

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0054866</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																													
Facility Name: <u>Prairie Creek Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.																																																																																													
Address: <u>2530 North Monroe</u> <u>Decatur</u> <u>62526</u>																																																																																															
Number City Zip Code																																																																																															
County: <u>Macon</u>																																																																																															
Telephone Number: <u>(217) 875-0920</u> Fax # <u>(217) 876-9351</u>																																																																																															
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Denise A. Leonard, CPA</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>1111 Superior Ave Suite 1250 Cleveland OH 44114</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>1/1/2018</u></td><td colspan="2">(Telephone) <u>(216) 274-6514</u> Fax # <u>(248) 233-7349</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td></tr><tr><td colspan="2"></td><td colspan="2"></td></tr><tr><td colspan="2"></td><td colspan="2"></td></tr><tr><td colspan="2"></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Denise A. Leonard, CPA</u></td><td colspan="2">Telephone Number: <u>(216) 274-6514</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Denise A. Leonard, CPA</u> <u>Partner</u>	(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>1111 Superior Ave Suite 1250 Cleveland OH 44114</u>	Date of Initial License for Current Owners: <u>1/1/2018</u>		(Telephone) <u>(216) 274-6514</u> Fax # <u>(248) 233-7349</u>		Type of Ownership:		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		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust					☐	Other _____															In the event there are further questions about this report, please contact:				Name: <u>Denise A. Leonard, CPA</u>		Telephone Number: <u>(216) 274-6514</u>		Email Address: _____			
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Facility Name & ID Number Prairie Creek Village

0054866 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>195</u>	Skilled (SNF)	<u>195</u>	<u>71,370</u>	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	<u>195</u>	TOTALS	<u>195</u>	<u>71,370</u>	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>41,615</u>	<u>2,183</u>	<u>5,995</u>	<u>49,793</u>
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>41,615</u>	<u>2,183</u>	<u>5,995</u>	<u>49,793</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.77%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 01/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 195 and days of care provided 5,207

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 Prairie Creek Village # 0054866 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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	308,913	62,490	16,425	387,828		387,828	5,425	393,253			1
2	Food Purchase		361,212		361,212		361,212	(2,806)	358,406			2
3	Housekeeping	249,031		35,500	284,531		284,531	(3,166)	281,365			3
4	Laundry	36,112		31,734	67,846		67,846	(361)	67,485			4
5	Heat and Other Utilities			167,224	167,224		167,224	(21,491)	145,733			5
6	Maintenance	68,947	182,173		251,120		251,120	126,990	378,110			6
7	Other (specify):*			41,688	41,688		41,688	25,025	66,713			7
8	TOTAL General Services	663,003	605,875	292,571	1,561,449		1,561,449	129,616	1,691,065			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	3,299,006	94,026	794,240	4,187,272		4,187,272	48,827	4,236,099			10
10a	Therapy			997,627	997,627		997,627		997,627			10a
11	Activities	103,284	4,397	2,699	110,380		110,380		110,380			11
12	Social Services	188,720		3,271	191,991		191,991		191,991			12
13	CNA Training											13
14	Program Transportation			2,947	2,947		2,947		2,947			14
15	Other (specify):*							12,232	12,232			15
16	TOTAL Health Care and Programs	3,591,010	98,423	1,815,784	5,505,217		5,505,217	61,059	5,566,276			16
	C. General Administration											
17	Administrative	104,905			104,905		104,905	146,071	250,976			17
18	Directors Fees											18
19	Professional Services			1,501,510	1,501,510		1,501,510	(1,390,506)	111,004			19
20	Dues, Fees, Subscriptions & Promotions			26,795	26,795		26,795	2,949	29,744			20
21	Clerical & General Office Expenses	116,790	49,352	80,558	246,700		246,700	238,491	485,191			21
22	Employee Benefits & Payroll Taxes			772,636	772,636		772,636	(240)	772,396			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,789	3,789		3,789	376	4,165			24
25	Other Admin. Staff Transportation			2,919	2,919		2,919	6,746	9,665			25
26	Insurance-Prop.Liab.Malpractice			238,927	238,927		238,927	2,144	241,071			26
27	Other (specify):*			18,594	18,594		18,594	32,710	51,304			27
28	TOTAL General Administration	221,695	49,352	2,645,728	2,916,775		2,916,775	(961,259)	1,955,516			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,475,708	753,650	4,754,083	9,983,441		9,983,441	(770,584)	9,212,857			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			39,057	39,057		39,057	197,471	236,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,036	39,036		39,036	208,817	247,853			32
33	Real Estate Taxes			151,008	151,008		151,008	15,165	166,173			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			2,177	2,177		2,177	4,930	7,107			35
36	Other (specify):*			2,900	2,900		2,900	(2,900)				36
37	TOTAL Ownership			612,178	612,178		612,178	45,483	657,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	106,026	138,015	199,582	443,623		443,623	(14,480)	429,143			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			377,317	377,317		377,317		377,317			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	106,026	138,015	576,899	820,940		820,940	(14,480)	806,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,581,734	891,665	5,943,160	11,416,559		11,416,559	(739,581)	10,676,978			45

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

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	(23,161)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(78,230)	30		9
10	Interest and Other Investment Income	(2,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(900)	36		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	(10,483)	21		18
19	Entertainment				19
20	Contributions	(330)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,264)	27		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	(58,557)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (192,363)		\$	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)	(547,218)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (547,218)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (739,581)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Collections Expense	\$ (6,715)	19	1
2	Bank Fees	(3,400)	21	2
3	Theft & Damange Losses	(1,240)	21	3
4	Non-Allowable Interest	(1,000)	32	4
5	Amortization of Financing Fees	(2,000)	36	5
6	Jury Duty Income	(70)	10	6
7	Capitalized R&M	(5,664)	06	7
8	Additional R&M	3,938	06	8
9	Non-Allowable Legal	(1,953)	19	9
10	Website Expenses	(2,108)	19	10
11	Public Relations	(4,901)	19	11
12		0		12
13		0		13
14		0		14
15		0		15
16	Generations HC Property of Decatur LLC	0		16
17	Office Expenses & Fees	(584)	21	17
18	Legal and Accounting Fees	(3,100)	19	18
19	Amortization of Financing/Org. Costs	(26,860)	31	19
20	Capitalized R&M	(2,900)	06	20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
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37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	Total	(58,557)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Creek Village# 0054866

