FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 0054833

Facility Name: Prairie Oasis

Address: 16000 Wabash Avenue (Number) South Holland (City) 60473 (Zip Code)

County: Cook

Telephone Number: (708) 339-0600 **Fax #** (708) 339-2766

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2018

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach **Telephone Number:** (773) 945-9528
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Joshua S. Banach, CPA
(Title) Asst. Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	135	Skilled (SNF)	135	45,090	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	135	TOTALS	135	45,090	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,707	2,707	8
9	SNF/PED					9
10	ICF	33,023	555	2,273	35,851	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,023	555	4,980	38,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.51%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 2,707

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	224,579	23,748	65,173	313,500		313,500		313,500			1
2	Food Purchase		192,245		192,245		192,245	1,750	193,995			2
3	Housekeeping	134,563	19,178		153,741		153,741	2,578	156,319			3
4	Laundry	48,624	16,355	26,878	91,857		91,857		91,857			4
5	Heat and Other Utilities			127,009	127,009		127,009	(8,375)	118,634			5
6	Maintenance	77,608		75,432	153,040		153,040	(3,949)	149,091			6
7	Other (specify):*											7
8	**TOTAL General Services**	485,374	251,526	294,492	1,031,392		1,031,392	(7,996)	1,023,396			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	2,153,074	31,889	126,675	2,311,638		2,311,638	(66,326)	2,245,312			10
10a	Therapy	48,956			48,956		48,956		48,956			10a
11	Activities	102,004	3,402	1,415	106,821		106,821		106,821			11
12	Social Services	130,320		1,721	132,041		132,041		132,041			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,472	3,472			15
16	**TOTAL Health Care and Programs**	2,434,354	35,291	162,811	2,632,456		2,632,456	(62,854)	2,569,602			16
	C. General Administration											
17	Administrative	130,994		423,000	553,994		553,994	(352,935)	201,059			17
18	Directors Fees											18
19	Professional Services			84,529	84,529		84,529	(8,267)	76,262			19
20	Dues, Fees, Subscriptions & Promotions			44,117	44,117		44,117	(13,395)	30,722			20
21	Clerical & General Office Expenses	69,621		140,709	210,330		210,330	37,082	247,412			21
22	Employee Benefits & Payroll Taxes			504,075	504,075		504,075		504,075			22
23	Inservice Training & Education											23
24	Travel and Seminar			717	717		717	973	1,690			24
25	Other Admin. Staff Transportation			1,836	1,836		1,836	3,904	5,740			25
26	Insurance-Prop.Liab.Malpractice			201,745	201,745		201,745	1,623	203,368			26
27	Other (specify):*							31,515	31,515			27
28	**TOTAL General Administration**	200,615		1,400,728	1,601,343		1,601,343	(299,500)	1,301,843			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,120,343	286,817	1,858,031	5,265,191		5,265,191	(370,350)	4,894,841			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.

Prairie Oasis
Travel Detail
12/31/2018

Account Number	Date	Employee	Function	Description	
8600.6	12/31/2018	Victoria Vasser	Admissions	Mileage within Illinois	1,496.43
8600.6	12/31/2018	Various- Facility Employees	A&G	Mileage within Illinois- Facility Errands	340.00
	12/31/2018	Allocated From iCare Consulting			3904
		Total			5,740.43

Facility Name & ID Number Prairie Oasis #0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							8,788	8,788			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,235	10,235		10,235	134	10,369			32
33	Real Estate Taxes			473,453	473,453		473,453	3,608	477,061			33
34	Rent-Facility & Grounds			451,000	451,000		451,000	13,981	464,981			34
35	Rent-Equipment & Vehicles			5,068	5,068		5,068		5,068			35
36	Other (specify):*											36
37	**TOTAL Ownership**			939,756	939,756		939,756	26,511	966,267			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	21,125	141,885	449,280	612,290		612,290		612,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,906	280,906		280,906		280,906			42
43	Other (specify):*			16,365	16,365		16,365	(16,365)				43
44	**TOTAL Special Cost Centers**	21,125	141,885	746,551	909,561		909,561	(16,365)	893,196			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,141,468	428,702	3,544,338	7,114,508		7,114,508	(360,204)	6,754,304			45

