			2004	7,188		20			7,188	22
23	Various			2005	94,154		20	4,708	4,708	61,200	23
24	Various			2006	34,118		20	1,706	1,706	20,471	24
25	Various			2007	48,568		20	2,428	2,428	26,712	25
26	Various			2008	232,319		20	11,616	11,616	116,160	26
27	Various			2009	27,382		20	1,369	1,369	12,322	27
28	Various			2010	80,460		20	4,023	4,023	31,581	28
29	Various			2011	9,101		20	455	455	3,185	29
30	Various			2012	378,759		20	18,938	18,938	114,854	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: 01/01/18 Ending: 12/31/18

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)		66,824	1,043		1,043		44,860	68
69	Financial Statement Depreciation			116,815			(116,815)		69
70	TOTAL (lines 4 thru 69)		$ 6,909,377	$ 187,711		$ 264,700	$ 76,989	$ 3,217,545	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: 01/01/18 Ending: 12/31/18

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		$ 6,909,377	$ 187,711		$ 264,700	$ 76,989	$ 3,217,545	1
2	Installation Of New Emg Panel	2015	4,560		20	228	228	684	2
3	Installed 6 Delayed Egress Magnetic Lock On 2Nd Floor	2016	13,586		20	1,359	1,359	2,717	3
4	Double Face, Pole Illuminated, Pylon Sign	2016	15,400		20	1,540	1,540	3,080	4
5	Floor Covering-2Nd Floor North & South Shower Rooms	2016	11,732		20	587	587	1,173	5
6	Mosaic Tile - Resident Rooms - 2Nd Floor	2016	31,577		20	1,579	1,579	3,158	6
7	New Haven & Oasis Tile - Resident Rooms - 2Nd Floor	2016	11,289		20	564	564	1,129	7
8	Installed Self Regulating Roof/Gutter Heating Cable To 25 Down Sp	2016	11,653		20	583	583	1,165	8
9	Flooring-2Nd Floor Hallway & Rooms/Dining Room/Lobby	2016	59,774		20	2,989	2,989	5,977	9
10	Installed 42 Vanity Tops In Resident Rooms 201-240, Nurse Station	2016	23,730		20	1,187	1,187	2,373	10
11	Second Floor Sprinkler Renovations	2016	3,395		20	170	170	340	11
12	Counter Tops For 2Nd Floor Nurses Station, Dining Room, & Activ	2016	32,500		20	1,625	1,625	3,250	12
13	2Nd Floor Nw Doors & Installation	2016	3,180		20	159	159	318	13
14	Install 2 Dura Glide Automatic Sliding Door Assemblies	2016	9,500		20	475	475	950	14
15	2Nd Floor Resident Rooms/Corridors/Showers Flooring	2016	119,525		20	5,976	5,976	11,953	15
16	Architect Fees For Facility Remodeling Projects	2016	6,175		20	309	309	618	16
17	Labor For Floor Installation In Resident Rooms And Hallways	2016	32,363		20	1,618	1,618	3,236	17
18	Installled Call Light Switch, New Panels, And 3 Fax Lines	2016	4,149		20	207	207	415	18
19	Installed Wall Air Conditioner	2016	3,109		20	155	155	311	19
20	2Nd Flr East-Private Bathrm Construction-Floors/Walls/Fixtures	2017	15,000		20	750	750	1,500	20
21	Masonry Brick Opening	2017	6,100		20	305	305	610	21
22	Vestibule Renovation- Enlarged Front Entrance/New Sliding Doors	2017	5,270		20	264	264	527	22
23	Structural Materials Testing Services For Renovation Projects	2017	3,550		20	355	355	710	23
24	Geotechnical Engineering Services For Renovation Projects	2017	4,775		20	239	239	478	24
25	2Nd Fl Sprinklers, Doors, Wallpaperwindows, Shower Tiles, Ac	2017	282,261		20	14,113	14,113	28,226	25
26	Furnish And Install Automatic Doors	2017	3,594		20	180	180	359	26
27	Ptac Units In Walls	2017	9,272		20	464	464	927	27
28	Repair Fire Alarm System Panel	2018	5,852		20	293	293	293	28
29	Repair Elevator Door	2018	3,554		20	178	178	178	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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: 01/01/18 Ending: 12/31/18