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	6,212	0	(787)	0	0	0	0	0	5,425	1
2	Food Purchase	0	0	(2,806)	0	0	0	0	0	0	0	0	(2,806)	2
3	Housekeeping	0	0	0	0	0	(3,166)	0	0	0	0	0	(3,166)	3
4	Laundry	0	0	0	0	0	(361)	0	0	0	0	0	(361)	4
5	Heat and Other Utilities	(23,161)	0	0	1,670	0	0	0	0	0	0	0	(21,491)	5
6	Maintenance	(4,626)	2,900	13,660	115,490	0	(434)	0	0	0	0	0	126,990	6
7	Other (specify):*	0	0	1,722	23,303	0	0	0	0	0	0	0	25,025	7
8	TOTAL General Services	(27,787)	2,900	12,576	146,675	0	(4,748)	0	0	0	0	0	129,616	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(70)	0	65,547	0	(3,041)	(13,609)	0	0	0	0	0	48,827	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	12,232	0	0	0	0	0	0	0	0	12,232	15
16	TOTAL Health Care and Programs	(70)	0	77,779	0	(3,041)	(13,609)	0	0	0	0	0	61,059	16
	C. General Administration													
17	Administrative	0	0	20,797	125,274	0	0	0	0	0	0	0	146,071	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,777)	3,100	(1,387,737)	12,908	0	0	0	0	0	0	0	(1,390,506)	19
20	Fees, Subscriptions & Promotions	0	0	2,949	0	0	0	0	0	0	0	0	2,949	20
21	Clerical & General Office Expenses	(15,707)	584	253,528	105	(20)	0	0	0	0	0	0	238,490	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(240)	0	0	0	0	0	0	(240)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	376	0	0	0	0	0	0	0	0	376	24
25	Other Admin. Staff Transportation	0	0	6,746	0	0	0	0	0	0	0	0	6,746	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,940	204	0	0	0	0	0	0	0	2,144	26
27	Other (specify):*	(18,594)	0	22,258	29,046	0	0	0	0	0	0	0	32,710	27
28	TOTAL General Administration	(53,078)	3,684	(1,079,143)	167,537	(260)	0	0	0	0	0	0	(961,260)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,935)	6,584	(988,788)	314,212	(3,301)	(18,357)	0	0	0	0	0	(770,585)	29

STATE OF ILLINOIS

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(78,230)	271,440	0	4,261	0	0	0	0	0	0	0	197,471	30
31	Amortization of Pre-Op. & Org.	(26,860)	26,859	0	0	0	0	0	0	0	0	0	(1)	31
32	Interest	(3,438)	210,831	(1,667)	3,091	0	0	0	0	0	0	0	208,817	32
33	Real Estate Taxes	0	7,756	0	7,409	0	0	0	0	0	0	0	15,165	33
34	Rent-Facility & Grounds	0	(378,000)	0	0	0	0	0	0	0	0	0	(378,000)	34
35	Rent-Equipment & Vehicles	0	0	4,930	0	0	0	0	0	0	0	0	4,930	35
36	Other (specify):*	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	36
37	TOTAL Ownership	(111,428)	138,886	3,263	14,761	0	0	0	0	0	0	0	45,482	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	(14,480)	0	0	0	0	0	0	(14,480)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	(14,480)	0	0	0	0	0	0	(14,480)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(192,363)	145,470	(985,525)	328,973	(17,781)	(18,357)	0	0	0	0	0	(739,583)	45

VII. RELATED PARTIES

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

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

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 378,000	Generations Healthcare Property of Decatur, LLC	100.00%	\$	(378,000)	1
2	V	33	Real Estate Taxes	151,008	Generations Healthcare Property of Decatur, LLC	100.00%	158,764	7,756	2
3	V	21	Office Expenses & Fees		Generations Healthcare Property of Decatur, LLC	100.00%	584	584	3
4	V	32	Interest		Generations Healthcare Property of Decatur, LLC	100.00%	210,831	210,831	4
5	V	31	Amortization		Generations Healthcare Property of Decatur, LLC	100.00%	26,859	26,859	5
6	V	30	Depreciation		Generations Healthcare Property of Decatur, LLC	100.00%	271,440	271,440	6
7	V	19	Legal & Accounting		Generations Healthcare Property of Decatur, LLC	100.00%	3,100	3,100	7
8	V	06	R&M Expense		Generations Healthcare Property of Decatur, LLC	100.00%	2,900	2,900	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 529,008			\$ 674,478	\$ * 145,470	14

