

		FOR BHF USE					

LL1

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>0054874</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>Villa Clara Post Acute</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>500 W McKinley Ave</u> <u>Decatur</u> <u>62526</u>																																																																																									
Number City Zip Code																																																																																									
County: <u>Macon</u>																																																																																									
Telephone Number: <u>(217) 875-0020</u> Fax # <u>(217) 875-0647</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">MAIL TO: BUREAU OF HEALTH FINANCE</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><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Name: <u>Denise A. Leonard, CPA</u></td><td colspan="2">Phone # (217) 782-1630</td></tr><tr><td colspan="2">Telephone Number: <u>(216) 274-6514</u></td><td colspan="2"></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		<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 _____			201 S. Grand Avenue East		In the event there are further questions about this report, please contact:		Springfield, IL 62763-0001		Name: <u>Denise A. Leonard, CPA</u>		Phone # (217) 782-1630		Telephone Number: <u>(216) 274-6514</u>				Email Address: _____			
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																																																																																							
<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 _____			201 S. Grand Avenue East																																							
☐	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:		Springfield, IL 62763-0001																																																																																							
Name: <u>Denise A. Leonard, CPA</u>		Phone # (217) 782-1630																																																																																							
Telephone Number: <u>(216) 274-6514</u>																																																																																									
Email Address: _____																																																																																									

Facility Name & ID Number Villa Clara Post Acute

0054874 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
N/A					
1	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	150	Skilled (SNF)	150	54,900	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	150	TOTALS	150	54,900	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,186	3,271	8,905	29,362	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,186	3,271	8,905	29,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.48%

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 1/1/2018

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 150 and days of care provided 7,924

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ 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 Villa Clara Post Acute # 0054874 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	254,632	48,324	14,699	317,655		317,655	1,882	319,537			1
2	Food Purchase		242,392		242,392		242,392	(1,250)	241,142			2
3	Housekeeping	209,561		36,738	246,299		246,299	(2,912)	243,387			3
4	Laundry	89,211		34,275	123,486		123,486	(356)	123,130			4
5	Heat and Other Utilities			117,558	117,558		117,558	(22,418)	95,140			5
6	Maintenance	50,477	172,266		222,743		222,743	147,145	369,888			6
7	Other (specify):*			44,313	44,313		44,313	30,919	75,232			7
8	TOTAL General Services	603,881	462,982	247,583	1,314,446		1,314,446	153,010	1,467,456			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,225,272	157,699	1,058,879	3,441,850		3,441,850	10,865	3,452,715			10
10a	Therapy			989,377	989,377		989,377		989,377			10a
11	Activities	104,954	6,895	2,699	114,548		114,548		114,548			11
12	Social Services	127,529		2,699	130,228		130,228		130,228			12
13	CNA Training											13
14	Program Transportation			5,481	5,481		5,481		5,481			14
15	Other (specify):*							5,449	5,449			15
16	TOTAL Health Care and Programs	2,457,755	164,594	2,074,135	4,696,484		4,696,484	16,314	4,712,798			16
	C. General Administration											
17	Administrative	108,865			108,865		108,865	65,073	173,938			17
18	Directors Fees											18
19	Professional Services			792,733	792,733		792,733	(690,193)	102,540			19
20	Dues, Fees, Subscriptions & Promotions			30,250	30,250		30,250	1,314	31,564			20
21	Clerical & General Office Expenses	161,188	38,801	67,435	267,424		267,424	102,041	369,465			21
22	Employee Benefits & Payroll Taxes			589,969	589,969		589,969	(153)	589,816			22
23	Inservice Training & Education											23
24	Travel and Seminar			772	772		772	168	940			24
25	Other Admin. Staff Transportation			4,476	4,476		4,476	3,005	7,481			25
26	Insurance-Prop.Liab.Malpractice			204,841	204,841		204,841	955	205,796			26
27	Other (specify):*			20,091	20,091		20,091	2,765	22,856			27
28	TOTAL General Administration	270,053	38,801	1,710,567	2,019,421		2,019,421	(515,025)	1,504,396			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,331,689	666,377	4,032,285	8,030,351		8,030,351	(345,701)	7,684,650			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			19,099	19,099		19,099	338,199	357,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,868	34,868		34,868	324,072	358,940			32
33	Real Estate Taxes			120,516	120,516		120,516	9,387	129,903			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles			2,177	2,177		2,177	2,196	4,373			35
36	Other (specify):*			3,235	3,235		3,235	(985)	2,250			36
37	TOTAL Ownership			767,895	767,895		767,895	84,869	852,764			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	106,036	159,810	341,445	607,291		607,291	(25,246)	582,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,608	221,608		221,608		221,608			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	106,036	159,810	563,053	828,899		828,899	(25,246)	803,653			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,437,725	826,187	5,363,233	9,627,145		9,627,145	(286,078)	9,341,067			45

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

	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	79,321	30		9
10	Interest and Other Investment Income	(1,392)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(985)	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				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	(19,761)	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	(81,964)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,272)		\$	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)	(237,826)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (237,826)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (286,098)		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	\$ (6,116)	19	1
2	Bank Fees	(2,685)	21	2
3	Credit Card Fees	(2,546)	21	3
4	Theft & Damage Loss	(788)	21	4
5	Non-Allowable Interest Expense	(1,660)	32	5
6	Miscellaneous Income	(4,847)	21	6
7	Prior Year Oxygen Expense	(842)	10	7
8	Capitalized R&M	(13,248)	06	8
9	Non-Allowable Legal Expense	(2,016)	19	9
10	Website Design	(2,110)	19	10
11		0		11
12		0		12
13		0		13
14		0		14
15	Generations HC Property of McKinley, LLC	0		15
16	Office Expenses & Fees	(596)	21	16
17	Professional Fees	(3,100)	19	17
18	Amortization	(42,697)	31	18
19	Additional R&M	1,286	06	19
20		0		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
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
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	(81,965)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Clara Post Acute

