		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0051284

Facility Name: The Springs at Crystal Lake

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

County: McHenry

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

HFS ID Number:

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

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	RSM US LLP 20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173
	(Telephone)	(847) 517-7070 Fax # (847)517-7067

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,961	2,310	7,144	14,415	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,961	2,310	7,144	14,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.60%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 5,382

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	345,765	21,730	-	367,495		367,495		367,495			1
2	Food Purchase		147,470		147,470		147,470	(640)	146,830			2
3	Housekeeping	153,717	29,249	-	182,966		182,966		182,966			3
4	Laundry	237	4,007	-	4,244		4,244		4,244			4
5	Heat and Other Utilities			89,968	89,968		89,968		89,968			5
6	Maintenance	59,693	20,802	96,744	177,239		177,239	4,025	181,264			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	559,412	223,258	186,712	969,382		969,382	3,385	972,767			8
	B. Health Care and Programs											
9	Medical Director	-	-	10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	1,962,008	115,350	16,715	2,094,073		2,094,073	44,016	2,138,089			10
10a	Therapy	-	-	-								10a
11	Activities	78,490	2,559	2,216	83,265		83,265	369	83,634			11
12	Social Services	104,082	-	-	104,082		104,082	288	104,370			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	2,144,580	117,909	29,731	2,292,220		2,292,220	44,673	2,336,893			16
	C. General Administration											
17	Administrative	125,567	-	343,892	469,459		469,459	(260,813)	208,646			17
18	Directors Fees			-								18
19	Professional Services			210,322	210,322		210,322	(38,270)	172,052			19
20	Dues, Fees, Subscriptions & Promotions			32,937	32,937		32,937	(7,614)	25,323			20
21	Clerical & General Office Expenses	267,198	26,394	42,521	336,113		336,113	(15,717)	320,397			21
22	Employee Benefits & Payroll Taxes			580,453	580,453		580,453		580,453			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			775	775		775		775			24
25	Other Admin. Staff Transportation		-	1,352	1,352		1,352		1,352			25
26	Insurance-Prop.Liab.Malpractice			434,034	434,034		434,034	19,566	453,600			26
27	Other (specify):*			-								27
28	**TOTAL General Administration**	392,765	26,394	1,646,286	2,065,445		2,065,445	(302,848)	1,762,598			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,096,757	367,561	1,862,729	5,327,047		5,327,047	(254,790)	5,072,257			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Springs at Crystal Lake #0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			82,296	82,296		82,296	317,997	400,293			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			-				291,785	291,785			32
33	Real Estate Taxes			-				152,168	152,168			33
34	Rent-Facility & Grounds			707,544	707,544		707,544	(707,544)				34
35	Rent-Equipment & Vehicles			16,090	16,090		16,090		16,090			35
36	Other (specify):* Mortgage Ins			-				49,266	49,266			36
37	TOTAL Ownership			805,930	805,930		805,930	103,672	909,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	399,077	558,484	957,561		957,561		957,561			39
40	Barber and Beauty Shops	-	1,348	-	1,348		1,348	(97)	1,251			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			98,578	98,578		98,578		98,578			42
43	Other (specify):* Non-Allowable Cos	119,281	-	159,573	278,854		278,854	(278,854)				43
44	TOTAL Special Cost Centers	119,281	400,425	816,635	1,336,341		1,336,341	(278,951)	1,057,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,216,038	767,986	3,485,294	7,469,318		7,469,318	(430,069)	7,039,249			45

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(640)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,921)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,661	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,248)	43		18
19	Entertainment	(1,058)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,854)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,223)	43		24
25	Fund Raising, Advertising and Promotional	(4,457)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(452,562)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (504,322)		$	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)	74,253		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 74,253		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (430,069)		37

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

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

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

The Springs at Crystal Lake

ID# 0051284

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing salaries	$ (119,281)	43	1
2	Labs - Part A	(25,397)	43	2
3	X-Rays - Part A	(9,210)	43	3
4	Offset barber/beauty revenue	(97)	40	4
5	Misc Income	(15,110)	21	5
6	Chamber of Commerce Dues	(655)	20	6
7	Medicare Consolidated Billing Expense	(19,059)	43	7
8	Non Allowable Lobbying Expense	(6,959)	20	8
9	Adjust Owner Compensation	(260,813)	17	9
10	Real estate taxes	(6)	33	10
11	Reclass from Leasehold to Repair and maintenance	4,025	6	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**	(452,562)		49