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

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	<u>Atied Associates, LLC</u>	<u>33.33%</u>	<u>Albany Care, Inc.</u>	<u>Evanston, IL</u>	<u>Generations Prop.</u>	<u>Lincolnwood, IL</u>	<u>Bldg. Company</u>	1
2	<u>Barrish Group Limited Partnership</u>	<u>24.63%</u>	<u>Generations at Applewood, LLC</u>	<u>Matteson, IL</u>	<u>Generations HC</u>			2
3	<u>Juliana Barrish</u>	<u>24.63%</u>	<u>Auburn Village</u>	<u>Auburn, IN</u>	<u>Transitions</u>	<u>Lincolnwood, IL</u>	<u>Mgmt. Company</u>	3
4	<u>Michael Giannini</u>	<u>8.70%</u>	<u>Bryan Mawr Care, Inc.</u>	<u>Chicago, IL</u>	<u>SIR Management</u>	<u>Lincolnwood, IL</u>	<u>Mgmt. Company</u>	4
5	<u>Celest Giannini</u>	<u>8.70%</u>	<u>Decatur Manor Healthcare, LLC</u>	<u>Decatur, IL</u>	<u>SIR Properties</u>	<u>Lincolnwood, IL</u>	<u>Bldg. Company</u>	5
6			<u>Generations at Elmwood Park, Inc.</u>	<u>Elmwood Park, IL</u>	<u>Max RX, LLC</u>	<u>Des Plaines, IL</u>	<u>Pharmacy</u>	6
7			<u>Greenwood Care, Inc.</u>	<u>Evanston, IL</u>	<u>Big Ten Supply</u>	<u>Libertyville, IL</u>	<u>Ancillary Supplies</u>	7
8			<u>Generations at Lincoln, LLC</u>	<u>Lincoln, IL</u>	<u>Generations HC</u>	<u>Decatur</u>	<u>Bldg. Company</u>	8
9			<u>Villa Clara Post Acute</u>	<u>Decatur, IL</u>	<u>of Decatur LLC</u>			9
10			<u>Wilson Care, Inc.</u>	<u>Chicago, IL</u>				10
11			<u>Generations at Neighbors, LLC</u>	<u>Byron, IL</u>				11
12			<u>Generations at Oakton Arms, LLC</u>	<u>Des Plaines, IL</u>				12
13			<u>Generations at Oakton Pavillion, LLC</u>	<u>Des Plaines, IL</u>				13
14			<u>Generations at Peoria</u>	<u>Peoria, IL</u>				14
15			<u>Generations at Regency, LLC</u>	<u>Niles, IL</u>				15
16			<u>Generations at Riverview, LLC</u>	<u>East Peoria, IL</u>				16
17			<u>Generations at Riverview Senior Living</u>	<u>East Peoria, IL</u>				17
18			<u>Generations at Rock Island, LLC</u>	<u>Rock Island, IL</u>				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

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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Dietary Other and Rebates	\$	Generations Healthcare Network , LLC	100.00%	\$ (2,806)	\$ (2,806)	15
16	V	6 Repairs & Maintenance		Generations Healthcare Network , LLC	100.00%	13,660	13,660	16
17	V	7 Emp. Ben. - General Svc.		Generations Healthcare Network , LLC	100.00%	1,722	1,722	17
18	V	9 Medical Director Consults		Generations Healthcare Network , LLC	100.00%	0		18
19	V	10 Nursing		Generations Healthcare Network , LLC	100.00%	65,547	65,547	19
20	V	15 Emp. Ben. - Health Care		Generations Healthcare Network , LLC	100.00%	12,232	12,232	20
21	V	17 Administrative		Generations Healthcare Network , LLC	100.00%	20,797	20,797	21
22	V	19 Professional Fees	1,396,040	Generations Healthcare Network , LLC	100.00%	8,303	(1,387,737)	22
23	V	20 Fee, Subscriptions		Generations Healthcare Network , LLC	100.00%	2,949	2,949	23
24	V	21 Clerical & General		Generations Healthcare Network , LLC	100.00%	253,528	253,528	24
25	V	24 Education & Seminar		Generations Healthcare Network , LLC	100.00%	376	376	25
26	V	25 Other Admin. Staff Transportation		Generations Healthcare Network , LLC	100.00%	6,746	6,746	26
27	V	26 Insurance		Generations Healthcare Network , LLC	100.00%	1,940	1,940	27
28	V	27 Emp. Ben. - Gen. Admin.		Generations Healthcare Network , LLC	100.00%	22,258	22,258	28
29	V	32 Interest		Generations Healthcare Network , LLC	100.00%	(1,667)	(1,667)	29
30	V	35 Auto Rental		Generations Healthcare Network , LLC	100.00%	4,189	4,189	30
31	V	35 Equipment Rental		Generations Healthcare Network , LLC	100.00%	741	741	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,396,040			\$ 410,515	\$ * (985,525)	39

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

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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	<u>5</u> Utilities	\$	Generations Healthcare Network , LLC	100.00%	\$ 1,670	\$ 1,670	15
16	V	<u>6</u> Repairs & Maintenance		Generations Healthcare Network , LLC	100.00%	1,440	1,440	16
17	V	<u>19</u> Professional Fees		Generations Healthcare Network , LLC	100.00%	407	407	17
18	V	<u>21</u> Clerical & General		Generations Healthcare Network , LLC	100.00%	105	105	18
19	V	<u>25</u> Auto & Travel		Generations Healthcare Network , LLC	100.00%	0		19
20	V	<u>26</u> Insurance		Generations Healthcare Network , LLC	100.00%	204	204	20
21	V	<u>30</u> Depreciation		Generations Healthcare Network , LLC	100.00%	4,261	4,261	21
22	V	<u>32</u> Interest		Generations Healthcare Network , LLC	100.00%	3,091	3,091	22
23	V	<u>33</u> Real Estate Taxes		Generations Healthcare Network , LLC	100.00%	7,409	7,409	23
24	V							24
25	V	<u>1</u> Dietary Salaries		Generations Healthcare Network , LLC	100.00%	6,212	6,212	25
26	V	<u>7</u> Emp. Ben. - Dietary		Generations Healthcare Network , LLC	100.00%	1,162	1,162	26
27	V	<u>10</u> Nursing Salaries		Generations Healthcare Network , LLC	100.00%	0		27
28	V	<u>15</u> Emp. Ben. - Nursing		Generations Healthcare Network , LLC	100.00%	0		28
29	V	<u>17</u> Admin./Legal Salaries		Generations Healthcare Network , LLC	100.00%	125,274	125,274	29
30	V	<u>19</u> Fin. Consult./Regl. Dir.		Generations Healthcare Network , LLC	100.00%	12,501	12,501	30
31	V	<u>27</u> Emp. Ben. - Administrative		Generations Healthcare Network , LLC	100.00%	29,046	29,046	31
32	V							32
33	V	<u>6</u> Maintenance Salaries		Generations Healthcare Network , LLC	100.00%	114,050	114,050	33
34	V	<u>7</u> Employee Benefits		Generations Healthcare Network , LLC	100.00%	22,141	22,141	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 328,973	\$ * 328,973	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing & Medical Records	\$ 32,541	MAC Rx, LLC	100.00%	\$ 29,500	\$ (3,041)	15
16	V	21	Clerical & General Exp	215	MAC Rx, LLC	100.00%	195	(20)	16
17	V	22	Employee Benefits	2,569	MAC Rx, LLC	100.00%	2,329	(240)	17
18	V	39	Ancillary	154,936	MAC Rx, LLC	100.00%	140,456	(14,480)	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			\$ 190,261			\$ 172,480	\$ * (17,781)	39