0054874

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	2,767	0	(885)	0	0	0	0	0	1,882	1
2	Food Purchase	0	0	(1,250)	0	0	0	0	0	0	0	0	(1,250)	2
3	Housekeeping	0	0	0	0	0	(2,912)	0	0	0	0	0	(2,912)	3
4	Laundry	0	0	0	0	0	(356)	0	0	0	0	0	(356)	4
5	Heat and Other Utilities	(23,161)	0	0	743	0	0	0	0	0	0	0	(22,418)	5
6	Maintenance	(11,962)	0	6,085	153,291	0	(269)	0	0	0	0	0	147,145	6
7	Other (specify):*	0	0	767	30,152	0	0	0	0	0	0	0	30,919	7
8	TOTAL General Services	(35,123)	0	5,602	186,953	0	(4,422)	0	0	0	0	0	153,010	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	(842)	0	29,200	0	(1,308)	(16,185)	0	0	0	0	0	10,865	10
10a	Therapy	0	0	0	0	0	(20)	0	0	0	0	0	(20)	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	5,449	0	0	0	0	0	0	0	0	5,449	15
16	TOTAL Health Care and Programs	(842)	0	34,649	0	(1,308)	(16,205)	0	0	0	0	0	16,294	16
	C. General Administration													
17	Administrative	0	0	9,265	55,808	0	0	0	0	0	0	0	65,073	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,342)	3,100	(685,701)	5,750	0	0	0	0	0	0	0	(690,193)	19
20	Fees, Subscriptions & Promotions	0	0	1,314	0	0	0	0	0	0	0	0	1,314	20
21	Clerical & General Office Expenses	(11,462)	596	112,943	47	(84)	0	0	0	0	0	0	102,040	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(153)	0	0	0	0	0	0	(153)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	168	0	0	0	0	0	0	0	0	168	24
25	Other Admin. Staff Transportation	0	0	3,005	0	0	0	0	0	0	0	0	3,005	25
26	Insurance-Prop.Liab.Malpractice	0	0	864	91	0	0	0	0	0	0	0	955	26
27	Other (specify):*	(20,091)	0	9,916	12,940	0	0	0	0	0	0	0	2,765	27
28	TOTAL General Administration	(44,895)	3,696	(548,226)	74,636	(237)	0	0	0	0	0	0	(515,026)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,860)	3,696	(507,975)	261,589	(1,545)	(20,627)	0	0	0	0	0	(345,722)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	79,321	256,982	0	1,896	0	0	0	0	0	0	0	338,199	30
31	Amortization of Pre-Op. & Org.	(42,697)	42,697	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,052)	326,491	(742)	1,375	0	0	0	0	0	0	0	324,072	32
33	Real Estate Taxes	0	6,091	0	3,296	0	0	0	0	0	0	0	9,387	33
34	Rent-Facility & Grounds	0	(588,000)	0	0	0	0	0	0	0	0	0	(588,000)	34
35	Rent-Equipment & Vehicles	0	0	2,196	0	0	0	0	0	0	0	0	2,196	35
36	Other (specify):*	(985)	0	0	0	0	0	0	0	0	0	0	(985)	36
37	TOTAL Ownership	32,587	44,261	1,454	6,567	0	0	0	0	0	0	0	84,869	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	(25,246)	0	0	0	0	0	0	(25,246)	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	(25,246)	0	0	0	0	0	0	(25,246)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(48,273)	47,957	(506,521)	268,156	(26,791)	(20,627)	0	0	0	0	0	(286,099)	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 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ 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	\$ 588,000	Generations Healthcare Property of McKinley, LLC	100.00%	\$	(588,000)	1
2	V	33	Real Estate Taxes	120,516	Generations Healthcare Property of McKinley, LLC	100.00%	126,607	6,091	2
3	V	21	Office Expenses & Fees		Generations Healthcare Property of McKinley, LLC	100.00%	596	596	3
4	V	32	Interest		Generations Healthcare Property of McKinley, LLC	100.00%	326,491	326,491	4
5	V	19	Accounting & Legal		Generations Healthcare Property of McKinley, LLC	100.00%	3,100	3,100	5
6	V	31	Amortization		Generations Healthcare Property of McKinley, LLC	100.00%	42,697	42,697	6
7	V	30	Depreciation		Generations Healthcare Property of McKinley, LLC	100.00%	256,982	256,982	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 708,516			\$ 756,473	\$ * 47,957	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	Atied Associates, LLC	33.33%	Albany Care, Inc.	Evanston, IL	Generations Prop.	Lincolnwood, IL	Bldg. Company	1
2	Barrish Group Limited Partnership	24.63%	Generations at Applewood, LLC	Matteson, IL	Generations HC			2
3	Juliana Barrish	24.63%	Auburn Village	Auburn, IN	Transitions	Lincolnwood, IL	Mgmt. Company	3
4	Michael Giannini	8.70%	Bryan Mawr Care, Inc.	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	4
5	Celeste Giannini	8.70%	Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	5
6			Generations at Elmwood Park, Inc.	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	6
7			Greenwood Care, Inc.	Evanston, IL	Big Ten Supply	Libertyville, IL	Ancillary Supplies	7
8			Generations at Lincoln, LLC	Lincoln, IL	Generations HC	Decatur, IL	Bldg. Company	8
9			Wilson Care, Inc.	Chicago, IL	Property-McKinley			9
10			Prairie Creek Village	Decatur, IL				10