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$	TS Realty, LLC	100%	$ 68,832	$ 68,832	1
2	V	30	Depreciation		TS Realty, LLC	100%	253,336	253,336	2
3	V	32	Interest	39	TS Realty, LLC	100%	291,824	291,785	3
4	V	33	Real Estate Taxes		TS Realty, LLC	100%	152,174	152,174	4
5	V	34	Rent Expense	707,544	TS Realty, LLC	100%		(707,544)	5
6	V	19	Professional Fees		TS Realty, LLC	100%	15,600	15,600	6
7	V	21	Bank Fees		TS Realty, LLC	100%	50	50	7
8	V	43	Income Taxes		TS Realty, LLC	100%	20	20	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 707,583			$ 781,836	$ * 74,253	14

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Weldler	Manager	Finance	35	See Att Sch 7A	20+	50.00	Guar Payment	$ 83,079	L17, C3&7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 83,079		13

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1			`			$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First American Capital Group		X	Building	Varies	2/1/2016	$ 8,091,100	$ 7,520,313	3/1/2051	0.0385	$ 291,824	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SBA-PPP Loan		X	Payroll & other expense	No	4/20/2020	841,476	841,476	4/22/2022	0.01	-	6
7												7
8												8
9	TOTAL Facility Related						$ 8,932,576	$ 8,361,789			$ 291,824	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(39)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (39)	14
15	TOTALS (line 9+line14)						$ 8,932,576	$ 8,361,789			$ 291,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 49,266 Line # 36

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

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2019 report.		$ 135,885	1
2	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.)	2019	$ 141,895	2
3	3. Under or (over) accrual (line 2 minus line 1).		$ 6,010	3
4	4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 146,158	4
5	5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 152,168	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	135,718	8
2016	137,246	9
2017	137,912	10
2018	135,879	11
2019	141,895	12

FY19 RE Taxes X 103%
2019 RE Tax Accrual 141,895 X 103% = 146,152.
Use $146,158.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Springs at Crystal Lake, LLC COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0051284

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

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

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-27-201-007	Nursing home	$ 141,895.22	$ 141,895.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 141,895.22	$ 141,895.22

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		2011	1989	$ 5,730,339	$	40	$ 143,258	$ 143,258	$ 1,354,981	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Telephone and Computer Wiring			2011	43,312	4,331	10	4,331		41,145	9
10	Furnace			2011	4,900	490	10	490		4,655	10
11	Water Heater			2011	6,950	695	10	695		6,603	11
12											12
13	Sprinkler system valve			2012	6,579	658	10	658		5,593	13
14	Replaced compressor			2013	3,474	695	10	347	(347)	2,605	14
15	Install fire alarm system			2013	4,665	933	10	467	(467)	3,499	15
16	Install 5 ton AC unit			2013	4,136	827	10	414	(414)	3,103	16
17	Break tank system			2013	15,990	3,198	10	1,599	(1,599)	11,993	17
18	Ejector pump			2013	3,596	719	10	360	(360)	2,698	18
19	Galvanized Steel Door			2013	2,902	580	10	290	(290)	2,176	19
20											20
21	Compressor Replacement for walk in Freezer - Kitchen			2014	5,853	585	10	585		3,805	21
22	Remove and replace thermostats - Resident Rooms			2014	3,311	331	10	331		2,153	22
23	Replaced leaking RPZ valve - Mechanical room			2014	3,116	312	10	312		2,026	23
24	Replaced evaporator for walk in freezer - Kitchen			2014	4,764	476	10	476		3,096	24
25	Exterior Paint - Building Exterior			2014	4,614	461	10	461		2,999	25
26	Dialysis Project-Concrete, Carpentry, Millwork, Doors,			2014	170,539	17,054	10	17,054		110,850	26
27	Frames, Painting, Roofing, Flooring, Fire Protection,										27
28	Plumbing, HVAC, Electrical & Labor										28
29	Mass Grading-Permits, Tree Removal, Silt Fencing, Blueprints,			2014	161,393	10,392	10	16,139	5,747	104,906	29
30	Engineering, Dewatering, Discing, Earthwork Labor,										30
31	Storm Sewer Material & Labor										31
32	Corridor/Nurse Station/Room Remodel-Handrails, Wood			2014	904,043		10	90,404	90,404	587,628	32
33	Trim, Acoustic Ceiling, Toilet Acc., Marble Sills, Doors,										33
34	Blinds, Lights, Cabinetry, Solid Surface Tops, Flooring										34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sealcoat and hot crack filler for main roadway,	2015	$ 5,170	$ 517	10	$ 517	$	$ 2,844	37
38	front parking lot, fire lane, and walkway								38
39	Sprinkler repair/replace parts (Total)	2015	24,574	2,457	10	2,457		13,516	39
40	Demo, drywall, carpentry, doors, flooring, paint - Library	2015	79,397	7,940	10	7,940		43,668	40
41	Demo, carpeting, trim & stain-Dir/HR/MR Offices & Reception	2015	15,200	1,520	10	1,520		8,360	41
42	New light pole in parking lot	2015	2,517		10	252	252	1,384	42
43	Hot water heater	2015	3,586		10	359	359	1,972	43
44	Replaced ejector pit pump	2015	4,471		10	447	447	2,459	44
45									45
46	Installed handrails on handicap ramp in outdoor entrance and	2016	5,475	548	10	548		2,466	46
47	striping handicap stalls in bathroom								47
48	Furnished and installed doors throughout facility	2016	3,436	344	10	344		1,548	48
49	Furnished corian solid surface counter tops in kitchen	2016	2,599	260	10	260		1,170	49
50	Replaced fuel priming pump in basement	2016	6,719	672	10	672		3,024	50
51	Installed outdoor lighting at the front of the building	2016	3,000	300	10	300		1,350	51
52	Fire sprinkler repair/replace parts in shower room of E wing,	2016	15,843	1,584	10	1,584		7,128	52
53	D wing, C wing, 1st floor, & basement								53
54	Backflow repair of fireline in basement	2016	7,443	744	10	744		3,348	54
55	Replaced evaporator coil for walk-in cooler	2017	4,000	400	10	400		1,400	55
56	Parking lot patching - multiple areas of lot	2017	5,986	599	10	599		2,095	56
57	Water heater- Boiler Room	2017	6,635	664	10	664		2,322	57
58	Lavoatories on 1st floor plugged, rodded drain, found leak on don	2017	6,328	633	10	633		2,215	58
59	Shower valve repair	2018	2,974	297	10	297		744	59
60	Replace boiler with 100 gallon water heater	2018	8,795		10	880	880	2,199	60
61	Glue down carpet	2018	4,139	414	10	414		1,035	61
62	Replace damaged pump	2018	2,970	297	10	297		743	62
63	Sealcoat and hot crack filler	2018	7,793	779	10	779		1,949	63
64	Solid state motor starter	2018	5,460	546	10	546		1,365	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,318,986	$ 64,253		$ 302,123	$ 237,870	$ 2,366,817	70

