

Facility Name Plum Creek SLFReport Period Beginning: 1/1/2021 Ending: 12/31/2021

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>28,182</u>	1
2	<u>25</u>	Double Unit Apartment	<u>25</u>	<u>9,150</u>	2
3		Other			3
4	102	TOTALS	102	37,332	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>21,185</u>	<u>984</u>		<u>22,169</u>	5
6	Double Unit	<u>7,061</u>	<u>843</u>		<u>7,904</u>	6
7	Other					7
8	TOTALS	28,246	1,827		30,073	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 80.56%D. Indicate the number of paid bed-hold days the SLF had during this year 447 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 3 (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? No 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? No 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? No 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	356,121	342,194		698,315		698,315	1
2	Housekeeping, Laundry and Maintenance	128,903	13,796	150,477	293,176		293,176	2
3	Heat and Other Utilities			142,745	142,745		142,745	3
4	Other (specify):							4
5	TOTAL General Services	485,024	355,990	293,222	1,134,236		1,134,236	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	551,313	14,716		566,029		566,029	6
7	Activities and Social Services	27,974	61,964		89,938	(50,760)	39,178	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	579,287	76,680		655,967	(50,760)	605,207	9
	C. General Administration							
10	Administrative and Clerical	303,803	75,485	1,266	380,554		380,554	10
11	Marketing Materials, Promotions and Advertising	49,847	53,033		102,880		102,880	11
12	Employee Benefits and Payroll Taxes	119,563	9,268		128,831		128,831	12
13	Insurance-Property, Liability and Malpractice			198,829	198,829		198,829	13
14	Other (specify): Professional Fees			736,302	736,302		736,302	14
15	TOTAL General Administration	473,213	137,786	936,397	1,547,396		1,547,396	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,537,524	570,456	1,229,619	3,337,599	(50,760)	3,286,839	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			478,626	478,626		478,626	17
18	Interest			587,276	587,276		587,276	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): Amtz of Ppd Closing Costs			27,185	27,185		27,185	22
23	TOTAL Ownership			1,213,087	1,213,087		1,213,087	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,537,524	570,456	2,442,706	4,550,686	(50,760)	4,499,926	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	\$ 34.86	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	15.75	3
4	Activity Director & Assistants	1	17.79	4
5	Social Service Workers			5
6	Head Cook	3	18.00	6
7	Cook Helpers/Assistants	6	13.00	7
8	Dishwashers			8
9	Maintenance Workers	1	18.00	9
10	Housekeepers	2	13.00	10
11	Laundry			11
12	Managers	2	25.24	12
13	Other Administrative	4	37.73	13
14	Clerical	2	15.00	14
15	Marketing	2	25.00	15
16	Other			16
17	Total (lines 1 thru 16)	37	\$ 19.84	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	\$ 210,000	1
2			2
Total		\$ 210,000	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	480,126	40	315,068	(165,058)		2
3											3
4											4
5											5
	Improvement Type										
6		Not Noted		2007	13,910		40	348	348		6
7		Not Noted		2009	8,578		40	214	214		7
8		New Roof		2017	78,000		40	1,950	1,950		8
9		Parking Lot, Dining Room Floor		2018	56,515		40	1,413	1,413		9
10		Dining Room Chairs & Painting, Roof Repair		2019	41,804		40	1,045	1,045		10
11		Dining Room Chairs, Lobby Redo, Elevator		2020	124,054		40	3,101	3,101		11
12		Elevator Modernization Project		2021	48,606		40	1,215	1,215		12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 12,974,201	\$ 480,126		\$ 324,355	\$ (155,771)	\$	17

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	\$ 67,091	\$	(67,091)	7	\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 469,639	\$ 67,091	\$ (67,091)		\$	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	8,775,000	12/1/37	0.0667	587,276	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,600,000	\$ 8,775,000			\$ 587,276	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,600,000	\$ 8,775,000			\$ 587,276	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.

STATE OF ILLINOIS

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 641,239	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	518,092 (235,971)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,128		7
8	Accounts Receivable (owners or related parties)	227,524		8
9	Other(specify): FMAP Receivable	527,306		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,701,318	\$	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	478,175		15
16	Equipment, at Historical Cost	592,855		16
17	Accumulated Depreciation (book methods)	(7,694,777)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	815,538		19
	Accumulated Amortization -	(428,161)		
20	Organization & Pre-Operating Costs	2,032,845		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)	\$ 9,154,727	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,856,045	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,599	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	433,977		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,111		30
31	Accrued Taxes Payable	118,199		31
32	Accrued Interest Payable	47,531		32
33	Deferred Compensation	701,099		33
34	Federal and State Income Taxes	685		34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,408,201	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable	8,775,000		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)	\$ 8,775,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,183,201	\$	45
46	TOTAL EQUITY	\$ 672,845	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,856,046	\$	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	\$ 4,165,277	1
2	Discounts and Allowances	(3,269)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,162,008	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	1,113	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,113	14
	D. Other Revenue (specify):		
15	Grant Revenue	581,392	15
16	SNAP, Ancillary Telephone & Misc	207,537	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 788,929	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,952,050	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,134,236	19
20	Health Care/ Personal Care	605,207	20
21	General Administration	1,547,396	21
	B. Capital Expense		
22	Ownership		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)	\$ 3,286,839	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,665,211	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,665,211	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 659,354	32
33	Private Pay - Net Inpatient Revenue	1,646,982	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Managed Care</u>	2,111,960	35
36	Other-(specify) <u>Tenant Vacancies</u>	(256,288)	36
37	TOTAL (This total must agree to Line 3)	\$ 4,162,008	37