11			Generations at Neighbors, LLC	Byron, IL				11
12			Generations at Oakton Arms, LLC	Des Plaines, IL				12
13			Generations at Oakton Pavillion, LLC	Des Plaines, IL				13
14			Generations at Peoria	Peoria, IL				14
15			Generations at Regency, LLC	Niles, IL				15
16			Generations at Riverview, LLC	East Peoria, IL				16
17			Generations at Riverview Senior Living	East Peoria, IL				17
18			Generations at Rock Island, LLC	Rock Island, IL				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%	\$ (1,250)	\$ (1,250)	15
16	V	6 Repairs & Maintenance		Generations Healthcare Network, LLC	100.00%	6,085	6,085	16
17	V	7 Emp. Ben. - General Svc.		Generations Healthcare Network, LLC	100.00%	767	767	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%	29,200	29,200	19
20	V	15 Emp. Ben. - Health Care		Generations Healthcare Network, LLC	100.00%	5,449	5,449	20
21	V	17 Administrative		Generations Healthcare Network, LLC	100.00%	9,265	9,265	21
22	V	19 Professional Fees	689,400	Generations Healthcare Network, LLC	100.00%	3,699	(685,701)	22
23	V	20 Fee, Subscriptions		Generations Healthcare Network, LLC	100.00%	1,314	1,314	23
24	V	21 Clerical & General		Generations Healthcare Network, LLC	100.00%	112,943	112,943	24
25	V	24 Education & Seminar		Generations Healthcare Network, LLC	100.00%	168	168	25
26	V	25 Other Admin. Staff Transportation		Generations Healthcare Network, LLC	100.00%	3,005	3,005	26
27	V	26 Insurance		Generations Healthcare Network, LLC	100.00%	864	864	27
28	V	27 Emp. Ben. - Gen. Admin.		Generations Healthcare Network, LLC	100.00%	9,916	9,916	28
29	V	32 Interest		Generations Healthcare Network, LLC	100.00%	(742)	(742)	29
30	V	35 Auto Rental		Generations Healthcare Network, LLC	100.00%	1,866	1,866	30
31	V	35 Equipment Rental		Generations Healthcare Network, LLC	100.00%	330	330	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 689,400			\$ 182,879	\$ * (506,521)	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	5 Utilities	\$	Generations Healthcare Network, LLC	100.00%	\$ 743	\$ 743	15
16	V	6 Repairs & Maintenance		Generations Healthcare Network, LLC	100.00%	640	640	16
17	V	19 Professional Fees		Generations Healthcare Network, LLC	100.00%	181	181	17
18	V	21 Clerical & General		Generations Healthcare Network, LLC	100.00%	47	47	18
19	V	25 Auto & Travel		Generations Healthcare Network, LLC	100.00%	0		19
20	V	26 Insurance		Generations Healthcare Network, LLC	100.00%	91	91	20
21	V	30 Depreciation		Generations Healthcare Network, LLC	100.00%	1,896	1,896	21
22	V	32 Interest		Generations Healthcare Network, LLC	100.00%	1,375	1,375	22
23	V	33 Real Estate Taxes		Generations Healthcare Network, LLC	100.00%	3,296	3,296	23
24	V							24
25	V	1 Dietary Salaries		Generations Healthcare Network, LLC	100.00%	2,767	2,767	25
26	V	7 Emp. Ben. - Dietary		Generations Healthcare Network, LLC	100.00%	517	517	26
27	V	10 Nursing Salaries		Generations Healthcare Network, LLC	100.00%	0		27
28	V	15 Emp. Ben. - Nursing		Generations Healthcare Network, LLC	100.00%	0		28
29	V	17 Admin./Legal Salaries		Generations Healthcare Network, LLC	100.00%	55,808	55,808	29
30	V	19 Fin. Consult./Regl. Dir.		Generations Healthcare Network, LLC	100.00%	5,569	5,569	30
31	V	27 Emp. Ben. - Administrative		Generations Healthcare Network, LLC	100.00%	12,940	12,940	31
32	V							32
33	V	6 Maintenance Salaries		Generations Healthcare Network, LLC	100.00%	152,651	152,651	33
34	V	7 Employee Benefits		Generations Healthcare Network, LLC	100.00%	29,635	29,635	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 268,156	\$ * 268,156	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	\$ 13,997	MAC Rx LLC	100.00%	\$ 12,689	\$ (1,308)	15
16	V	21	Clerical & General Office Exp	900	MAC Rx LLC	100.00%	816	(84)	16
17	V	22	Employee Benefits	1,639	MAC Rx LLC	100.00%	1,486	(153)	17
18	V	39	Ancillary	270,131	MAC Rx LLC	100.00%	244,885	(25,246)	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			\$ 286,667			\$ 259,876	\$ * (26,791)	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	01 Dietary	\$ 9,202	Big Ten Supply, LLC	100.00%	\$ 8,317	\$ (885)	15
16	V	03 Housekeeping	30,305	Big Ten Supply, LLC	100.00%	27,393	(2,912)	16
17	V	04 Laundry	3,708	Big Ten Supply, LLC	100.00%	3,352	(356)	17
18	V	06 R&M	2,793	Big Ten Supply, LLC	100.00%	2,524	(269)	18
19	V	10 Nursing & Medical Records	168,394	Big Ten Supply, LLC	100.00%	152,209	(16,185)	19
20	V	10A Therapy	213	Big Ten Supply, LLC	100.00%	193	(20)	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		\$ 214,615			\$ 193,988	\$ * (20,627)	39