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,318,986	$ 64,253		$ 302,123	$ 237,870	$ 2,366,817	1
2									2
3	Replaced compressor in kitchen	2019	4,465	223	10	447	223	670	3
4	Patch damaged asphalt, restripe	2019	2,948	147	10	295	147	442	4
5	Sprinkler repair	2019	5,213	261	10	521	261	782	5
6	Replace sprinkler heads	2019	3,928	196	10	393	196	590	6
7									7
8	Replacement of pump servicing lift station	2019	46,364		20	2,318	2,318	3,477	8
9	Fire sprinkler system work	2019	3,449		20	172	172	259	9
10	Electrical work in resident rooms	2019	53		20	3	3	4	10
11	Water heater work	2019	1,237		20	62	62	93	11
12	Compressor on Trane condenser unit in kitchen	2019	4,465		20	223	223	335	12
13	Replace fuel tank	2019	10,299		20	515	515	772	13
14	Single phane 3.4 hp weil pump with necessary pipe and fittings	2019	3,895		20	195	195	292	14
15									15
16	Sprinkler work - replaced compressor, backup system	2020	9,149		20	229	229	229	16
17	Fuel supply repair - Mechanical Room	2020	6,170		20	154	154	154	17
18	Temperature and pressure relief valves on hot water tanks - Mech	2020	2,815		20	70	70	70	18
19	Discharge check valve replacement- Mechanical Room	2020	3,007		20	75	75	75	19
20	Repiped hot water and return line valves- Mechanical Room	2020	6,728		20	168	168	168	20
21	Rewiring electric cables for phone system - Electric/Telephone Ro	2020	3,575		10	179	179	179	21
22									22
23									23
24	Current book depreciation adjustment			(12,290)			12,290		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)		$ 7,436,746	$ 52,791		$ 308,142	$ 255,351	$ 2,375,409	34

