FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0056440

Facility Name: Prairie City Rehab HC

Address: 825 E Main RR2 Bx 97 (Number) | Prairie City (City) | 61470 (Zip Code)

County: McDonough

Telephone Number: (309)775-3313 **Fax #** (309)775-3311

HFS ID Number:

Date of Initial License for Current Owners: 9/9/2008

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309)689-5850
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 1/1/2020 to 12/31/2020 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) Mark Petersen
	(Title) Chief Executive Officer
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 City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	47	Skilled (SNF)	47	17,155	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	47	TOTALS	47	17,155	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	8,738	1,488	568	10,794	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,738	1,488	568	10,794	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.92%

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)
Meals on Wheels

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 9/9/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/9/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 560

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	122,057	13,474		135,531		135,531	2,874	138,405			1
2	Food Purchase		82,029		82,029		82,029	(2,067)	79,962			2
3	Housekeeping	77,335	19,430		96,765		96,765	56	96,821			3
4	Laundry		5,448		5,448		5,448		5,448			4
5	Heat and Other Utilities			26,632	26,632		26,632	196	26,828			5
6	Maintenance	40,440	14,147	22,988	77,575		77,575	1,726	79,301			6
7	Other (specify):*											7
8	**TOTAL General Services**	239,832	134,528	49,620	423,980		423,980	2,785	426,765			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	567,902	49,861	9,030	626,793		626,793	157	626,950			10
10a	Therapy			66,191	66,191		66,191		66,191			10a
11	Activities	56,223	90		56,313		56,313		56,313			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	624,125	49,951	84,221	758,297		758,297	157	758,454			16
	C. General Administration											
17	Administrative	69,996		87,000	156,996		156,996	(71,016)	85,980			17
18	Directors Fees											18
19	Professional Services			8,618	8,618		8,618	9,934	18,552			19
20	Dues, Fees, Subscriptions & Promotions			4,308	4,308		4,308	1,571	5,879			20
21	Clerical & General Office Expenses	5,492	1,238	12,283	19,013		19,013	17,712	36,725			21
22	Employee Benefits & Payroll Taxes			108,189	108,189		108,189	4,892	113,081			22
23	Inservice Training & Education							30	30			23
24	Travel and Seminar							9	9			24
25	Other Admin. Staff Transportation			7,557	7,557		7,557	2,059	9,616			25
26	Insurance-Prop.Liab.Malpractice			22,691	22,691		22,691	314	23,005			26
27	Other (specify):*											27
28	**TOTAL General Administration**	75,488	1,238	250,646	327,372		327,372	(34,495)	292,877			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	939,445	185,717	384,487	1,509,649		1,509,649	(31,553)	1,478,096			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 Prairie City Rehab HC #0056440 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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			4,014	4,014		4,014	34,700	38,714			30
31	Amortization of Pre-Op. & Org.							24,333	24,333			31
32	Interest							94,905	94,905			32
33	Real Estate Taxes			4,436	4,436		4,436	113	4,549			33
34	Rent-Facility & Grounds			19,049	19,049		19,049	(19,049)				34
35	Rent-Equipment & Vehicles			22,622	22,622		22,622	1,044	23,666			35
36	Other (specify):*											36
37	**TOTAL Ownership**			50,121	50,121		50,121	136,046	186,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,780		14,780		14,780		14,780			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,699	87,699		87,699		87,699			42
43	Other (specify):*			35,039	35,039		35,039	(35,039)				43
44	**TOTAL Special Cost Centers**		14,780	122,738	137,518		137,518	(35,039)	102,479			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	939,445	200,497	557,346	1,697,288		1,697,288	69,454	1,766,742			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 City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(2,067)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,952)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	233	30		9
10	Interest and Other Investment Income	(51)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(192)	43		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	(12,681)	43		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	(11,000)	43		24
25	Fund Raising, Advertising and Promotional	(387)	43		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	(8,472)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,569)		$	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)	109,023	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 109,023		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 69,454		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 City Rehab HC

