

Facility Name Plum Creek SLFReport Period Beginning: 1/1/2019 Ending: 12/31/2019

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	<u>77</u>	Single Unit Apartment	<u>77</u>	<u>28,105</u>	1
2	<u>25</u>	Double Unit Apartment	<u>25</u>	<u>9,125</u>	2
3		Other			3
4	102	TOTALS	102	37,230	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	<u>24,673</u>	<u>1,126</u>		<u>25,799</u>	5
6	Double Unit	<u>8,011</u>	<u>159</u>		<u>8,170</u>	6
7	Other					7
8	TOTALS	32,684	1,285		33,969	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.24%D. Indicate the number of paid bed-hold days the SLF had during this year 430 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 2 (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES ☐ NO ☒

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES ☐ NO ☒

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: _____ Fiscal Year: _____

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? _____ If yes, did the facility make all of the required payments of interest and principal? _____
If no, explain. _____K. Does the facility have any loans from the Federal Home Loan Bank outstanding? _____ If yes, did the facility make all of the required payments of interest and principal? _____
If no, explain. _____L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? _____ If yes, did the facility make all of the required payments of interest and principal? _____
If no, explain. _____

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IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	259,281	282,255		541,536		541,536	1
2	Housekeeping, Laundry and Maintenance	73,587	14,877	166,022	254,486	(36,543)	217,943	2
3	Heat and Other Utilities			138,253	138,253		138,253	3
4	Other (specify):							4
5	TOTAL General Services	332,868	297,132	304,275	934,275	(36,543)	897,732	5
B. Health Care and Programs								
6	Health Care/ Personal Care	420,473	10,723		431,196		431,196	6
7	Activities and Social Services	34,434	26,458		60,892	(8,462)	52,430	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	454,907	37,181		492,088	(8,462)	483,626	9
C. General Administration								
10	Administrative and Clerical	307,770	90,751		398,521		398,521	10
11	Marketing Materials, Promotions and Advertising	39,577	41,691		81,268		81,268	11
12	Employee Benefits and Payroll Taxes	85,896	19,696		105,592		105,592	12
13	Insurance-Property, Liability and Malpractice			175,864	175,864		175,864	13
14	Other (specify): Professional & Mngmnt Fees			583,045	583,045		583,045	14
15	TOTAL General Administration	433,243	152,138	758,909	1,344,290		1,344,290	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,221,018	486,451	1,063,184	2,770,653	(45,005)	2,725,648	16
Capital Expenses								
D. Ownership								
17	Depreciation			486,274	486,274		486,274	17
18	Interest			624,082	624,082		624,082	18
19	Real Estate Taxes			120,000	120,000		120,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Amortization of Prepaid Closing Costs			27,185	27,185		27,185	22
23	TOTAL Ownership			1,257,541	1,257,541		1,257,541	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,221,018	486,451	2,320,725	4,028,194	(45,005)	3,983,189	24

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V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 24.04	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	13	12.48	3
4	Activity Director & Assistants	1	14.42	4
5	Social Service Workers			5
6	Head Cook	2	16.65	6
7	Cook Helpers/Assistants	7	10.12	7
8	Dishwashers			8
9	Maintenance Workers	1	11.00	9
10	Housekeepers	2	9.25	10
11	Laundry			11
12	Managers	2	21.42	12
13	Other Administrative	3	24.41	13
14	Clerical	2	10.00	14
15	Marketing	2	15.87	15
16	Other			16
17	Total (lines 1 thru 16)	36	\$ 14.22	17

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES ☐ NO ☐

Name of related entity: _____ If yes, what is the value of those services? \$ _____

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES ☐ NO ☐

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties**Amount of Fee**

1	Royal Care Management	\$ 227,500	1
2			2
Total		\$ 227,500	3

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VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1					\$	\$		\$	\$	\$	1
2	102		2006	2006	12,602,734	486,274	40	315,068	(171,206)		2
3											3
4											4
5											5
	Improvement Type										
6	Building Improvements:										
7		Not Noted		2007	10,518		40	263	263		6
8		Not Noted		2007	3,392		40	85	85		7
9		Not Noted		2009	8,578		40	214	214		8
10		New Roof		2017	78,000		40	1,950	1,950		9
11		Parking Lot		2018	47,000		40	1,175	1,175		10
12		Dining Room Floor		2018	9,515		40	238	238		11
13		Dining Room Chairs		2019	16,807		7	2,401	2,401		12
14		Roof Repairs		2019	20,497		40	512	512		13
15		Dining Room Painting		2019	4,500		40	113	113		14
16											15
17	TOTAL (lines 1 thru 16)				\$ 12,801,541	\$ 486,274		\$ 322,019	\$ (164,255)	\$	16

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 469,639	\$	\$ 69,943	69,943	7	\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 469,639	\$	\$ 69,943	69,943	\$	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)		\$	\$	24

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IX. RENTAL COSTS**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental? ☐ YES ☐ NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1					/ /	\$		/ /		\$	1
2	Bond		X	Building Purchase / Remodel	4/1 /06	11,600,000	9,375,000	12/1/37	0.0667	624,082	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,600,000	\$ 9,375,000			\$ 624,082	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,600,000	\$ 9,375,000			\$ 624,082	10

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 566,570	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 49,339)	809,000 (49,339)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,326,231	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	849,401		13
14	Buildings, at Historical Cost	12,508,851		14
15	Leasehold Improvements, at Historical Cost	305,515		15
16	Equipment, at Historical Cost	592,854		16
17	Accumulated Depreciation (book methods)	(6,736,021)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	815,538		19
	Accumulated Amortization - Organization & Pre-Operating Costs	(373,791) 2,248,206		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,210,553	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,536,784	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,662	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	525,136		28
29	Short-Term Notes Payable	478,401		29
30	Accrued Salaries Payable	29,247		30
31	Accrued Taxes Payable	119,003		31
32	Accrued Interest Payable	50,785		32
33	Deferred Compensation	627,310		33
34	Other Accrued Expenses	13,512		34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,885,056	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable	9,375,000		40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,375,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,260,056	\$	45
46	TOTAL EQUITY	\$ 276,728	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,536,784	\$	47

*(See instructions.)

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XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

1			
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 3,499,727	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,499,727	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	41,889	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 41,889	14
	D. Other Revenue (specify):		
15	Ancillary Telephone Revenue	10,570	15
16	Food Stamp Revenue	113,309	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 123,879	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,665,495	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	897,732	19
20	Health Care/ Personal Care	483,626	20
21	General Administration	1,344,290	21
	B. Capital Expense		
22	Ownership	1,257,541	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,983,189	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (317,694)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (317,694)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 516,839	32
33	Private Pay - Net Inpatient Revenue	1,462,226	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Managed Care</u>	1,522,690	35
36	Other-(specify) <u>Medical Expense</u>	(2,028)	36
37	TOTAL (This total must agree to Line 3)	\$ 3,499,727	37