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,013)	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	8,788	30		9
10	Interest and Other Investment Income	(1,494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(28)	02		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	(1,100)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,174)	21		24
25	Fund Raising, Advertising and Promotional	(1,182)	20		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	(54,819)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,522)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,522)		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

Prairie Oasis

ID# 0054833

Report Period Beginning: 02/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (22,274)	21	1
2	Marketing	(1,165)	43	2
3	Bank Charges	(6,567)	21	3
4	PAC Dues	(12,011)	20	4
5	Medical Records Income	(844)	10	5
6	Non-Allowable Legal	(11,958)	19	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
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,819)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28)	0	1,308	0	470	0	0	0	0	0	0	1,750	2
3	Housekeeping	0	0	2,578	0	0	0	0	0	0	0	0	2,578	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,013)	0	1,638	0	0	0	0	0	0	0	0	(8,375)	5
6	Maintenance	0	0	2,419	0	(6,368)	0	0	0	0	0	0	(3,949)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,041)	0	7,943	0	(5,898)	0	0	0	0	0	0	(7,996)	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	(844)	0	0	0	(65,482)	0	0	0	0	0	0	(66,326)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	3,472	0	0	0	0	0	0	3,472	15
16	**TOTAL Health Care and Programs**	(844)	0	0	0	(62,010)	0	0	0	0	0	0	(62,854)	16
	C. General Administration													
17	Administrative	0	0	(368,880)	0	15,945	0	0	0	0	0	0	(352,935)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,958)	0	1,007	90	2,594	0	0	0	0	0	0	(8,267)	19
20	Fees, Subscriptions & Promotions	(13,693)	0	257	7	34	0	0	0	0	0	0	(13,395)	20
21	Clerical & General Office Expenses	(88,115)	0	91,322	0	33,875	0	0	0	0	0	0	37,082	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	572	0	401	0	0	0	0	0	0	973	24
25	Other Admin. Staff Transportation	0	0	0	0	3,904	0	0	0	0	0	0	3,904	25
26	Insurance-Prop.Liab.Malpractice	0	0	485	0	1,138	0	0	0	0	0	0	1,623	26
27	Other (specify):*	0	0	22,028	0	9,487	0	0	0	0	0	0	31,515	27
28	**TOTAL General Administration**	(113,766)	0	(253,209)	97	67,378	0	0	0	0	0	0	(299,500)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(124,651)	0	(245,266)	97	(530)	0	0	0	0	0	0	(370,350)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Oasis # 0054833 **Report Period Beginning:** 02/01/2018 **Ending:** 12/31/2018

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

	Capital Expense D. Ownership	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)	
30	Depreciation	8,788	0	0	0	0	0	0	0	0	0	0	8,788	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,494)	0	0	1,628	0	0	0	0	0	0	0	134	32
33	Real Estate Taxes	0	0	0	3,608	0	0	0	0	0	0	0	3,608	33
34	Rent-Facility & Grounds	0	0	20,475	(6,494)	0	0	0	0	0	0	0	13,981	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,294	0	20,475	(1,258)	0	0	0	0	0	0	0	26,511	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	0	0	0	0	0	0	0	0	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):*	(1,165)	0	0	0	(15,200)	0	0	0	0	0	0	(16,365)	43
44	**TOTAL Special Cost Centers**	(1,165)	0	0	0	(15,200)	0	0	0	0	0	0	(16,365)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(118,522)	0	(224,791)	(1,161)	(15,730)	0	0	0	0	0	0	(360,204)	45