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

Facility Name & ID Number Villa Clara Post Acute # 0054874 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	1.07	2.70%	Alloc Salary	\$ 1,539	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00%	See Attachment	1.07	2.67%	Alloc Fees	5,569	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00%	See Attachment	0.93	2.33%	Alloc Salary	6,664	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attachment	1.33	2.67%	Alloc Salary	3,427	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00%	See Attachment	1.60	2.67%	Alloc Salary	6,664	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00%	See Attachment	1.07	2.67%	Alloc Salary	1,614	21-7	6
7	Kirsten Schloss	Relative	Maintenance	0.00%	See Attachment	1.07	2.67%	Alloc Salary	4,156	6-7	7
8	Burton Barrish	Relative	Administrative	0.00%	See Attachment	1.07	2.67%	Alloc Salary	2,886	17-7	8
9	Jeff Oravec	Relative	Administrative	0.00%	See Attachment	1.07	2.67%	Alloc Salary	2,601	17-7	9
10	Lynn Ethell	Relative	Clerical	0.00%	See Attachment	1.07	2.67%	Alloc Salary	1,606	21-7	10
11	Michael Giannini	Owner	Administrative	8.70%	See Attachment	1.07	2.37%	Alloc Salary	4,812	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00%	See Attachment	1.07	2.67%	Alloc Salary	2,767	1-7	12
13								TOTAL	\$ 44,305		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	Kim Shelton	Relative	Clerical	0.00%	See Attached	1.07	2.67%	Alloc Salary	2,362	21-7	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	\$ 2,362		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 Villa Clara Post Acute # 0054874 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 Prop of McKinley LLC
Street Address 6840 N. Lincoln
City / State / Zip Code Lincolnwood, Illinois 60712
Phone Number (847) 675-7979
Fax Number (847) 675-0555

	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 Villa Clara Post Acute# 0054874 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, Illinois 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)	\$	22,182	\$ (1,250)	1
2	6	Repairs & Maintenance	Resident Days	832,144	19	228,292	155,904	22,182	6,085	2
3	7	Emp. Ben. - General Svc.	Resident Days	832,144	19	28,781		22,182	767	3
4	9	Medical Director Consults	Resident Days	832,144	19			22,182		4
5	10	Nursing	Resident Days	832,144	19	1,095,433	1,094,370	22,182	29,200	5
6	15	Emp. Ben. - Health Care	Resident Days	832,144	19	204,429		22,182	5,449	6
7	17	Administrative	Resident Days	832,144	19	347,566	347,566	22,182	9,265	7
8	19	Professional Fees	Resident Days	832,144	19	138,762		22,182	3,699	8
9	20	Fee, Subscriptions	Resident Days	832,144	19	49,284		22,182	1,314	9
10	21	Clerical & General	Resident Days	832,144	19	4,236,976	3,850,828	22,182	112,943	10
11	24	Education & Seminar	Resident Days	832,144	19	6,287		22,182	168	11
12	25	Other Admin. Staff Transportation	Resident Days	832,144	19	112,731		22,182	3,005	12
13	26	Insurance	Resident Days	832,144	19	32,419		22,182	864	13
14	27	Emp. Ben. - Gen. Admin.	Resident Days	832,144	19	371,977		22,182	9,916	14
15	32	Interest	Resident Days	832,144	19	(27,854)		22,182	(742)	15
16	35	Auto Rental	Resident Days	832,144	19	70,001		22,182	1,866	16
17	35	Equipment Rental	Resident Days	832,144	19	12,377		22,182	330	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,860,575	\$ 5,448,668		\$ 182,879	25

Facility Name & ID Number Villa Clara Post Acute# 0054874 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, Illinois 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	\$	343	\$ 743	1
2	6	Repairs & Maintenance	Alloc Square Footage	12,879	19	24,049		343	640	2
3	19	Professional Fees	Alloc Square Footage	12,879	19	6,801		343	181	3
4	21	Clerical & General	Alloc Square Footage	12,879	19	1,754		343	47	4
5	25	Auto & Travel	Alloc Square Footage	12,879	19			343		5
6	26	Insurance	Alloc Square Footage	12,879	19	3,403		343	91	6
7	30	Depreciation	Alloc Square Footage	12,879	19	71,181		343	1,896	7
8	32	Interest	Alloc Square Footage	12,879	19	51,631		343	1,375	8
9	33	Real Estate Taxes	Alloc Square Footage	12,879	19	123,763		343	3,296	9
10										10
11	1	Dietary Salaries	Resident Days	832,144	19	103,820	103,820	22,182	2,767	11
12	7	Emp. Ben. - Dietary	Resident Days	832,144	19	19,413		22,182	517	12
13	10	Nursing Salaries	Resident Days	832,144	19			22,182		13
14	15	Emp. Ben. - Nursing	Resident Days	832,144	19			22,182		14
15	17	Admin./Legal Salaries	Resident Days	832,144	19	2,093,591	2,093,591	22,182	55,808	15
16	19	Fin. Consult./Regl. Dir.	Resident Days	832,144	19	208,920		22,182	5,569	16
17	27	Emp. Ben. - Administrative	Resident Days	832,144	19	485,424		22,182	12,940	17
18										18
19	6	Maintenance Salaries	Maint. Revenues	702,930	17	726,469	726,469	147,705	152,651	19
20	7	Employee Benefits	Maint. Revenues	702,930	17	141,032		147,705	29,635	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,089,151	\$ 2,923,880		\$ 268,156	25

