		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:** 0018044

Facility Name: Prairieview Lutheran Home

Address: PO Box 4 (Number) Danforth (City) 60930 (Zip Code)

County: Iroquois

Telephone Number: 815-269-2970 **Fax #** 815-269-2930

HFS ID Number:

Date of Initial License for Current Owners: 2/14/74

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 c 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas McCann **Telephone Number:** 815-269-2970
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 1/1/18 to 12/31/18 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 informatior in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Thomas McCann
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Marcie Meents Kolberg, CPA
(Firm Name & Address) Smith Koelling Dykstra and Ohm PC, 1605 N Convent Bourbonnais, IL 60914
(Telephone) 815-937-1997 Fax # 815-935-0360

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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 _____

	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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	4,663	23,834	1,688	30,185	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,663	23,834	1,688	30,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.89%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
out-patient therapy

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 [x] NO [ ]

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 2/14/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,688

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	436,452	13,434	15,390	465,276		465,276		465,276			1
2	Food Purchase		300,117		300,117	(28,502)	271,615	(10,870)	260,745			2
3	Housekeeping	177,094	41,759		218,853		218,853		218,853			3
4	Laundry	83,464	16,863		100,327		100,327		100,327			4
5	Heat and Other Utilities			160,709	160,709		160,709	(24,697)	136,012			5
6	Maintenance	144,703	8,494	73,454	226,651		226,651		226,651			6
7	Other (specify):* waste disposal			33,707	33,707		33,707		33,707			7
8	**TOTAL General Services**	841,713	380,667	283,260	1,505,640	(28,502)	1,477,138	(35,567)	1,441,571			8
	B. Health Care and Programs											
9	Medical Director					4,800	4,800		4,800			9
10	Nursing and Medical Records	3,079,274	219,550	91,283	3,390,107	(63,911)	3,326,196		3,326,196			10
10a	Therapy			466,378	466,378		466,378	(79,338)	387,040			10a
11	Activities	257,165	3,679	1,866	262,710		262,710		262,710			11
12	Social Services	28,073		1,803	29,876		29,876		29,876			12
13	CNA Training	15,883	3,423		19,306		19,306		19,306			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,380,395	226,652	561,330	4,168,377	(59,111)	4,109,266	(79,338)	4,029,928			16
	C. General Administration											
17	Administrative	90,226			90,226		90,226		90,226			17
18	Directors Fees											18
19	Professional Services			61,417	61,417		61,417		61,417			19
20	Dues, Fees, Subscriptions & Promotions			52,231	52,231		52,231	(30,149)	22,082			20
21	Clerical & General Office Expenses	381,376	18,947	214,940	615,263		615,263	(107,656)	507,607			21
22	Employee Benefits & Payroll Taxes			1,254,224	1,254,224	23,702	1,277,926		1,277,926			22
23	Inservice Training & Education			2,444	2,444		2,444		2,444			23
24	Travel and Seminar			13,274	13,274		13,274	(1,269)	12,005			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,888	38,888		38,888		38,888			26
27	Other (specify):*											27
28	**TOTAL General Administration**	471,602	18,947	1,637,418	2,127,967	23,702	2,151,669	(139,074)	2,012,595			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,693,710	626,266	2,482,008	7,801,984	(63,911)	7,738,073	(253,979)	7,484,094			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.

Facility Name & ID Number Prairieview Lutheran Home #0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			216,385	216,385		216,385		216,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			823	823		823		823			32
33	Real Estate Taxes			2,742	2,742		2,742		2,742			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			219,950	219,950		219,950		219,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			29,826	29,826		29,826		29,826			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,751	223,751		223,751		223,751			42
43	Other (specify):*					63,911	63,911		63,911			43
44	**TOTAL Special Cost Centers**			253,577	253,577	63,911	317,488		317,488			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,693,710	626,266	2,955,535	8,275,511		8,275,511	(253,979)	8,021,532			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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(79,338)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,870)	2		4
5	Telephone, TV & Radio in Resident Rooms	(24,697)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,656)	21		24
25	Fund Raising, Advertising and Promotional	(30,149)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (252,710)		$	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))**	$ (252,710)		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			62,053	10, 2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 62,053		47

Prairieview Lutheran Home

ID# 0018044

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Travel for marketing	(1,269)	24	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				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**	(1,269)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairieview Lutheran Home # 0018044 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,870)	0	0	0	0	0	0	0	0	0	0	(10,870)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(24,697)	0	0	0	0	0	0	0	0	0	0	(24,697)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(35,567)	0	0	0	0	0	0	0	0	0	0	(35,567)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	(79,338)	0	0	0	0	0	0	0	0	0	0	(79,338)	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	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(79,338)	0	0	0	0	0	0	0	0	0	0	(79,338)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(30,149)	0	0	0	0	0	0	0	0	0	0	(30,149)	20
21	Clerical & General Office Expenses	(107,656)	0	0	0	0	0	0	0	0	0	0	(107,656)	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	(1,269)	0	0	0	0	0	0	0	0	0	0	(1,269)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(139,074)	0	0	0	0	0	0	0	0	0	0	(139,074)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(253,979)	0	0	0	0	0	0	0	0	0	0	(253,979)	29