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

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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$ 8,192	Big Ten Supply, LLC	100.00%	\$ 7,405	\$ (787)	15
16	V	3 Housekeeping	32,936	Big Ten Supply, LLC	100.00%	29,770	(3,166)	16
17	V	4 Laundry	3,762	Big Ten Supply, LLC	100.00%	3,401	(361)	17
18	V	6 R&M	4,508	Big Ten Supply, LLC	100.00%	4,074	(434)	18
19	V	10 Nursing & Medical Records	141,591	Big Ten Supply, LLC	100.00%	127,982	(13,609)	19
20	V	10A Therapy		Big Ten Supply, LLC	100.00%			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		\$ 190,989			\$ 172,632	\$ * (18,357)	39

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

Facility Name & ID Number Prairie Creek Village # 0054866 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Elka Abramchik	Relative	Clerical	0.00%	See Attachment	1.73	4.38%	Alloc Salary	\$ 3,455	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00%	See Attachment	2.39	5.98%	Alloc Fees	12,501	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00%	See Attachment	2.09	5.24%	Alloc Salary	14,959	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attachment	2.99	5.98%	Alloc Salary	7,692	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00%	See Attachment	3.59	5.98%	Alloc Salary	14,959	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00%	See Attachment	2.39	5.98%	Alloc Salary	3,623	21-7	6
7	Jeff Oravec	Relative	Administrative	0.00%	See Attachment	2.39	5.98%	Alloc Salary	5,838	17-7	7
8	Kirsten Schloss	Relative	Maintenance	0.00%	See Attachment	2.39	5.98%	Alloc Salary	9,329	6-7	8
9	Kim Shelton	Relative	Clerical	0.00%	See Attachment	2.39	5.98%	Alloc Salary	5,302	21-7	9
10	Lynn Ethell	Relative	Clerical	0.00%	See Attachment	2.39	5.98%	Alloc Salary	3,604	21-7	10
11	Michael Giannini	Owner	Administrative	8.70%	See Attachment	2.39	5.32%	Alloc Salary	10,803	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00%	See Attachment	2.39	5.98%	Alloc Salary	6,212	1-7	12
13								TOTAL	\$ 98,277		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.

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Burton Barrish	Relative	Administrative	0.00%	See Attached	2.39	5.98%	Alloc. Salary	6,478	17-7	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	\$ 6,478		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 Prairie Creek Village # 0054866 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 ☒

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Prairie Creek Village# 0054866 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 ☐

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

Name of Related Organization Generations HC Network, LLC
 Street Address 6840 N. Lincoln
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 675-7979
 Fax Number (847) 675-0555

	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	2	Dietary Other and Rebates	Resident Days	832,144	19	\$ (46,886)	\$	49,793	\$ (2,806)	1
2	6	Repairs & Maintenance	Resident Days	832,144	19	228,292	155,904	49,793	13,660	2
3	7	Emp. Ben. - General Svc.	Resident Days	832,144	19	28,781		49,793	1,722	3
4	9	Medical Director Consults	Resident Days	832,144	19			49,793		4
5	10	Nursing	Resident Days	832,144	19	1,095,433	1,094,370	49,793	65,547	5
6	15	Emp. Ben. - Health Care	Resident Days	832,144	19	204,429		49,793	12,232	6
7	17	Administrative	Resident Days	832,144	19	347,566	347,566	49,793	20,797	7
8	19	Professional Fees	Resident Days	832,144	19	138,762		49,793	8,303	8
9	20	Fee, Subscriptions	Resident Days	832,144	19	49,284		49,793	2,949	9
10	21	Clerical & General	Resident Days	832,144	19	4,236,976	3,850,828	49,793	253,528	10
11	24	Education & Seminar	Resident Days	832,144	19	6,287		49,793	376	11
12	25	Other Admin. Staff Transportation	Resident Days	832,144	19	112,731		49,793	6,745	12
13	26	Insurance	Resident Days	832,144	19	32,419		49,793	1,940	13
14	27	Emp. Ben. - Gen. Admin.	Resident Days	832,144	19	371,977		49,793	22,258	14
15	32	Interest	Resident Days	832,144	19	(27,854)		49,793	(1,667)	15
16	35	Auto Rental	Resident Days	832,144	19	70,001		49,793	4,189	16
17	35	Equipment Rental	Resident Days	832,144	19	12,377		49,793	741	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,860,575	\$ 5,448,668		\$ 410,514	25

Facility Name & ID Number Prairie Creek Village# 0054866 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 ☐

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

Name of Related Organization Generations HC Network, LLC
 Street Address 6840 N. Lincoln
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 675-7979
 Fax Number (847) 675-0555

	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	5	Utilities	Alloc Square Footage	12,879	19	\$ 27,900	\$	771	\$ 1,670	1
2	6	Repairs & Maintenance	Alloc Square Footage	12,879	19	24,049		771	1,440	2
3	19	Professional Fees	Alloc Square Footage	12,879	19	6,801		771	407	3
4	21	Clerical & General	Alloc Square Footage	12,879	19	1,754		771	105	4
5	25	Auto & Travel	Alloc Square Footage	12,879	19			771		5
6	26	Insurance	Alloc Square Footage	12,879	19	3,403		771	204	6
7	30	Depreciation	Alloc Square Footage	12,879	19	71,181		771	4,261	7
8	32	Interest	Alloc Square Footage	12,879	19	51,631		771	3,091	8
9	33	Real Estate Taxes	Alloc Square Footage	12,879	19	123,763		771	7,409	9
10										10
11	1	Dietary Salaries	Resident Days	832,144	19	103,820	103,820	49,793	6,212	11
12	7	Emp. Ben. - Dietary	Resident Days	832,144	19	19,413		49,793	1,162	12
13	10	Nursing Salaries	Resident Days	832,144	19			49,793		13
14	15	Emp. Ben. - Nursing	Resident Days	832,144	19			49,793		14
15	17	Admin./Legal Salaries	Resident Days	832,144	19	2,093,591	2,093,591	49,793	125,274	15
16	19	Fin. Consult./Regl. Dir.	Resident Days	832,144	19	208,920		49,793	12,501	16
17	27	Emp. Ben. - Administrative	Resident Days	832,144	19	485,424		49,793	29,046	17
18										18
19	6	Maintenance Salaries	Maint. Revenues	702,930	17	726,469	726,469	110,355	114,050	19
20	7	Employee Benefits	Maint. Revenues	702,930	17	141,032		110,355	22,141	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,089,151	\$ 2,923,880		\$ 328,973	25