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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	Shimon Webster	44.07%	Center Home Hispanic Elderly	Chicago	Premier HC & Financi	Skokie	Consulting Co.	1
2	Yeruchom Levovitz	41.11%	Pine Crest Health Care	Hazel Crest	Premier HC Realty	Skokie	Building Co	2
3	Jeffrey Webster	1.48%	Park View Rehab Center	Chicago	iCare Consulting Servi	Skokie	Consulting Co.	3
4	Eli Webster	0.74%	River View Rehab Center	Elgin				4
5	EZ&A LLC	0.74%	Forest City Nursing & Rehab	Rockford				5
6	Kevin Chankin	7.41%	Rock River Health Center	Rockford				6
7	CTCAAR LLC	1.48%	Pearl Pavilion	Freeport				7
8	Chaim Levovitz	1.48%	Oak Park Oasis	Oak Park				8
9	MIR Consultants Inc.	1.48%	Austin Oasis	Chicago				9
10								10
11								11
12								12
13								13
14								14
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29								29
30								30

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	02	Food	$	Premier Healthcare & Financial Services	100.00%	$ 1,308	$ 1,308	15
16	V	03	Housekeeping		Premier Healthcare & Financial Services	100.00%	2,578	2,578	16
17	V	05	Utilities		Premier Healthcare & Financial Services	100.00%	1,638	1,638	17
18	V	06	Repairs & Maintenance		Premier Healthcare & Financial Services	100.00%	2,419	2,419	18
19	V	17	Administrative Expenses		Premier Healthcare & Financial Services	100.00%	54,120	54,120	19
20	V	19	Professional Fees		Premier Healthcare & Financial Services	100.00%	1,007	1,007	20
21	V	20	Dues & Subscriptions		Premier Healthcare & Financial Services	100.00%	257	257	21
22	V	21	Clerical & General Salaries		Premier Healthcare & Financial Services	100.00%	86,424	86,424	22
23	V	21	Clerical & General Other Costs		Premier Healthcare & Financial Services	100.00%	4,898	4,898	23
24	V	24	Seminar & Education		Premier Healthcare & Financial Services	100.00%	572	572	24
25	V	26	Insurance		Premier Healthcare & Financial Services	100.00%	485	485	25
26	V	27	Employee Benefits		Premier Healthcare & Financial Services	100.00%	22,028	22,028	26
27	V	34	Rent Expense		Premier Healthcare & Financial Services	100.00%	20,475	20,475	27
28	V	17	Consulting Fees	423,000	Premier Healthcare & Financial Services	100.00%		(423,000)	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			$ 423,000			$ 198,209	$ * (224,791)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Premier HC Real Estate LLC	100.00%	$ 90	$ 90	15
16	V	20	Dues & Subscriptions		Premier HC Real Estate LLC	100.00%	7	7	16
17	V	32	Interest Expense		Premier HC Real Estate LLC	100.00%	1,628	1,628	17
18	V	33	Real Estate Taxes		Premier HC Real Estate LLC	100.00%	3,608	3,608	18
19	V	34	Rental Income	6,494	Premier HC Real Estate LLC	100.00%		(6,494)	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			$ 6,494			$ 5,333	$ * (1,161)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	02	Food	$	iCare Consulting Services	100.00%	$ 470	$ 470	15
16	V	06	Maint & Plant Operation Salary	15,800	iCare Consulting Services	100.00%	9,432	(6,368)	16
17	V	10	Nursing Salary	93,100	iCare Consulting Services	100.00%	27,618	(65,482)	17
18	V	15	Nursing Benefits/Taxes		iCare Consulting Services	100.00%	3,472	3,472	18
19	V	17	Admin Salary- Non Related		iCare Consulting Services	100.00%	15,945	15,945	19
20	V	19	Professional Fees		iCare Consulting Services	100.00%	2,594	2,594	20
21	V	20	Dues & Subscriptions		iCare Consulting Services	100.00%	34	34	21
22	V	21	A&G Expenses	18,100	iCare Consulting Services	100.00%	1,879	(16,221)	22
23	V	21	A&G Salaries		iCare Consulting Services	100.00%	50,096	50,096	23
24	V	24	Seminars & Education		iCare Consulting Services	100.00%	401	401	24
25	V	25	Auto & Travel		iCare Consulting Services	100.00%	3,904	3,904	25
26	V	26	Insurance		iCare Consulting Services	100.00%	1,138	1,138	26
27	V	27	Employee Benefits/PR Taxes		iCare Consulting Services	100.00%	9,487	9,487	27
28	V	43	Marketing Consultant	15,200	iCare Consulting Services	100.00%		(15,200)	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			$ 142,200			$ 126,470	$ * (15,730)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$ 0	$ *	39