Facility Name & ID Number Villa Clara Post Acute# 0054874 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, Illinois 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			\$	\$		12,689	1
2	21	Clerical & General Office Exp	Direct Allocation						816	2
3	22	Employee Benefits	Direct Allocation						1,486	3
4	39	Ancillary	Direct Allocation						244,885	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					\$	\$		259,876	25

Facility Name & ID Number Villa Clara Post Acute# 0054874 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, Illinois 60048

Phone Number

(312) 502-5882

Fax Number

(847) 816-3425

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			\$	\$		8,317	1
2	03	Housekeeping	Direct Allocation						27,393	2
3	04	Laundry	Direct Allocation						3,352	3
4	06	R&M	Direct Allocation						2,524	4
5	10	Nursing & Medical Records	Direct Allocation						152,209	5
6	10A	Therapy	Direct Allocation						193	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					\$	\$		193,988	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			\$ 5,361,375	\$ 5,122,978			\$ 290,509	1
2	Republic Bank		X	Improvement Financing				1,048,550			35,982	2
3												3
4												4
5												5
	Working Capital											
6	Republic Bank		X	Line of Credit				370,000			33,208	6
7	Allocated From Generations		X								633	7
8	Related Party Interest	X									1,660	8
9	TOTAL Facility Related						\$ 5,361,375	\$ 6,541,528			\$ 361,992	9
	B. Non-Facility Related*											
10	Non-Allowable Interest	X									(1,660)	10
11	Interest Income		X								(1,392)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (3,052)	14
15	TOTALS (line 9+line14)						\$ 5,361,375	\$ 6,541,528			\$ 358,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # 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.	\$	131,000		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.)	\$	128,815		2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,185)		3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	131,945		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.)	\$	143		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.	\$	129,903		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	123,470	8	
	2016	129,933	9	
	2017	127,506	10	
	2018	124,570	11	
	2019	125,662	12	
2020 Accrual: \$125,662 X 1.05 = 131,945				
Allocated From Generations: \$3,296				

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Clara Post Acute COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054874

CONTACT PERSON REGARDING THIS REPORT Denise A. Leonard, CPA

TELEPHONE (216) 274-6514 FAX #: (248) 233-7349

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-12-03-251-015	Long Term Care Property	\$ 125,661.80	\$ 125,661.80
2. Alloc. - SIR Management	Home Office Allocation	\$ 148,905.51	\$ 3,105.78
3. 10-31-401-046-0000	Allocated From Regency	\$ 796,746.36	\$ 257.82
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,071,313.67	\$ 129,025.40

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	60,100	B. General Construction Type:	Exterior	Brick	Frame	Wood	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	-------------	--------------------------	----------

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	Facility		2018	\$ 150,000
2				
3	TOTALS			\$ 150,000