Facility Name & ID Number Prairie Creek Village# 0054866 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 ☐

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 & Medical Records	Direct Allocation			\$	\$		29,500	1
2	21	Clerical & General Exp	Direct Allocation						195	2
3	22	Employee Benefits	Direct Allocation						2,329	3
4	39	Ancillary	Direct Allocation						140,456	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					\$	\$		172,480	25

Facility Name & ID Number Prairie Creek Village # 0054866 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 ☐

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

Name of Related Organization Big Ten Supply, LLC
Street Address 15632 West Sprucewood Lane
City / State / Zip Code Libertyville, IL 60048
Phone Number (312) 502-5882
Fax Number (847) 816-3425

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$		\$ 7,405	1
2	3	Housekeeping	Direct Allocation						29,770	2
3	4	Laundry	Direct Allocation						3,401	3
4	6	R&M	Direct Allocation						4,074	4
5	10	Nursing & Medical Records	Direct Allocation						127,982	5
6	10A	Therapy	Direct Allocation							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					\$	\$		\$ 172,632	25

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	Republic Bank		X	Mortgage			\$ 3,262,500	\$ 3,117,431		5.5000	\$ 176,780	1
2	Republic Bank		X	Improvement Financing				1,039,575			34,050	2
3												3
4												4
5												5
	Working Capital											
6	Republic Bank		X	Line of Credit				50,000		5.2500	33,966	6
7	1st Source		X	Auto Loan	\$1,119.00		56,198	25,004		7.2500	3,032	7
8	Related Party Interest	X									1,000	8
9	TOTAL Facility Related				\$1,119.00		\$ 3,318,698	\$ 4,232,010			\$ 248,828	9
	B. Non-Facility Related*											
10	Alloc. SIR / Generations	X									1,424	10
11	Interest Income		X								(2,438)	11
12	Misc. Interest Expense		X								1,039	12
13	Non-Allowable Interest	X									(1,000)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (975)	14
15	TOTALS (line 9+line14)						\$ 3,318,698	\$ 4,232,010			\$ 247,853	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.)

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.			
1. Real Estate Tax accrual used on 2019 report.		\$	164,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	164,534	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	534	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	165,318	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.)		\$	321	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.		\$	166,173	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	154,700	8	
		2016	162,797	9	
		2017	159,756	10	
		2018	156,077	11	
		2019	157,446	12	
2020 Accrual: \$157,446 X 1.05 = \$165,318					
Allocated From Generations: \$7,409					

		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.

FACILITY NAME Prairie Creek Village COUNTY Macon
FACILITY IDPH LICENSE NUMBER 0054866
CONTACT PERSON REGARDING THIS REPORT Denise A. Leonard, CPA
TELEPHONE (216) 274-6514 FAX #: (248) 233-7349

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.

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: 59,720 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (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? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2018</u>	<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 75,000</u>	<u>3</u>