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 816,009	$ 29,505	$ 92,151	$ 62,646	5-10	$ 746,718	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	11,167					11,167	73
74								74
75	TOTALS	$ 827,176	$ 29,505	$ 92,151	$ 62,646		$ 757,885	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	Ford E250 2009	2011	$ 41,990	$ -	$ -	$	5	$ 41,990	76
77	Facility Use	GMC Truck 2011	2011	40,311	-	-		5	40,311	77
78					-	-				78
79					-	-				79
80	TOTALS			$ 82,301	$	$	$		$ 82,301	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)	$ 8,571,223	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,296	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 400,293	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 317,997	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,215,595	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 322,037	92
93			93
94			94
95		$ 322,037	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 16,090 Description: See Sch 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/20**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing & Medical Equipment	11,200
Dietary Equipment	1,563
Maintenance Equipment	3,093
Office equipment	234
Total - Line 16	**16,090**

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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(2 & 3)	hrs	$	2,698	$ 194,288	$ 1,660	2,698	$ 195,948	1
2	Licensed Speech and Language Development Therapist	39(2 & 3)	hrs		1,254	90,293	113	1,254	90,406	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2 & 3)	hrs		2,930	210,988	451	2,930	211,439	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				383,299		383,299	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					13,554		13,554	12
13	Other (specify): Dialysis	39(3)			874	62,915		874	62,915	13
14	TOTAL			$	7,756	$ 558,484	$ 399,077	7,756	$ 957,561	14

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 978,989	$ 1,014,557	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 69,034)	1,216,179	1,216,179	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	79,887	93,788	6
7	Other Prepaid Expenses	30,271	30,271	7
8	Accounts Receivable (owners or related parties)	1,104,102	1,104,102	8
9	Other(specify): Rent Receivable	-	26,953	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,409,428	$ 3,485,850	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	225,000	13
14	Buildings, at Historical Cost	-	5,730,339	14
15	Leasehold Improvements, at Historical Cost	624,316	1,706,407	15
16	Equipment, at Historical Cost	354,741	909,477	16
17	Accumulated Depreciation (book methods)	(681,116)	(3,215,595)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	-	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	-	117,228	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (spe CIP	284,681	322,037	22
23	Other(specify): See Sch 17A	-	423,163	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 582,622	$ 6,218,056	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,992,050	$ 9,703,906	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 740,185	$ 741,851	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	134,028	29
30	Accrued Salaries Payable	178,430	178,430	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,931	8,931	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	146,158	32
33	Accrued Interest Payable	-	24,128	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,102,101	1,139,919	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,029,647	$ 2,373,445	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	841,476	8,227,761	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43		-	-	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 841,476	$ 8,227,761	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,871,123	$ 10,601,206	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,120,927	$ (897,300)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,992,050	$ 9,703,906	48

*(See instructions.)

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/20**

Schedule 17A

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Ts Escrow Mip	-	44,396
Ts Escrow - Insurance	-	41,078
Ts Escrow - Real Estate Taxes	-	46,359
Ts Escrow - Replacement Reserve	-	291,330
Total - Line 9	**-**	**423,163**
	-	-

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

Description	Operating	After Consolidation
Accrued Management Fees	844,756	844,756
Loans - Members	-	2,350
Accrued Rent	26,953	26,953
Accrued Assessment Fee - #2	4,043	4,043
Insurance Payable	18,806	18,806
Hhs Stimulus (Federal)	84,179	84,179
Hfs Stimulus (State)	33,396	33,396
Due To State	60,000	60,000
Due To/From Adminastar	40,175	40,175
Resident Credit Balances	13,272	13,272
Due To /From Primary Insurance	10,000	10,000
Due To/From Bc-Bs	10,000	10,000
Due To/From Ts Realty	(43,479)	(8,011)
Total - Line 36	**1,102,101**	**1,139,919**
	-	-

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,807,403	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(178,312)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,629,091	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(508,164)	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)**	$ (508,164)	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)**	$ 1,120,927	24 *

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 5,591,205	1
2	Discounts and Allowances for all Levels	(1,306,959)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,284,246	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,246,551	6
7	Oxygen	12,092	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,258,643	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	719,890	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	393	12
13	Barber and Beauty Care	97	13
14	Non-Patient Meals	247	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	359,981	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	80,053	19
20	Radiology and X-Ray	9,210	20
21	Other Medical Services	231,567	21
22	Laundry	1,572	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,403,010	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	-	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	15,255	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,255	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,961,154	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	969,382	31
32	Health Care	2,292,220	32
33	General Administration	2,065,445	33
	B. Capital Expense		
34	Ownership	805,930	34
	C. Ancillary Expense		
35	Special Cost Centers	1,237,763	35
36	Provider Participation Fee	98,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,469,318	40
41	**Income before Income Taxes (line 30 minus line 40)****	(508,164)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (508,164)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,133,360	44
45	Private Pay - Net Inpatient Revenue	2,066,009	45
46	Medicare - Net Inpatient Revenue	701,879	46
47	Other-(specify) Managed care	275,507	47
48	Other-(specify) Hospice	107,491	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,284,246	49

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

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

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

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

^Entity is a cash basis taxpayer.