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		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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
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17									17
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19									19
20									20
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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)		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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: 01/01/18 Ending: 12/31/18

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		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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)		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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: 01/01/18 Ending: 12/31/18

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		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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)		$ 7,645,802	$ 187,711		$ 303,148	$ 115,437	$ 3,294,199	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
14									14
15									15
16									16
17									17
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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: 01/01/18 Ending: 12/31/18

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 Extended Care Consulting-Care Center Bldg	2002	18,317	470	39	470		7,652	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	5,737	127	45	127		1,461	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	15,131		20			15,131	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	17,832		20			17,832	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	886		20			886	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	160	8	20	8		80	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,534	77	20	77		384	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	252	13	20	13		109	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	996	50	20	50		149	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,727	86	20	86		173	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2018	792	40	20	40		40	17
18	Allocated from Extended Care Consulting	2007	110	5	20	5		66	18
19	Allocated from Extended Care Consulting	2009	66	3	20	3		33	19
20	Allocated from Extended Care Consulting	2010	645	32	20	32		290	20
21	Allocated from Extended Care Consulting	2011	232	12	20	12		93	21
22	Allocated from Extended Care Consulting	2012	76	4	20	4		27	22
23	Allocated from Extended Care Consulting	2014	1,060	53	20	53		265	23
24	Allocated from Extended Care Consulting	2016	1,271	64	20	64		191	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)		$ 66,824	$ 1,043		$ 1,043	$	$ 44,860	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: 01/01/18 Ending: 12/31/18

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		$ 66,824	$ 1,043		$ 1,043	$	$ 44,860	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)		$ 66,824	$ 1,043		$ 1,043	$	$ 44,860	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: 01/01/18 Ending: 12/31/18

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	$ 386,707	$ 545	$ 38,671	$ 38,126	10	$ 105,608	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	408,826				10	408,826	73
74								74
75	TOTALS	$ 795,533	$ 545	$ 38,671	$ 38,126		$ 514,434	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		Alloc. Extended Care Consulting	1900	$ 609	$ 122	$ 122	$ (0)	5	$ 609	76
77										77
78										78
79										79
80	TOTALS			$ 609	$ 122	$ 122	$ (0)		$ 609	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)	$ 8,791,235	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 188,378	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 341,940	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 153,563	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,809,241	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: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off Site Storage				110			5
6								6
7	TOTAL				$ 110 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 3,814 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 301,542	$		$ 301,542	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			62,646			62,646	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			302,077			302,077	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				146,687		146,687	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					40,938	31,079		72,017	13
14	TOTAL			$		$ 707,203	$ 177,766		$ 884,969	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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 5,625	$ 5,625	1
2	Cash-Patient Deposits	6,113	6,113	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,713,971	1,713,971	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,893	77,893	6
7	Other Prepaid Expenses	3,067	3,067	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	68,950	68,950	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,875,619	$ 1,875,619	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	694,010	694,010	15
16	Equipment, at Historical Cost	432,369	768,369	16
17	Accumulated Depreciation (book methods)	(300,483)	(2,565,229)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 825,896	$ 4,521,150	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,701,515	$ 6,396,769	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,891,408	$ 2,691,408	26
27	Officer's Accounts Payable	10,000	10,000	27
28	Accounts Payable-Patient Deposits	4,351	4,351	28
29	Short-Term Notes Payable	720,617	757,442	29
30	Accrued Salaries Payable	244,955	244,955	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,151	12,151	31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,768	86,768	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	90,276	90,276	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,060,526	$ 3,897,351	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	4,436,399	9,017,194	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,436,399	$ 9,017,194	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,496,925	$ 12,914,545	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,795,410)	$ (6,517,776)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,701,515	$ 6,396,769	48

*(See instructions.)