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	195		2018		\$ 3,227,500	\$	40	\$ 80,688	\$ 80,688	\$ 248,813	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Insulated Clear Glass - 1st Floor Conference Room			2019	2,769		20	138	138	276	9
10	Front Entrance Landscaping: Planting Trees,Stone,Edging			2019	7,296		20	365	365	730	10
11	Retaining Wall/ Install Perforated Tiling for Drainage-West Side			2019	9,610		20	481	481	962	11
12	Interior Fire Door Installation (Hallways/Stairwells)			2019	2,800		20	140	140	280	12
13	Wet Chemical Fire Suppression System Throughout Facility			2019	3,226		20	161	161	322	13
14	Signage With Lighting/Lettering/Masonry-Entrance/Outdoors			2019	13,740		20	687	687	1,374	14
15	Floor Exposed Fan Coil Unit In Lobby			2019	4,154		20	208	208	416	15
16	Repair South Water Heater- New Gas Valve			2019	2,554		20	128	128	256	16
17	Repair To Booster Heater- For Water Heater			2019	3,383		20	169	169	338	17
18	Elevator Repair			2019	2,536		20	127	127	254	18
19	Repaired Chilled Water Insulation (Piping-Whole Facility)			2020	2,925		20	146	146	146	19
20	Generator Work- Gaskets, O-Rings, Seals			2020	3,713		20	186	186	186	20
21	Replace Boiler in Mechanical Room-Piping/Power/Controls			2020	215,408		20	10,770	10,770	10,770	21
22	Exterior Signage- Front and Back Entrances			2020	7,175		20	359	359	359	22
23	Security System- Floors 1-5 & Exterior- Cameras and NVR			2020	24,865		20	1,243	1,243	1,243	23
24	Custom Built-in Cabinetry-1st, 3rd-5th Floors-Dining/Reception			2020	49,950		20	2,498	2,498	2,498	24
25	Custom Built in Cabinetry-1st Floor Dining/Theater/Library Rooms			2020	36,000		20	1,800	1,800	1,800	25
26	1st Floor Common Room Flooring- Rubber Floors, Carpet, Tiles			2020	51,604		20	2,580	2,580	2,580	26
27	Wall and Corner Guards- Throughout 3rd Floor			2020	40,577		20	2,029	2,029	2,029	27
28	Custom Wardrobe Closet Work- 3rd Floor Resident Rooms			2020	22,250		20	1,113	1,113	1,113	28
29	Wall & Corner Guards- Corridors/Rooms			2020	7,568		20	378	378	378	29
30	Window Treatments With Clutch System - 1st & 3rd Floor DR			2020	5,273		20	264	264	264	30
31	Window Treatments With Clutch System -3rd Floor			2020	13,418		20	671	671	671	31
32	3rd Floor Tile- Resident Rooms			2020	25,602		20	1,280	1,280	1,280	32
33	3rd Floor Tiling- Shower Rooms & Common Bathroom-Inc Plumbing			2020	17,166		20	858	858	858	33
34	3rd Floor Vinyl Plank- Corridors and Resident Rooms			2020	85,575		20	4,279	4,279	4,279	34
35	Plumbing-Repairs to Water Shut-Off Valve -Shower Rooms			2020	2,739		20	137	137	137	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Labor Costs: 1st-5th Floor Flooring, Plumbing, and Cabinetry Installation	2020	\$ 105,015	\$	20	\$ 5,251	\$ 5,251	\$ 5,251	37
38	Materials/Supplies: 1st-5th Floor Flooring, Plumbing, and Cabinetry	2020	33,446		20	1,672	1,672	1,672	38
39	Exterior Signage-Corner Signs Installation	2020	2,900		20	145	145	145	39
40	Electrical Work 4th Floor-Add Power and Coax Cabling-All Rooms	2020	4,426		20	221	221	221	40
41	Lighting/Ceiling Tiles- Corridors/Rooms- Floors 1-5	2020	5,221		20	261	261	261	41
42	Corridor LED Troffer Lighting on 3rd Floor	2020	3,433		20	172	172	172	42
43	Overbed Lighting for 3rd Floor Resident Rooms	2020	4,224		20	211	211	211	43
44	Electrical Work 3rd Floor-Add Power and Coax Cabling-All Rooms	2020	9,987		20	499	499	499	44
45	100 Gallon Natural Gas Water Heater	2020	8,450		20	423	423	423	45
46	New Exposed Fan Coils- Lobby Area	2020	6,805		20	340	340	340	46
47	4" Copper Domestic Water Line Repair on the First Floor	2020	4,430		20	222	222	222	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	FS Depreciation- Generations at McKinley Place, LLC			39,057			(39,057)		66
67	FS Depreciation- Generations Healthcare Property of Decatur, LLC			271,440			(271,440)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,079,713	\$ 310,497		\$ 123,298	\$ (187,199)	\$ 294,028	70

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

Facility Name & ID Number Prairie Creek Village

0054866

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		\$ 4,079,713	\$ 310,497		\$ 123,298	\$ (187,199)	\$ 294,028	1
2	<u>Generations Healthcare Property of Decatur, LLC</u>								2
3	<u>Access control</u>	2018	8,664		20	433	433	1,300	3
4	<u>Asphalt parking</u>	2018	91,956		20	4,598	4,598	13,793	4
5	<u>Asphalt parking</u>	2018	1,920		20	96	96	288	5
6	<u>Insulation work</u>	2018	49,794		20	2,490	2,490	7,469	6
7	<u>Guards for walls & corners</u>	2018	26,221		20	1,311	1,311	3,933	7
8	<u>Flooring 5th floor</u>	2019	115,368		20	5,768	5,768	11,537	8
9	<u>Wall construction work (5th floor)</u>	2019	45,950		20	2,298	2,298	4,595	9
10	<u>Custom cabinetrywall units</u>	2019	48,400		20	2,420	2,420	4,840	10
11	<u>Plumbing work 5th floor project</u>	2019	11,670		20	583	583	1,167	11
12	<u>Privacy room dividers</u>	2019	13,913		20	696	696	1,391	12
13	<u>Window treatments</u>	2019	13,624		20	681	681	1,362	13
14	<u>Sliding windows/doors</u>	2019	15,999		20	800	800	1,600	14
15	<u>Corridor & lobby 1st floor</u>	2019	17,175		20	859	859	1,718	15
16	<u>Electrical work 5th floor</u>	2019	8,260		20	413	413	826	16
17	<u>Electrical work dining & activity</u>	2019	8,559		20	428	428	856	17
18	<u>Interior glass for renovation</u>	2019	10,240		20	512	512	1,024	18
19	<u>Architect Work- Renovation- Interior- Design/Admin</u>	2019	64,271		20	3,214	3,214	6,427	19
20	<u>Bathroom- Vanity Base- Marble With Faucet</u>	2019	3,927		20	196	196	393	20
21	<u>Bathroom- Plumbing- Ultra Bowl</u>	2019	3,592		20	180	180	359	21
22	<u>5th Floor Ceiling Tiles- SLT 48SF- Radar Illusion</u>	2019	3,347		20	167	167	335	22
23	<u>5th Floor Flooring Work- Supplies</u>	2019	10,575		20	529	529	1,057	23
24	<u>5th Floor Ceiling Tiles- SLT 48SF- Radar Illusion</u>	2019	2,913		20	146	146	291	24
25	<u>5th Floor Lighting- Dining/Corridor- LED/3945 Lumens</u>	2019	4,716		20	236	236	472	25
26	<u>5th Floor Overbed Lighting - LED</u>	2019	3,256		20	163	163	326	26
27	<u>5th Floor Remodel for Renovation - Lighting, Plumbing, Tiling</u>	2019	2,923		20	146	146	292	27
28	<u>5th Floor- Outside Labor Costs - Plumbing, Lighting, Tiling, Etc</u>	2019	39,536		20	1,977	1,977	3,954	28
29	<u>Wall Covering/Corner Guards- 5th/4th Floors</u>	2019	6,020		20	301	301	602	29
30	<u>5th Floor Remodel- Materials - Glass/Plumbing/Sanding</u>	2019	6,976		20	349	349	698	30
31	<u>4th Floor Wallcovering</u>	2019	31,990		20	1,599	1,599	3,199	31
32	<u>5th Floor Chilled Water Leak Repair</u>	2019	7,870		20	394	394	787	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,336	\$ 310,497		\$ 157,279	\$ (153,218)	\$ 370,918	34