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Member	Administrative	44.07%	See Attached	3.61	9.02%	Alloc Salary	$ 18,040	17-7	1
2	Yeruchom Levovitz	Member	Administrative	41.11%	See Attached	3.61	9.02%	Alloc Salary	18,040	17-7	2
3	Kevin Chankin	Member	Administrative	7.41 %	See Attached	3.61	9.02%	Alloc Salary	18,040	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 54,120		13

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 2/31/2018

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 [X] NO [ ]

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

Name of Related Organization: Premier HC & Financial Services
Street Address: 8131 Monticello
City / State / Zip Code: Skokie, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	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	02	Food	Resident Days	427,478	10	$ 14,500	$	38,558	$ 1,308	1
2	03	Housekeeping	Resident Days	427,478	10	28,586		38,558	2,578	2
3	05	Utilities	Resident Days	427,478	10	18,155		38,558	1,638	3
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817		38,558	2,419	4
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	38,558	54,119	5
6	19	Professional Fees	Resident Days	427,478	10	11,167		38,558	1,007	6
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851		38,558	257	7
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	38,558	86,424	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299		38,558	4,898	9
10	24	Seminar & Education	Resident Days	427,478	10	6,339		38,558	572	10
11	26	Insurance	Resident Days	427,478	10	5,376		38,558	485	11
12	27	Employee Benefits	Resident Days	427,478	10	244,216		38,558	22,028	12
13	34	Rent Expense	Resident Days	427,478	10	227,000		38,558	20,475	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					$ 2,197,453	$ 1,558,147		$ 198,208	25

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 2/31/2018

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 [X] NO [ ]

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

Name of Related Organization: Premier HC Real Estate
Street Address: 8131 Monticello
City / State / Zip Code: Skokie, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	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	19	Professional Fees	Resident Days	427,478	10	$ 1,000	$	38,558	$ 90	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75		38,558	7	2
3	32	Interest Expense	Resident Days	427,478	10	18,053		38,558	1,628	3
4	33	Real Estate Tax	Resident Days	427,478	10	40,000		38,558	3,608	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					$ 59,128	$		$ 5,333	25

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 2/31/2018

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 [X] NO [ ]

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

Name of Related Organization: iCare Consulting Services
Street Address: 8131 Monticello
City / State / Zip Code: Skokie, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	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	02	Food	Resident Days	313,091	7	$ 3,818	$	38,558	$ 470	1
2	06	Maint & Plant Operation Salary	Resident Days	313,091	7	76,592	76,576	38,558	9,432	2
3	10	Nursing Salary	Resident Days	313,091	7	224,262	224,262	38,558	27,618	3
4	15	Nursing Benefits/Taxes	Resident Days	313,091	7	28,189		38,558	3,472	4
5	17	Admin Salary- Non Related	Resident Days	313,091	7	129,477	129,477	38,558	15,945	5
6	19	Professional Fees	Resident Days	313,091	7	21,060		38,558	2,594	6
7	20	Dues & Subscriptions	Resident Days	313,091	7	280		38,558	34	7
8	21	A&G Expenses	Resident Days	313,091	7	15,257		38,558	1,879	8
9	21	A&G Salaries	Resident Days	313,091	7	406,781	406,781	38,558	50,096	9
10	24	Seminars & Education	Resident Days	313,091	7	3,253		38,558	401	10
11	25	Auto & Travel	Resident Days	313,091	7	31,703		38,558	3,904	11
12	26	Insurance	Resident Days	313,091	7	9,242		38,558	1,138	12
13	27	Employee Benefits/PR Taxes	Resident Days	313,091	7	77,031		38,558	9,487	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					$ 1,026,943	$ 837,096		$ 126,470	25