Facility Name & ID Number Prairieview Lutheran Home # 0018044 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(253,979)	0	0	0	0	0	0	0	0	0	0	(253,979)	45

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Pastor Joel Brown, President	BOD						1
2	Diane Goldenstein, Vice President	BOD						2
3	Sam Sweeney, Treasurer	BOD						3
4	Myra Manssen, Secretary	BOD						4
5	Cyndy Clapp	BOD						5
6	Doug Benner	BOD						6
7	Jerry Henrichs	BOD						7
8	Fred Hurliman	BOD						8
9	Kristine Ritxma	BOD						9
10								10
11								11
12	Note: none of the BOD receive any compensation							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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Capital lease		x	purchase of copiers	$86.25	9/24/13	$ 4,200	$	9/24/18	8.9140	$ 14	1
2	Capital lease		x	purchase of copiers	$371.12	7/24/13	17,599		7/24/18	10.2860	57	2
3	Capital lease		x	purchase of copiers	$1,045.00	9/20/18	29,703	28,400	12/20/23	NA	752	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,502.37		$ 51,502	$ 28,400			$ 823	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 51,502	$ 28,400			$ 823	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA Line # NA

* 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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.)		$ 2,742	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,742	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.)**		$	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		$ 2,742	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	2,845	8
	2014	2,731	9
	2015	2,787	10
	2016	2,790	11
	2017	2,742	12

	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 Prairieview Lutheran Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0018044

CONTACT PERSON REGARDING THIS REPORT Thomas McCann

TELEPHONE 815-269-2970 FAX #: 815-269-2930

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.	17-18-201-006	PT W2 NE 2.08 acres	$ 413.00	$ 413.00
2.	17-18-202-001/17-18-202-002	Prairieview 3rd add lt 6 and 5	$ 120.68	$ 120.68
3.	17-18-202-003/17-18-202-004	Prairieview 3rd add lt 4 and 3	$ 120.68	$ 120.68
4.	17-18-202-005/17-18-202-006	Prairieview 4th add lt 6 and 7	$ 120.68	$ 120.68
5.	17-18-226-002	Prairieview add lt 1	$ 15.00	$ 15.00
6.	17-18-226-006	Prairieview 4th add lt 5	$ 392.62	$ 392.62
7.	17-18-226-007	Prairieview th add lt 4	$ 389.92	$ 389.92
8.	17-18-226-008	Prairieview 4th add lt 3	$ 389.92	$ 389.92
9.	17-18-226-009	Prairieview 4th add lt 2	$ 389.92	$ 389.92
10.	17-18-226-010	Prairieview 4th add lt 1	$ 389.92	$ 389.92
		TOTALS	$ 2,742.34	$ 2,742.34

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? _____ YES x 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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,200 B. General Construction Type: Exterior brick Frame steel and brick Number of Stories 1

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

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

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

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

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

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	building/grounds	304,920	1971	$ 9,115	1
2					2
3	TOTALS	304,920		$ 9,115	3