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

Facility Name & ID Number Prairie Creek Village

0054866

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 12C, Carried Forward		\$ 5,176,191	\$ 310,497		\$ 178,122	\$ (132,375)	\$ 409,339	1
2	Related Party Allocations								2
3									3
4	Training Building Allocation- Generations HC Network	2009	29,932	799	39	767	(32)	8,474	4
5	Building Allocation- SIR Properties/Generations HC	1993	27,099	860	35	774	(86)	20,517	5
6									6
7	Allocated From Generations HC Network	1993	6,870	191	20		(191)	6,870	7
8	Allocated From Generations HC Network	1994	21		20			21	8
9	Allocated From Generations HC Network	1995	157		20			157	9
10	Allocated From Generations HC Network	1997	10,557	236	20		(236)	10,557	10
11	Allocated From Generations HC Network	1999	830		20	31	31	830	11
12	Allocated From Generations HC Network	1999			20				12
13	Allocated From Generations HC Network	2000	980		20	22	22	980	13
14	Allocated From Generations HC Network	2007	3,149		20	157	157	2,077	14
15	Allocated From Generations HC Network	2008	8,678		20	321	321	6,347	15
16	Allocated From Generations HC Network	2009	21,564		20	1,078	1,078	12,124	16
17	Allocated From Generations HC Network	2011	534	53	20	53		502	17
18	Allocated From Generations HC Network	2012	1,707	85	20	85		633	18
19	Allocated From Generations HC Network	2014	239	24	20	12	(12)	79	19
20	Allocated From Generations HC Network	2016	311	16	20	16		69	20
21	Allocated From Generations HC Network	2019	1,553	76	20	76		97	21
22	Allocated From Generations HC Network	2020	1,265	26	20	26		26	22
23									23
24	Allocated From SIR Properties/Generations HC	2012	1,660		20	83	83	582	24
25	Allocated From SIR Properties/Generations HC	2010	1,635		20	82	82	763	25
26	Allocated From SIR Properties/Generations HC	2009	1,627		20	81	81	879	26
27	Allocated From SIR Properties/Generations HC	2007	160	9	20	8	(1)	104	27
28	Allocated From SIR Properties/Generations HC	2002	107		20	5	5	94	28
29	Allocated From SIR Properties/Generations HC	1999	3,434		20	86	86	3,434	29
30	Allocated From SIR Properties/Generations HC	1998			20				30
31	Allocated From SIR Properties/Generations HC	1997			20				31
32	Allocated From SIR Properties/Generations HC	1994	258	7	20		(7)	258	32
33	Allocated From SIR Properties/Generations HC	1993	439	2	20		(2)	439	33
34	TOTAL (lines 1 thru 33)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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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)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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 12E, Carried Forward		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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 12G, Carried Forward		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	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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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)		\$ 5,300,957	\$ 312,881		\$ 181,885	\$ (130,996)	\$ 486,252	34

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

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	\$ 110,020	\$	\$ 11,002	\$ 11,002	10	\$ 24,174	71
72	Current Year Purchases	51,057		5,106	5,106	10	5,106	72
73	Fully Depreciated Assets					10		73
74	See Attached	332,772	1,287	25,447	24,160	10	134,086	74
75	TOTALS	\$ 493,849	\$ 1,287	\$ 41,554	\$ 40,267		\$ 163,365	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	2018 Ford Transit	2019	\$ 60,107	\$	\$ 12,021	\$ 12,021	5	\$ 24,043	76
77	Allocated From Generations		2020	7,059	589	1,066	477		3,782	77
78										78
79										79
80	TOTALS			\$ 67,166	\$ 589	\$ 13,087	\$ 12,498		\$ 27,825	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 5,936,972	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 314,757	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,527	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (78,230)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 677,442	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.

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								5
6								6
7	TOTAL				\$			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 2,918 Description: \$2,177 Copier/Printer; \$741 Allocated From Generations
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From Generations		\$	\$ 4,189	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,189	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.

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

☒ 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)	\$			

(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.