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		2018		\$ 5,475,972	\$	40	\$ 136,899	\$ 136,899	\$ 410,698	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater		2018		4,408		20	220	220	661	9
10	Fire Alarm System		2018		6,502		20	325	325	975	10
11	8 Rooms Install Wiring & Lights		2018		3,884		20	194	194	583	11
12	10 Ton Lennox RTU (HVAC)		2018		19,164		20	958	958	2,875	12
13	New Lights & Switches 300 Hall		2018		4,687		20	234	234	703	13
14	Shower & Tubs 300 EM Unit		2018		2,775		20	139	139	416	14
15	Repair of Leak on Freezer Condensor/New Compressor		2019		4,662		20	233	233	466	15
16	Installation of Cameras and Security System		2019		17,140		20	857	857	1,714	16
17	Exterior Landscaping: Trees, Sodding, Drainage		2019		27,815		20	1,391	1,391	2,782	17
18	Landscaping- Grading, Seeding, Drainage- North Side		2019		6,068		20	303	303	607	18
19	Landscaping Istallation- Planter Boxes Near Entrance		2019		3,098		20	155	155	310	19
20	New Signage For All Resident Rooms		2019		5,228		20	261	261	523	20
21	Plumbing in New Bathroom- Toilets and Sinks		2019		2,815		20	141	141	281	21
22	Plumbing Repair on South West Side- Bathroom Plumbing		2019		3,140		20	157	157	314	22
23	Ceiling Repair Due to Water Damage- Leaks on South West Side		2019		3,224		20	161	161	322	23
24	Install Delay Egress System - Throughout Facility		2019		3,576		20	179	179	358	24
25	HVAC Unit Replacement- New 7.5 Ton Lennox RTU		2020		8,500		20	425	425	425	25
26	Replcement of Air Compressor on Sprinkler System		2020		4,938		20	247	247	247	26
27	Labor All Wings-Res Rm,Common Rms,Bath-Plumbing/Flooring/Renov		2020		43,035		20	2,152	2,152	2,152	27
28	Materials-Res/Common/Bath Rooms-Plumbing/Flooring/Renov		2020		17,425		20	871	871	871	28
29	Built in Cabinetry/Quartz Top & Wardrobes-Res Rooms/Sports Bar Area		2020		15,000		20	750	750	750	29
30	New 100 Gallon NG Water Heater		2020		8,450		20	423	423	423	30
31	Intercom System-1st FI Nurses Station-Relay/Egress,Wiring Box		2020		6,772		20	339	339	339	31
32											32
33	Financial Statement Depreciation- Villa Clara					19,099			(19,099)		33
34	Financial Statement Depreciation- Generations HC Property of McKinley LLC					256,982			(256,982)		34
35	Financial Statement Depreciation- SIR Mgmt/Generations HC Network LLC										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	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		\$	\$		\$	\$	\$	37
38								38
39								39
40	2018	273,396		20	13,670	13,670	41,009	40
41	2018	137,934		20	6,897	6,897	20,690	41
42	2018	2,880		20	144	144	432	42
43	2018	127,940		20	6,397	6,397	19,191	43
44	2018	48,814		20	2,441	2,441	7,322	44
45	2019	63,531		20	3,177	3,177	6,353	45
46	2019	19,857		20	993	993	1,986	46
47	2019	19,650		20	983	983	1,965	47
48	2019	58,698		20	2,935	2,935	5,870	48
49	2019	26,105		20	1,305	1,305	2,611	49
50	2019	52,500		20	2,625	2,625	5,250	50
51	2019	42,000		20	2,100	2,100	4,200	51
52	2019	12,700		20	635	635	1,270	52
53	2019	61,600		20	3,080	3,080	6,160	53
54	2019	26,000		20	1,300	1,300	2,600	54
55	2019	35,750		20	1,788	1,788	3,576	55
56	2019	70,756		20	3,538	3,538	7,076	56
57	2019	25,330		20	1,267	1,267	2,534	57
58	2019	24,345		20	1,217	1,217	2,434	58
59	2019	17,775		20	889	889	1,778	59
60	2019	65,500		20	3,275	3,275	6,550	60
61	2019	19,592		20	980	980	1,960	61
62	2019	105,000		20	5,250	5,250	10,500	62
63	2019	4,318		20	216	216	432	63
64	2019	6,220		20	311	311	622	64
65	2019	11,444		20	572	572	1,144	65
66	2019	3,000		20	150	150	300	66
67	2019	5,684		20	284	284	568	67
68	2019	16,608		20	830	830	1,660	68
69								69
70		\$ 7,083,206	\$ 276,081		\$ 217,261	\$ (58,820)	\$ 597,836	70

**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 12A, Carried Forward		\$ 7,083,206	\$ 276,081		\$ 217,261	\$ (58,820)	\$ 597,836	1
2	Generations HC Property of McKinley LLC (Continued)								2
3	Labor & Paint-Renovation Work-Bath,Common Area,Dining,Res R	2019	43,000		20	2,150	2,150	4,300	3
4	Supplies & Materials - Bathroom & Resident Room Renovation	2019	2,605		20	130	130	260	4
5	Labor -Renovation Work-Bath,Common Area,Dining,Res Rooms	2019	58,000		20	2,900	2,900	5,800	5
6	Lighting & Bathroom Supplies- Resident and Common Bathrooms	2019	12,435		20	622	622	1,244	6
7	Lighting & Bathroom Supplies- Resident and Common Bathrooms	2019	6,016		20	301	301	602	7
8	Supplies & Materials - Bathroom & Resident Room Renovation	2019	2,775		20	139	139	278	8
9	Labor -Renovation Work-Bath,Common Area,Dining,Res Rooms	2019	17,416		20	871	871	1,742	9
10	Lighting/Wall Covering/Plates-100 Wing Hall/Resident Rms	2020	5,750		20	287	287	287	10
11	Labor All Wings-Res Rm,Common Rms,Bath-Plumbing/Flooring/R	2020	12,120		20	606	606	606	11
12	Ceramic Floor Tiling In Common Areas	2020	26,615		20	1,331	1,331	1,331	12
13	Floor Tiling in 10 Resident Rooms	2020	19,857		20	993	993	993	13
14	Flooring- Vinyl Plank in 25 Resident Rooms	2020	65,531		20	3,277	3,277	3,277	14
15	Labor All Wings-Res/Common Rm,Bath-Plumbing/Flooring/Renov	2020	41,910		20	2,096	2,096	2,096	15
16	Overbed LED Lights & Walls in 200-Wing Resident Rooms	2020	10,368		20	518	518	518	16
17	Built-In Cabinets/Corian Tops-300Wing Resident/PT Rooms	2020	93,045		20	4,652	4,652	4,652	17
18	Labor All Wings-Res/Common Rm,Bath-Plumbing/Flooring/Renov	2020	49,440		20	2,472	2,472	2,472	18
19	Drywall/Plates/Paint Supplies-100-300Wing Resident Rms	2020	5,134		20	257	257	257	19
20	Floor Tiling in Individual Resident Rooms	2020	21,736		20	1,087	1,087	1,087	20
21	Vinyl Plank Flooring/Base- Back Hallway/2 Resident Rooms	2020	16,907		20	845	845	845	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)		\$ 7,593,865	\$ 276,081		\$ 242,794	\$ (33,287)	\$ 630,481	34