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	60			1973	$ 649,963	$ 16,249	40	$ 16,249	$	$ 635,485	4
5				1995	1,011,406	25,285	40	25,285		597,035	5
6	32			1996	1,834,874	45,872	40	45,872		993,896	6
7											7
8											8
	Improvement Type**										
9	Fully depreciated				772,490					772,490	9
10	Prior to 2009				599,830	2,110	various	2,110		350,594	10
11				2009	199,130	3,092	various	3,092		47,756	11
12				2010	254,622	6,366	various	6,366		53,590	12
13				2013	112,654	3,421	various	3,421		19,355	13
14											14
15											15
16	Shades-resident rooms			2014	19,390	970	20	970		4,041	16
17	Flooring-front waiting area			2014	918	92	10	92		452	17
18	Carpet-front reception area			2014	2,057	206	10	206		995	18
19	Cabinet and millwork			2014	1,575	79	20	79		382	19
20	Locks			2014	8,223	411	20	411		1,713	20
21	Patient rooms flooring (325-341, 422-429)			2015	31,378	3,138	10	3,138		11,506	21
22	Remodel nurses' station			2015	6,309	252	25	252		903	22
23	Loveseat/recliner			2015	1,470	147	10	147		539	23
24	New room heaters (6)			2015	9,868	987	10	987		3,290	24
25	Gas water heater			2015	7,828	783	10	783		3,067	25
26	Boiler replacement			2015	107,645	4,305	25	4,305		15,786	26
27	Sidewalk replacement			2015	10,861	1,086	10	1,086		3,892	27
28	Coverlets/bedding			2015	7,345	1,469	5	1,469		4,897	28
29	Full size sleeper			2015	849	85	10	85		340	29
30	Patient rooms telephone upgrades (325-341, 422-429)			2015	15,501	620	25	620		2,067	30
31	Patient rooms wallcoverings (325-341, 422-429)			2015	52,114	2,085	25	2,085		6,950	31
32	Patient rooms electrical upgrades (325-341, 422-429			2015	4,375	175	25	175		583	32
33	Patient rooms new cabinetry (325-341, 422-429)			2015	289,695	11,588	25	11,588		38,627	33
34	Patient rooms plumbing (325-341, 422-429)			2015	69,462	2,778	25	2,778		9,260	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Gas room furnace	2016	$ 6,392	$ 639	10	$ 639	$	$ 1,385	37
38	Patient rooms carpeting (235-251, 324, 112, 146, 414-417)	2016	11,748	1,175	10	1,175		3,222	38
39	Patient rooms cabinetry (235-251, 324, 112, 146, 414-417)	2016	171,857	6,874	25	6,874		18,978	39
40	Patient rooms plumbing (235-251, 324, 112, 146, 414-417)	2016	17,988	1,799	10	1,799		4,804	40
41	Window cubicle panels (63 rooms)	2016	19,750	1,975	10	1,975		5,102	41
42	Carpeting/flooring-nurses' station	2016	4,072	407	10	407		1,052	42
43	Hallway carpet and basecove	2016	47,287	4,729	10	4,729		11,494	43
44	Nurses' station plumbing	2016	1,650	165	10	165		399	44
45	Heat exchanger	2016	4,085	408	10	408		1,156	45
46	Carrier RTU roof top unit	2017	15,699	784	20	784		1,176	46
47	Aluminum cooler floor-kitchen	2017	2,990	299	10	299		399	47
48	Rooftop HVAC unit above conference room	2017	8,905	890	10	890		1,113	48
49	Heat exchanger-south roof top	2017	4,957	496	10	496		579	49
50	Kohler generator	2017	2,353	253	10	253		273	50
51	Heating units for patient rooms-Faith Place	2017	4,129	413	10	413		791	51
52	Locking system-Faith Place	2017	4,819	482	10	482		522	52
53	Metal roof rear porch-Faith Place	2017	5,461	137	40	137		194	53
54	Sealcoating repair-main lot	2017	15,244	762	20	762		1,080	54
55	Garden improvements	2018	2,670	100	20	100		100	55
56	Exterior sign 48" x 70"	2018	980	45	20	45		45	56
57	Delay egress magnet project	2018	2,768	208	10	208		208	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)		$ 6,437,636	$ 156,691		$ 156,691	$	$ 3,633,563	70

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 561,143	$ 43,251	$ 43,251	$	10	$ 365,180	71
72	Current Year Purchases	99,549	5,975	5,975		5-10	8,185	72
73	Fully Depreciated Assets	705,029					705,029	73
74								74
75	TOTALS	$ 1,365,721	$ 49,226	$ 49,226	$		$ 1,078,394	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	Resident transportation	2010 Ford Elkhart	2010	$ 45,949	$ 4,595	$ 4,595	$	10	$ 39,440	76
77	Resident transportation	2007 Ford Conversion Van	2010	36,393	3,639	3,639		10	29,719	77
78	Resident transportation	Major repair-van	2013	2,261	226	226		10	1,337	78
79	Resident transportation	2007 Chrysler Town/Ctry	2017	20,000	2,000	2,000		10	2,857	79
80	TOTALS			$ 104,603	$ 10,460	$ 10,460	$		$ 73,353	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)	$ 7,917,075	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,377	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 216,377	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,785,310	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.

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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: $ 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 & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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? [x] YES [ ] NO

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

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

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- 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		2,823		2,823
3	Classroom Wages (a)		6,173		6,173
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		9,710		9,710
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		600		600
9	TOTALS	$	$ 19,306	$	$ 19,306
10	SUM OF line 9, col. 1 and 2 (e)	$ 19,306			

C. CONTRACTUAL INCOME

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

$ NA

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,948	$ 167,504	$	1,948	$ 167,504	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		945	73,433		945	73,433	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		3,145	239,866		3,145	239,866	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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	6,038	$ 480,803	$	6,038	$ 480,803	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 & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 54,094	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	267,140		3
4	Supply Inventory (priced at cost)	78,273		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,197		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	258,913		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 680,617	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,115		13
14	Buildings, at Historical Cost	6,137,812		14
15	Leasehold Improvements, at Historical Cos	299,824		15
16	Equipment, at Historical Cost	1,470,324		16
17	Accumulated Depreciation (book methods)	(4,785,310)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,131,765	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,812,382	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 238,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,859		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,014		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Payroll wiithholdings	41,560		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 564,730	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	28,400		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,400	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 593,130	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,219,252	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,812,382	$	48