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/20**

Schedule 19A

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

	Description	Amount
41350	Equipment Rental	145
59911	Misc. Income	15,110
	Total - Line 28	**15,255**
		-

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,016	2,198	$ 116,141	$ 52.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,377	22,982	844,503	36.75	3
4	Licensed Practical Nurses	9,753	10,358	313,099	30.23	4
5	CNAs & Orderlies	29,382	30,613	562,379	18.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,882	2,080	54,460	26.18	9
10	Activity Assistants	1,751	1,968	24,030	12.21	10
11	Social Service Workers	3,253	3,866	104,082	26.92	11
12	Dietician	1,465	1,873	55,669	29.72	12
13	Food Service Supervisor	1,848	2,176	63,920	29.37	13
14	Head Cook	6,538	6,681	119,882	17.94	14
15	Cook Helpers/Assistants	8,951	9,311	106,294	11.42	15
16	Dishwashers					16
17	Maintenance Workers	2,149	2,481	59,693	24.06	17
18	Housekeepers	10,621	11,526	153,717	13.34	18
19	Laundry	17	17	237	13.74	19
20	Administrator	1,919	2,130	125,567	58.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,830	2,080	35,606	17.12	23
24	Clerical	8,850	9,809	231,592	23.61	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	1,587	1,834	29,277	15.96	31
32	Other Health C: MDS Coordinator	2,159	2,515	96,609	38.41	32
33	Other(specify) Admissions	4,567	4,918	119,281	24.25	33
34	TOTAL (lines 1 - 33)	121,913	131,415	$ 3,216,038 *	$ 24.47	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,800	9(3)	36
37	Medical Records Consultant	8	515	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	369	11(3)	44
45	Social Service Consultant	4	288	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	17	$ 28,172		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Springs at Crystal Lake # 0051284 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Stephanie Demitrinko	Administrator	0%	$	125,567
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	125,567

B. Administrative - Other

Description		Amount
Mark Welder - Guaranteed payments	$	343,892
(Adjusted on Schedule V Column 7)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	343,892

C. Professional Services

Vendor/Payee	Type		Amount
Brian A. Stines, P.C.	Legal	$	1,884
Marilyn P. Dunn	Legal		656
Much Shelist Attorneys At Law	Legal		7,626
Vanek, Larson & Kolb LLC	Legal		2,945
09302020 CC Pmt	Legal		(215)
RSM US LLP	Accounting		45,519
Paylocity	Payroll Fees		9,396
Ability Network, Inc.	Computer Services		4,784
Chase Card Services	Computer Services		4,855
Information Controls, Inc.	Computer Services		3,442
Relias Llc	Computer Services		3,319
See Sch 21C	Various		126,111
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	210,322

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	83,286
Unemployment Compensation Insurance		
FICA Taxes		256,403
Employee Health Insurance		229,131
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits		11,633
TOTAL (agree to Schedule V, line 22, col.8)	$	580,453

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

Description	Line #		Amount
N/A		$	
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	1,990
Advertising: Employee Recruitment		1,029
Health Care Worker Background Check		
(Indicate # of checks performed 11)		110
Patient Background Checks 307		6,083
Health Care Council of IL		13,918
Miscellaneous Dues & Licenses		9,807
Less : HCCI Lobbying		(6,959)
Less: Chamber of Commerce Dues		(655)
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	25,323

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		775
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	775

**See instructions.

Facility Name: **The Springs at Crystal Lake**
IDPH License ID Number: **0051284**
Fiscal Year End: **12/31/20**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Singer Networks Llc	Computer Services	16,125
Telemedicine Solutions, Llc	Computer Services	6,000
Zimmet Healthcare Services Group, Llc	Computer Services	51,900
Allscripts	Professional Fees	3,750
MDI Achieve	Professional Fees	44,016
The Joint Commission	Professional Fees	2,850
Personnel Planners, Inc.	Professional Fees	1,470
	Total (agree to Schedule V, line 19, column 3)	210,322
Allocated from Management Company	Legal Fees	15,600
MDI Achieve	Reclassed to Line 10	(44,016)
Less :	Non-Allowable Legal Fees	(9,854)
	Total (agree to Schedule V, line 19, column 8)	172,052

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Health Care Council of IL = 13,918**

(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. $ **14,535** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,578**
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? **Yes** Indicate the amount. $ **640**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.