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

Facility Name & ID Number Villa Clara Post Acute

0054874

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 12B, Carried Forward		\$ 7,593,865	\$ 276,081		\$ 242,794	\$ (33,287)	\$ 630,481	1
2	Related Party Allocations								2
3									3
4	Training Building Allocation- Generations Health Care	2009	13,316	355	39	341	(14)	3,770	4
5	Building Allocation- SIR Properties/Generations HC	1993	12,056	383	35	344	(39)	9,128	5
6									6
7	Allocated From Generations Health Care	1993	3,056	85	20		(85)	3,056	7
8	Allocated From Generations Health Care	1994	10		20			10	8
9	Allocated From Generations Health Care	1995	70		20			70	9
10	Allocated From Generations Health Care	1997	4,697	105	20		(105)	4,697	10
11	Allocated From Generations Health Care	1999	369		20	14	14	369	11
12	Allocated From Generations Health Care	1999			20				12
13	Allocated From Generations Health Care	2000	436		20	10	10	436	13
14	Allocated From Generations Health Care	2007	1,401		20	70	70	924	14
15	Allocated From Generations Health Care	2008	3,861		20	143	143	2,824	15
16	Allocated From Generations Health Care	2009	9,593		20	480	480	5,394	16
17	Allocated From Generations Health Care	2011	237	24	20	24		223	17
18	Allocated From Generations Health Care	2012	760	38	20	38		282	18
19	Allocated From Generations Health Care	2014	107	11	20	5	(6)	35	19
20	Allocated From Generations Health Care	2016	138	7	20	7		31	20
21	Allocated From Generations Health Care	2019	691	34	20	34		43	21
22	Allocated From Generations Health Care	2020	563	12	20	12		12	22
23									23
24	Allocated From SIR Properties/Generations Heealth Care	2012	738		20	37	37	259	24
25	Allocated From SIR Properties/Generations Heealth Care	2010	727		20	36	36	339	25
26	Allocated From SIR Properties/Generations Heealth Care	2009	724		20	36	36	391	26
27	Allocated From SIR Properties/Generations Heealth Care	2007	71	4	20	4		46	27
28	Allocated From SIR Properties/Generations Heealth Care	2002	48		20	2	2	42	28
29	Allocated From SIR Properties/Generations Heealth Care	1999	1,528		20	38	38	1,528	29
30	Allocated From SIR Properties/Generations Heealth Care	1998			20				30
31	Allocated From SIR Properties/Generations Heealth Care	1997			20				31
32	Allocated From SIR Properties/Generations Heealth Care	1994	115	3	20		(3)	115	32
33	Allocated From SIR Properties/Generations Heealth Care	1993	196	1	20		(1)	196	33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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 12C, Carried Forward		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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		\$7,649,373	\$277,143		\$244,469	\$(32,674)	\$664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,649,373	\$277,143		\$244,469	\$(32,674)	\$664,701	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,649,373	\$ 277,143		\$ 244,469	\$ (32,674)	\$ 664,701	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	\$114,555	\$	\$11,456	\$11,456	10	\$24,948	71
72	Current Year Purchases	26,377		2,638	2,638	10	2,638	72
73	Fully Depreciated Assets					10		73
74	See Attached	1,017,455	572	98,261	97,689	10	299,800	74
75	TOTALS	\$1,158,387	\$572	\$112,355	\$111,783		\$327,386	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated From Generations		2020	\$3,140	\$262	\$474	\$212		\$1,683	76
77										77
78										78
79										79
80	TOTALS			\$3,140	\$262	\$474	\$212		\$1,683	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)	\$8,960,900	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$277,977	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$357,298	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$79,321	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$993,769	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	Outdoor Signs/Intercom	\$10,850	92
93	Contruction- Wiring, Tiling,	267,132	93
94	Lighting, fans, Dining Room,		94
95	Bathrooms, Resident Rooms	\$277,982	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: \$ 2,507 Description: \$2,177 Copier/Printer; \$330 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		\$	\$ 1,866	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,866	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.

HFS 3745 (N-4-99)

IL478-2471

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	\$	4,811	\$ 403,238	\$	4,811	\$ 403,238	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,062	100,115		1,062	100,115	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		6,040	486,024		6,040	486,024	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	106,036					106,036	8
9	Pharmacy	V39	# of prescripts				320,830		320,830	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					20,615		20,615	12
13	Other (specify): BILLABLE SUPPLIES	V39					159,810		159,810	13
14	TOTAL			\$ 106,036	11,912	\$ 989,377	\$ 501,255	11,912	\$ 1,596,668	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 623,276	\$ 633,772	1
2	Cash-Patient Deposits	33,455	33,455	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,643,408	1,643,408	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,322	133,322	6
7	Other Prepaid Expenses	13,068	13,068	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	143,482	190,130	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,590,011	\$ 2,647,155	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		4,884,750	14
15	Leasehold Improvements, at Historical Cost	148,765	1,975,051	15
16	Equipment, at Historical Cost	120,507	1,016,205	16
17	Accumulated Depreciation (book methods)	(32,179)	(743,743)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		156,681	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(111,522)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached	277,982	1,734,429	22
23	Other(specify): See Attached	5,258	5,258	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 520,333	\$ 9,067,109	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,110,344	\$ 11,714,265	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 510,447	\$ 510,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,468	33,468	28
29	Short-Term Notes Payable	370,000	370,000	29
30	Accrued Salaries Payable	214,998	214,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	157,679	157,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,945	32
33	Accrued Interest Payable		22,814	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,985	9,985	35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	2,343,139	2,343,139	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,639,716	\$ 3,794,472	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,048,550	39
40	Mortgage Payable		5,122,978	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached		382,675	43
44	See Attached			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,554,203	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,639,716	\$ 10,348,675	46
47	TOTAL EQUITY (page 18, line 24)	\$ (529,372)	\$ 1,365,589	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,110,344	\$ 11,714,265	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 54,304	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 54,304	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(583,676)	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)	\$ (583,676)	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)	\$ (529,372)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Villa Clara Post Acute