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				40,000			10,235	6
7	Allocated From Premier RE		X								1,628	7
8												8
9	TOTAL Facility Related						$	$ 40,000			$ 11,863	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,494)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,494)	14
15	TOTALS (line 9+line14)						$	$ 40,000			$ 10,369	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	449,817	2
3. Under or (over) accrual (line 2 minus line 1).	$	449,817	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$		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.)**	$	27,244	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.	$	477,061	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	493,215	8
	2014	428,802	9
	2015	453,550	10
	2016	471,597	11
	2017	481,336	12

Allocated From Premier RE: $3,608

Facility is not owned, thus no real estate tax is accrued

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Oasis COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054833

CONTACT PERSON REGARDING THIS REPORT Joshua Banach

TELEPHONE (773) 945-9528 FAX #: (773) 945-9521

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	Long Term Care Property	$ 481,335.70	$ 481,335.70
2.	10-23-324-047-0000	Allocated From Home Office	$ 36,245.26	$ 3,269.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 517,580.96	$ 484,604.98

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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocated From Premier RE			1,714	2
3	TOTALS			$ 1,714	3

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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		$	$		$	$	$	1
2	Related Party Building Allocations								2
3	Allocated From Premier Real Estate	2011	33,591		35	960	960	7,678	3
4	Allocated From Premier Real Estate	2012	4,277		35	122	122	855	4
5									5
6									6
7									7
8	Related Party Leasehold Improvement Allocations								8
9	Allocated From Premier Real Estate	2011	59,743		20	2,987	2,987	23,897	9
10	Allocated From Premier Real Estate	2012	1,732		20	87	87	606	10
11									11
12									12
13	Allocated From Premier HC & Financial Services	2012	762		20	38	38	267	13
14	Allocated From Premier HC & Financial Services	2016	1,786		20	89	89	268	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)		$ 101,891	$		$ 4,283	$ 4,283	$ 33,571	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 101,891	$		$ 4,283	$ 4,283	$ 33,571	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)		$ 101,891	$		$ 4,283	$ 4,283	$ 33,571	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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	$ 26,363	$	$ 2,636	$ 2,636		$ 18,304	71
72	Current Year Purchases	18,587		1,859	1,859		1,859	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 44,950	$	$ 4,495	$ 4,495		$ 20,163	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 148,555	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 8,778	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,778	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 53,734	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Prairie Oasis
12/31/20018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Prairie Oasis				-	
Premier Healthcare & Financial	6,634		663	663	4,352
Premier Real Estate	19,729		1,973	1,973	13,952
				-	
Total	26,363	-	2,636	2,636	18,304

Current Year Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Prairie Oasis	18,587		1,859	1,859	1,859
Premier Healthcare & Financial					
Premier Real Estate					
Total	18,587	-	1,859	1,859	1,859

Fully Depreciated Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Prairie Oasis					
Premier Healthcare & Financial					
Premier Real Estate					
Total	-	-	-	-	-

Total Equipment	Cost	Book Depreciation	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Prairie Oasis	18,587	-	1,859	1,859	1,859
Premier Healthcare & Financial	6,634	-	663	663	4,352
Premier Real Estate	19,729	-	1,973	1,973	13,952
	-	-	-	-	-
Total	44,950	-	4,495	4,495	20,163

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 16000 South Wabash LLC

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	135	2/1/2018	$ 451,000			3
4	Additions							4
5								5
6	Allocated From Premier HC				13,981			6
7	TOTAL		135		$ 464,981 **			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: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 5,068 Description: ____
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

FACILITY NAME	**Prairie Oasis**
FACILITY NUMBER	**0054833**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

DESCRIPTION	AMOUNT
DISHMACHINE	385
COPIERS	4,683
TOTAL	5,068

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Prairie Oasis

STATE OF ILLINOIS
0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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

	1	2	3	4	5	6	7	8	
	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		hrs	$ 3,030		$ 178,481	$		$ 181,511	1
2	Licensed Speech and Language Development Therapist		hrs			51,605			51,605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	18,095		204,702			222,797	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				77,393		77,393	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					14,492	64,492		78,983	13
14	TOTAL			$ 21,125		$ 449,280	$ 141,885		$ 612,290	14