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	

(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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	\$	5,208	\$ 417,528	\$	5,208	\$ 417,528	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,245	102,165		1,245	102,165	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		6,057	477,935		6,057	477,935	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	106,026					106,026	8
9	Pharmacy	V39	# of prescripts				194,191		194,191	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					5,392		5,392	12
13	Other (specify): BILLABLE SUPPLIES	V39					138,015		138,015	13
14	TOTAL			\$ 106,026	12,511	\$ 997,628	\$ 337,598	12,511	\$ 1,441,252	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 676,841	\$ 688,728	1
2	Cash-Patient Deposits	101,550	101,550	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,513,260	1,513,260	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	180,397	180,397	6
7	Other Prepaid Expenses	16,015	16,015	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	534,316	592,770	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,022,379	\$ 3,092,720	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,000	13
14	Buildings, at Historical Cost		3,287,500	14
15	Leasehold Improvements, at Historical Cost	341,844	1,967,927	15
16	Equipment, at Historical Cost	231,984	1,415,923	16
17	Accumulated Depreciation (book methods)	(55,735)	(734,418)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		98,648	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(70,181)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached	1,185,984	1,185,984	22
23	Other(specify): See Attached		720,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,704,077	\$ 7,946,383	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,726,456	\$ 11,039,102	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 506,801	\$ 509,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,712	101,712	28
29	Short-Term Notes Payable	75,004	75,004	29
30	Accrued Salaries Payable	210,657	210,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	224,966	224,966	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,318	32
33	Accrued Interest Payable		14,824	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,313	22,313	35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	2,118,821	2,118,821	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,260,274	\$ 3,443,080	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,039,575	39
40	Mortgage Payable		3,117,431	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached			43
44	See Attached		1,185,984	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,342,990	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,260,274	\$ 8,786,070	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,466,182	\$ 2,253,032	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,726,456	\$ 11,039,102	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 541,503	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 541,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	924,679	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)	\$ 924,679	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)	\$ 1,466,182	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Prairie Creek Village# 0054866Report 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.**1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,702,586	1
2	Discounts and Allowances for all Levels	(2,490,001)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,212,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,717,730	6
7	Oxygen	73	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,717,803	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	181,093	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,445	19
20	Radiology and X-Ray	1,569	20
21	Other Medical Services	27,605	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 211,712	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,438	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,438	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		1,196,700	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,196,700	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,341,238	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,561,449	31
32	Health Care	5,505,217	32
33	General Administration	2,916,775	33
	B. Capital Expense		
34	Ownership	612,178	34
	C. Ancillary Expense		
35	Special Cost Centers	443,623	35
36	Provider Participation Fee	377,317	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,416,559	40
41	Income before Income Taxes (line 30 minus line 40)**	924,679	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 924,679	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,510,484	44
45	Private Pay - Net Inpatient Revenue	416,803	45
46	Medicare - Net Inpatient Revenue	2,511,219	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	171,799	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(2,397,721)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,212,585	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,577	1,597	\$ 74,832	\$ 46.86	1
2	Assistant Director of Nursing	1,369	1,465	49,555	33.83	2
3	Registered Nurses	5,245	5,544	194,756	35.13	3
4	Licensed Practical Nurses	43,056	46,203	1,453,279	31.45	4
5	CNAs & Orderlies	74,644	80,330	1,317,608	16.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,944	5,504	106,026	19.26	8
9	Activity Director					9
10	Activity Assistants	8,249	8,635	103,284	11.96	10
11	Social Service Workers	9,303	10,119	188,720	18.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,590	24,799	308,913	12.46	15
16	Dishwashers					16
17	Maintenance Workers	3,412	3,518	68,947	19.60	17
18	Housekeepers	20,533	21,699	249,031	11.48	18
19	Laundry	3,016	3,416	36,112	10.57	19
20	Administrator	1,794	1,826	104,905	57.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,285	6,834	116,790	17.09	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	6,785	7,519	208,976	27.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	213,802	229,008	\$ 4,581,734 *	\$ 20.01	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fees	\$ 16,424	V01-03	35
36	Medical Director	Monthly Fees	15,000	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	12,179	V10-03	39
40	Physical Therapy Consultant	Monthly Fees	7,337	V10A-03	40
41	Occupational Therapy Consultant	Monthly Fees	4,677	V10A-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly Fees	1,857	V10A-03	43
44	Activity Consultant	Monthly Fees	2,699	V11-03	44
45	Social Service Consultant	Monthly Fees	3,271	V12-03	45
46	Other(specify)				46
47	Restorative Nursing Consultant	Monthly Fees	2,715	V10-03	47
48	Chief Medical Officer	Monthly Fees	49,140	V10-03	48
49	TOTAL (lines 35 - 48)		\$ 115,299		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,051	\$ 336,164	V10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	11,029	394,042	V10-3	52
53	TOTAL (lines 50 - 52)	16,080	\$ 730,206		53

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

** See instructions.

STATE OF ILLINOIS

0054866

Report Period Beginning:

01/01/20

Ending:

12/31/20

Facility Name & ID Number

Prairie Creek Village

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Caren Williams</td> <td>Administrator</td> <td>0.00%</td> <td>\$ 104,905</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 104,905</td> </tr> </table>			Name	Function	Ownership %	Amount	Caren Williams	Administrator	0.00%	\$ 104,905																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,905	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 113,256</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>42,101</td> </tr> <tr> <td>FICA Taxes</td> <td>339,648</td> </tr> <tr> <td>Employee Health Insurance</td> <td>247,344</td> </tr> <tr> <td>Employee Meals</td> <td> </td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr> <td>Life Insurance</td> <td>1,819</td> </tr> <tr> <td>401K Matching Expense</td> <td>4,796</td> </tr> <tr> <td>Other Employee Benefits/COVID Benefits</td> <td>23,432</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> </tr> </table>			Description	Amount	Workers' Compensation Insurance	\$ 113,256	Unemployment Compensation Insurance	42,101	FICA Taxes	339,648	Employee Health Insurance	247,344	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Life Insurance	1,819	401K Matching Expense	4,796	Other Employee Benefits/COVID Benefits	23,432							TOTAL (agree to Schedule V, line 22, col.8)		F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$ 1,996</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>17,661</td> </tr> <tr> <td>Health Care Worker Background Check</td> <td>3,749</td> </tr> <tr> <td>(Indicate # of checks performed 326)</td> <td> </td> </tr> <tr> <td>Patient Background Checks</td> <td> </td> </tr> <tr> <td>Dues & Subscriptions</td> <td>601</td> </tr> <tr> <td>Licenses & Fees</td> <td>2,788</td> </tr> <tr> <td>Allocated From Generations</td> <td>2,949</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>Less: Public Relations Expense</td> <td>()</td> </tr> <tr> <td>Non-allowable advertising</td> <td>()</td> </tr> <tr> <td>Yellow page advertising</td> <td>()</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> </tr> </table>			Description	Amount	IDPH License Fee	\$ 1,996	Advertising: Employee Recruitment	17,661	Health Care Worker Background Check	3,749	(Indicate # of checks performed 326)		Patient Background Checks		Dues & Subscriptions	601	Licenses & Fees	2,788	Allocated From Generations	2,949					Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	
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STATE OF ILLINOIS

Facility Name & ID Number
0054866

Report Period Beginning: 01/01/20

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Ending: 12/31/20

Prairie Creek Village

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
Personnel Planners	Unemployment Consult	\$ 1,869				\$	Out-of-State Travel	\$
Pinnacle	Customer Satisfaction	850						
Ability Networks	Risk Mgmt/Scheduling	10,758						
Helathspring/Providigm	Quality Management	3,300					In-State Travel	
Patient Ping	Resident Management	4,375						
Access One	IT Consulting	7,405						
Playbook Communicate	Project Management	3,644						
Go Daddy	Website Costs (Adjusted)	2,009					Seminar Expense	
Reside Admissions	Admissions Consultant	1,990						
Generations HC Network	Consulting Fees	500,000						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 536,200				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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? No
If YES, give association name and amount. N/A

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,457 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. \$ 377,317
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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 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.