0054874

Report Period Beginning: 01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,156,516	1
2	Discounts and Allowances for all Levels	(3,312,196)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,844,320	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,893,800	6
7	Oxygen	28	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,893,828	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	286,366	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,378	19
20	Radiology and X-Ray	10,692	20
21	Other Medical Services	23,672	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 325,108	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,392	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,392	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		978,821	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 978,821	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,043,469	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,314,446	31
32	Health Care	4,696,484	32
33	General Administration	2,019,421	33
	B. Capital Expense		
34	Ownership	767,895	34
	C. Ancillary Expense		
35	Special Cost Centers	607,291	35
36	Provider Participation Fee	221,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,627,145	40
41	Income before Income Taxes (line 30 minus line 40)**	(583,676)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (583,676)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,109,356	44
45	Private Pay - Net Inpatient Revenue	705,005	45
46	Medicare - Net Inpatient Revenue	4,220,650	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	380,154	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(3,570,845)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,844,320	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	1,684	1,865	\$ 98,904	\$ 53.03	1
2	Assistant Director of Nursing	1,916	2,010	77,506	38.56	2
3	Registered Nurses	9,513	10,052	400,373	39.83	3
4	Licensed Practical Nurses	21,856	24,134	764,960	31.70	4
5	CNAs & Orderlies	41,523	45,230	733,578	16.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,673	5,026	106,036	21.10	8
9	Activity Director					9
10	Activity Assistants	6,724	7,310	104,954	14.36	10
11	Social Service Workers	3,892	4,163	127,529	30.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,510	19,950	254,632	12.76	15
16	Dishwashers					16
17	Maintenance Workers	2,537	2,750	50,477	18.36	17
18	Housekeepers	15,900	16,957	209,561	12.36	18
19	Laundry	7,721	8,444	89,211	10.57	19
20	Administrator	1,914	2,037	108,865	53.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,443	10,164	161,188	15.86	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	4,791	5,456	149,952	27.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,597	165,548	\$ 3,437,726 *	\$ 20.77	34

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

** See instructions.

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	\$ 14,699	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	7,821	V10-03	39
40	Physical Therapy Consultant	Monthly Fees	4,368	V10A-03	40
41	Occupational Therapy Consultant	Monthly Fees	2,653	V10A-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly Fees	1,056	V10A-03	43
44	Activity Consultant	Monthly Fees	2,699	V11-03	44
45	Social Service Consultant	Monthly Fees	2,699	V12-03	45
46	Other(specify)				46
47	Chief Medical Officer	Monthly Fees	49,140	V10-03	47
48	Restorative Nursing	Monthly Fees	7,188	V10-03	48
49	TOTAL (lines 35 - 48)		\$ 107,323		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,472	\$ 508,051	V10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	12,135	486,678	V10-03	52
53	TOTAL (lines 50 - 52)	18,607	\$ 994,729		53

STATE OF ILLINOIS

0054874

Page 21

Report Period Beginning: 01/01/20

Ending: 12/31/20

Facility Name & ID Number

Villa Clara Post Acute

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Dowell (Jan-July)	Administrator	0.00%	\$ 63,447
Dawn Job (Aug-Dec)	Administrator	0.00%	44,305
Michelle Arnold (July)	Administrator	0.00%	1,113
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,865

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Generations HC Network	Dir. of Environment Svcs	\$ 16,200
Generations HC Network	Outside Labor	1,200
Generations HC Network	Director of Food Service	21,600
Generations HC Network	Dir. of Financial Services	48,600
Generations HC Network	Dir. of Business Develop.	127,800
Generations HC Network	Dir. of Reimbursement	32,400
Generations HC Network	Dir. of Administrative Svcs	63,000
Generations HC Network	Dir. of Regulatory Services	18,000
Generations HC Network	Dir. of Information Tech.	10,800
Generations HC Network	Ancillary Administrative Chgs	45,000
Generations HC Network	Bookkeeping Services	126,000
See Supplemental Page 21		282,133
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 792,733

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 81,458
Unemployment Compensation Insurance	22,657
FICA Taxes	255,056
Employee Health Insurance	208,260
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits/COVID Benefits	18,430
401K Matching Expense	3,955
TOTAL (agree to Schedule V, line 22, col.8)	\$ 589,816

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 2,491
Advertising: Employee Recruitment	17,275
Health Care Worker Background Check (Indicate # of checks performed 328)	3,280
Patient Background Checks	
Dues & Subscriptions	1,520
Licenses &Permits	5,684
Allocated From Generations	1,314
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,564

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	772
Allocated From Generations	168
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 940

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,309 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. \$ 221,608
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. \$ No 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.