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

FACILITY NAME	**Prairie Oasis**
FACILITY NUMBER	**0054833**
REPORT BEGINNING	**02/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING SPECIAL SERVICES

SUPPLIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 6)

DESCRIPTION	AMOUNT
OXYGEN SUPPLY	1,419
NURSING SUPPLES	55,853
GLOVES	7,220
	-
	-
	-
	-
	-
	-
	-
	64,492

OTHER- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 5)

DESCRIPTION	AMOUNT
G TUBE	8,982
X-RAYS	2,452
LABORATORY	3,057
	-
	-
	-
	-
	-
	-
	-
	14,492

SALARIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 3)

DESCRIPTION	AMOUNT
	-
	-
	-
	-
	-
	-
	-
	-

STATE OF ILLINOIS

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 29,414	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,222,099		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,027		6
7	Other Prepaid Expenses	1,990		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	76,610		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,359,140	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,587		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	60,730		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 79,317	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,438,458	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 374,594	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	40,000		29
30	Accrued Salaries Payable	330,527		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,224		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	25,760		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 789,106	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	364,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 364,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,153,606	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 284,852	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,438,458	$	48

*(See instructions.)

FACILITY NAME	**Prairie Oasis**
FACILITY NUMBER	**0054833**
REPORT BEGINNING	**02/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM PRIOR OWNERS	76,610	
	76,610	

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO COST REPORT	6,983	
ACCRUED BED TAX	18,777	
	25,760	

OTHER NON-CURRENT ASSETS (PAGE 17, LINE 23)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
ORGANIZATION COSTS	46,747	
SECURITY DEPOSITS	3,450	
DUE FROM AFFILIATES	10,533	
	60,730	

OTHER NON-CURRENT LIABILITIES (PAGE 17, LINE 43)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO RELATED PARTY	364,500	
	364,500	

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,852	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)**	$ 284,852	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)**	$ 284,852	24 *

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,208,752	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,208,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,494	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,494	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	189,114	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 189,114	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,399,360	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,031,392	31
32	Health Care	2,632,456	32
33	General Administration	1,601,343	33
	B. Capital Expense		
34	Ownership	939,756	34
	C. Ancillary Expense		
35	Special Cost Centers	628,655	35
36	Provider Participation Fee	280,906	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,114,508	40
41	**Income before Income Taxes (line 30 minus line 40)****	284,852	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 284,852	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,202,895	44
45	Private Pay - Net Inpatient Revenue	122,398	45
46	Medicare - Net Inpatient Revenue	1,357,663	46
47	Other-(specify) Hospice	335,396	47
48	Other-(specify) Commercial	190,400	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,208,752	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.**

FACILITY NAME	**Prairie Oasis**
FACILITY NUMBER	**0054833**
REPORT BEGINNING	**02/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