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,595,816)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,595,816)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,199,594)	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)**	$ (1,199,594)	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)**	$ (6,795,410)	24 *

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

Facility Name & ID Number Spring Creek Nursing & Rehab Ctr, Llc # 0052613 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 8,246,488	1
2	Discounts and Allowances for all Levels	(3,037,991)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,208,497	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,715,222	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,715,222	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	143,368	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,217	19
20	Radiology and X-Ray	8,650	20
21	Other Medical Services	7,135	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 186,370	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,483	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,483	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	10,227	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,227	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,131,799	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,537,963	31
32	Health Care	3,947,861	32
33	General Administration	2,170,994	33
	B. Capital Expense		
34	Ownership	541,483	34
	C. Ancillary Expense		
35	Special Cost Centers	884,969	35
36	Provider Participation Fee	248,123	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,331,393	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,199,594)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,199,594)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,760,770	44
45	Private Pay - Net Inpatient Revenue	644,408	45
46	Medicare - Net Inpatient Revenue	600,120	46
47	Other-(specify) Hospice	128,739	47
48	Other-(specify) Insurance	74,460	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,208,497	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.**

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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	1,913	2,070	$ 115,551	$ 55.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,085	21,782	848,854	38.97	3
4	Licensed Practical Nurses	30,620	31,821	1,080,981	33.97	4
5	CNAs & Orderlies	37,706	38,318	545,190	14.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,744	1,855	37,699	20.32	8
9	Activity Director	4,121	4,147	67,959	16.39	9
10	Activity Assistants	11,110	11,486	111,070	9.67	10
11	Social Service Workers	11,536	12,058	262,121	21.74	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,116	40,498	19.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,807	5,836	80,539	13.80	15
16	Dishwashers	6,127	10,263	97,873	9.54	16
17	Maintenance Workers	25,122	25,735	353,335	13.73	17
18	Housekeepers	17,977	18,098	172,050	9.51	18
19	Laundry	2,417	2,481	24,584	9.91	19
20	Administrator	2,129	1,907	150,434	78.87	20
21	Assistant Administrator	1,987	2,097	68,710	32.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,215	4,241	43,962	10.37	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	1,805	1,993	32,561	16.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,404	198,304	$ 4,133,971 *	$ 20.85	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	313	$ 17,057	01-03	35
36	Medical Director	Monthly	28,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,880	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	313	$ 52,437		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	379	$ 9,617	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16,525	387,338	10-03	52
53	TOTAL (lines 50 - 52)	16,904	$ 396,955		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles Slagle	Administrator	20%	$ 150,434
Jesse Contreras	Asst. Admin	0	68,710
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 219,144

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
Marcum LLP	Accounting	$ 19,500
See Attached	Legal Fees	1,154
Extended Care Consulting	Home Office Expense	139,200
Personnel Planners	Unemployment Consultant	2,274
Pinnacle Quality Insight	Consumer Review	1,920
Resolute Healthcare	Medicaid Backlog Consultant	3,208
Legat Architects	Architects	750
Ability Network	Medicare Billing	3,297
Paycor	Payroll Processing	20,716
Matrixcare	Data Processing	30,438
National Datacare Corporation	Data Processing	11,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 233,457

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,654
Unemployment Compensation Insurance	19,994
FICA Taxes	293,596
Employee Health Insurance	254,772
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	43
Pension Expense	84,753
Other Employee Welfare	6,239
Holiday Expense	6,966
TOTAL (agree to Schedule V, line 22, col.8)	$ 790,017

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	53,520
Health Care Worker Background Check	
(Indicate # of checks performed 144)	2,139
Patient Background Checks	
Dues & Subscriptions	4,610
Licenses & Fees	5,514
Allocated from Extended Care Consult	1,287
Joint Commission	4,840
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,900

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,827
Allocated from Extended Care Consult	244
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,071

**See instructions.

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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. **HCCI $10920 ; AZL Assocation $83 ; Alliance of HC Council $184**

(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. $ **51,403** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **248,123**
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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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