***(See instructions.)**

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,927,823	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,927,823	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(708,571)	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)**	$ (708,571)	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)**	$ 3,219,252	24 *

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 7,426,097	1
2	Discounts and Allowances for all Levels	(924,014)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,502,083	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	76,889	5
6	Therapy	682,437	6
7	Oxygen	9,017	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 768,343	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	27,889	13
14	Non-Patient Meals	39,372	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)**	$ 67,261	23
	D. Non-Operating Revenue		
24	Contributions	200,000	24
25	Interest and Other Investment Income***	2,563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 202,563	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Reimbursements and other	26,690	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,690	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,566,940	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,506,846	31
32	Health Care	4,167,171	32
33	General Administration	2,127,967	33
	B. Capital Expense		
34	Ownership	219,950	34
	C. Ancillary Expense		
35	Special Cost Centers	29,826	35
36	Provider Participation Fee	223,751	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,275,511	40
41	**Income before Income Taxes (line 30 minus line 40)****	(708,571)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (708,571)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 613,084	44
45	Private Pay - Net Inpatient Revenue	5,502,700	45
46	Medicare - Net Inpatient Revenue	386,299	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,502,083	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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 & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,939	2,080	$ 86,311	$ 41.50	1
2	Assistant Director of Nursing	4,824	5,476	202,406	36.96	2
3	Registered Nurses	22,074	24,601	756,270	30.74	3
4	Licensed Practical Nurses	26,175	28,340	576,682	20.35	4
5	CNAs & Orderlies	98,560	106,030	1,387,089	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,656	1,872	30,064	16.06	9
10	Activity Assistants	13,919	15,157	165,878	10.94	10
11	Social Service Workers	2,080	2,264	36,180	15.98	11
12	Dietician					12
13	Food Service Supervisor	1,816	2,080	54,262	26.09	13
14	Head Cook	11,615	13,295	176,339	13.26	14
15	Cook Helpers/Assistants	23,450	25,171	254,550	10.11	15
16	Dishwashers					16
17	Maintenance Workers	4,997	5,677	149,009	26.25	17
18	Housekeepers	12,538	13,645	157,926	11.57	18
19	Laundry	6,466	7,115	81,607	11.47	19
20	Administrator	1,491	1,664	98,500	59.19	20
21	Assistant Administrator					21
22	Other Administrative	10,430	11,475	274,324	23.91	22
23	Office Manager					23
24	Clerical	6,099	6,446	77,253	11.98	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	845	854	10,106	11.83	31
32	Other Health Ca resident assts	12,911	13,524	118,954	8.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,885	286,766	$ 4,693,710 *	$ 16.37	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	179	$ 10,628	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	16	2,000	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	112	6,706	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,866	11, 3	44
45	Social Service Consultant	24	1,803	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	355	$ 23,003		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	55	$ 3,876	10, 3	50
51	Licensed Practical Nurses	291	14,852	10, 3	51
52	Certified Nurse Assistants/Aides	1,301	38,014	10, 3	52
53	TOTAL (lines 50 - 52)	1,647	$ 56,742		53

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas McCann			$ 90,226
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,226

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
Borrschnack Pellietier 7 Co	CPA auditor	$ 15,600
Smith Koelling Dykstra and Ohm	CPA accounting	28,492
Benefit Planning Consultants	HRA administration	902
Marcum Accountants Advisors	Medicare cost report	4,731
American United Life Ins	403B plan fees	1,170
Clifton Larson Allen LLP	CPA-401K auditor	8,650
Duane Morris	attorney	1,872
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 61,417

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 180,758
Unemployment Compensation Insurance	15,786
FICA Taxes	335,448
Employee Health Insurance	680,736
Employee Meals	28,502
Illinois Municipal Retirement Fund (IMRF)*	
Employee life insurance	9,860
	1,622
Pension	25,214
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,277,926

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 38)	1,501
Patient Background Checks 65	650
Dues and fees	14,895
Subscriptons	2,449
Views	2,587
Other promotion	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 71
In-State Travel	3,890
less: travel for marketing	(1,269)
Seminar Expense	9,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,005

**See instructions.

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

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

(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?

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **44,891** Line **10**

(7) Have all costs reported on this form been determined using accounting procedure 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.

(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 fo 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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **223,751**
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 t the Department, in addition to the daily rate, been properly classifiec 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 fo 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 benefit on Schedule V. $ **28,502** Has any meal income been offset against related costs? **no** Indicate the amount. $

(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 fo residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned for providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Borschnack Pelletier and Co**

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