DESCRIPTION	AMOUNT
MEDICAID W/O CO-INSURANCE	188,270
MEDICAL RECORDS INCOME (ADJ PG 5A)	844
TOTAL	189,114

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,662	2,014	$ 91,131	$ 45.25	1
2	Assistant Director of Nursing	1,608	1,914	69,198	36.15	2
3	Registered Nurses	8,829	10,152	301,843	29.73	3
4	Licensed Practical Nurses	24,678	26,796	752,185	28.07	4
5	CNAs & Orderlies	59,892	66,238	907,428	13.70	5
6	CNA Trainees					6
7	Licensed Therapist	353	500	21,125	42.25	7
8	Rehab/Therapy Aides	2,583	2,903	48,956	16.86	8
9	Activity Director	1,700	1,815	31,934	17.59	9
10	Activity Assistants	5,496	5,948	70,070	11.78	10
11	Social Service Workers	4,726	5,084	130,320	25.63	11
12	Dietician					12
13	Food Service Supervisor	1,752	1,784	45,731	25.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,397	13,048	178,848	13.71	15
16	Dishwashers					16
17	Maintenance Workers	3,172	3,594	77,608	21.59	17
18	Housekeepers	9,989	10,511	134,563	12.80	18
19	Laundry	3,787	4,023	48,624	12.09	19
20	Administrator	1,720	1,816	81,252	44.74	20
21	Assistant Administrator	1,744	1,816	49,742	27.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,835	4,441	69,621	15.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,695	1,819	31,289	17.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached					33
34	TOTAL (lines 1 - 33)	151,618	166,216	$ 3,141,468 *	$ 18.90	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	215	$ 10,415	01-03	35
36	Medical Director	Monthly	33,000	09-03	36
37	Medical Records Consultant	Monthly	2,000	10-03	37
38	Nurse Consultant	Monthly	93,100	10-03	38
39	Pharmacist Consultant	Monthly	6,805	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant	28	1,415	11-03	44
45	Social Service Consultant	28	1,721	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	Monthly	24,770	10-03	47
48	Contracted Dietary	Monthly	54,757	01-03	48
49	TOTAL (lines 35 - 48)	271	$ 227,984		49

C. CONTRACT NURSES

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

Prairie Oasis
Detail of Legal Expense
12/31/2018

GL Account	Date	Vendor	Description of Service	Amount	Adjustment	Allowable
8380.6	2/2/2018	MB Financial	LOC Fees	11,450.00	(11,450.00)	-
8380.6	8/15/2018	Meyer Magence	General Counseling	75.00	-	75.00
8380.6	2/21/2018	SB2	Monthly PA Review	550.00		550.00
8380.6	3/21/2018	SB2	Monthly PA Review	192.36		192.36
8380.6	3/21/2018	SB2	Monthly PA Review	506.25		506.25
8380.6	3/1/2018	SB2	Monthly PA Review	187.50		187.50
8380.6	7/31/2018	Polsinelli	Managed Care Contracting	3,821.96	(508.32)	3,313.64
8380.6	10/31/2018	Polsinelli	Managed Care Contracting	1,207.60		1,207.60
		Total		17,990.67	(11,958.32)	6,032.35

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Amico	Administrator	0.00%	$ 81,252
Tina Davis	Asst. Admin.	0.00%	49,742
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,994

B. Administrative - Other

Description	Amount
Consulting Fees Premier HC & Financial Services	$ 423,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 423,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 17,991
Marcum	Accounting	14,569
Skidelsky & Associates	Real Estate Appeal	27,249
Reliable Health Systems	Data Processing	10,450
Point Click Care	Data Processing	23,957
Streamline HR	HR Consulting	352
Creative Tehnology	IT Support	13,474
Zirmed	Data Processing- Claims Mgmt	473
OnShift	HR Consulting	1,000
EON Applications	Computer Services	385
Survey Marketing	Survey Platform	5
See Attached		1,868
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 111,773

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,400
Unemployment Compensation Insurance	32,959
FICA Taxes	235,019
Employee Health Insurance	110,967
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	22,705
Other Employee Expense	7,425
Holiday Expense	2,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 504,075

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,409
Health Care Worker Background Check	3,082
(Indicate # of checks performed 308)	
Patient Background Checks	
Dues	12,011
Licenses & Fees	1,922
Allocated From Premier HC & Financial	257
Allocated From Premier RE	7
Allocated From iCare Consulting	34
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,722

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	717
Allocated From Premier HC & Financial	572
Allocated From iCare Consulting	401
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,690

**See instructions.

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

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
Experian	Computer Services	$ 101
Ability Network	Data Processing- Claims Mgmt	1,767

TOTAL (agree to Schedule V, line 19, column 3) $ 1,868
(For legal fee disclosure, see page 39 of instructions)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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

Description	Line #	Amount
		$

TOTAL $

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 02/01/2018 Ending: 12/31/2018

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? **Yes**
If YES, give association name and amount. **ILCLTC $24,022**

(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. $ **21,462** Line **10-02**

(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. $ **280,906**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **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? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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