ID# 0056440

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (4,772)	43	1
2	X-Rays-Part A	(1,055)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,536)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(109)	21	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
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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**	(8,472)		49

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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 2,874	$ 2,874	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	56	56	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	196	196	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,726	1,726	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	2,693	2,693	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	87,000	Petersen Health Care Management, Inc.	100.00%	15,984	(71,016)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	9,441	9,441	12
13	V								13
14	Total			$ 87,000			$ 32,970	$ * (54,030)	14

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 1,471	$ 1,471	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	17,821	17,821	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	4,892	4,892	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	30	30	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	9	9	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,059	2,059	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	314	314	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	2,909	2,909	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	142	142	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	113	113	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,044	1,044	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			$			$ 30,804	$ * 30,804	39

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	1	Dietary	$	Midwest Health Operations, LLC	100.00%	$	$	15
16	V	2	Food		Midwest Health Operations, LLC	100.00%			16
17	V	3	Housekeeping		Midwest Health Operations, LLC	100.00%			17
18	V	5	Utilities		Midwest Health Operations, LLC	100.00%			18
19	V	6	Maintenance		Midwest Health Operations, LLC	100.00%			19
20	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			20
21	V	9	Medical Director		Midwest Health Operations, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%			22
23	V	10A	Therapy		Midwest Health Operations, LLC	100.00%			23
24	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			24
25	V	17	Administrative		Midwest Health Operations, LLC	100.00%			25
26	V	19	Professional Services		Midwest Health Operations, LLC	100.00%	493	493	26
27	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	100	100	27
28	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%			28
29	V	22	Employee Benefits and Payroll Taxes		Midwest Health Operations, LLC	100.00%			29
30	V	23	Inservice Training & Education		Midwest Health Operations, LLC	100.00%			30
31	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%			31
32	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%			32
33	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%			33
34	V	30	Depreciation		Midwest Health Operations, LLC	100.00%			34
35	V	31	Amortization		Midwest Health Operations, LLC	100.00%			35
36	V	32	Interest		Midwest Health Operations, LLC	100.00%	118	118	36
37	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%			38
39	Total			$			$ 711	$ * 711	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Prairie City Land, LLC	100.00%	$	$	15
16	V	19	Professional Services	$	Prairie City Land, LLC	100.00%			16
17	V	21	Equipment		Prairie City Land, LLC	100.00%			17
18	V	26	Insurance-Property		Prairie City Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Prairie City Land, LLC	100.00%			19
20	V	30	Depreciation		Prairie City Land, LLC	100.00%	31,558	31,558	20
21	V	31	Amortization		Prairie City Land, LLC	100.00%	24,333	24,333	21
22	V	32	Interest		Prairie City Land, LLC	100.00%	94,696	94,696	22
23	V	33	Real Estate Taxes		Prairie City Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	19,049	Prairie City Land, LLC	100.00%		(19,049)	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			$ 19,049			$ 150,587	$ * 131,538	39

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care \	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care 1	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	 Percent	7 Compensation Included in Costs for this Reporting Period** Description	 Amount	8 Schedule V. Line & Column Reference	
1									$		1
2											2
3	N/A										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 Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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

Name of Related Organization	Petersen Health Care Management, Inc.
Street Address	830 W. Trailcreek Drive
City / State / Zip Code	Peoria, IL 61614
Phone Number	(309) 691-8113
Fax Number	(309) 691-8622

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

	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	Dietary	Resident Days	1,282,791	75	$ 341,562	$ 398,718	10,794	$ 2,874	1
2	2	Food	Resident Days	1,282,791	75	0	0	10,794	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	10,794	56	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	10,794	196	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	10,794	1,726	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	10,794	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	10,794	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	10,794	2,693	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	10,794	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	10,794	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	10,794	15,984	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	10,794	9,441	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	10,794	1,471	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	10,794	17,821	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	10,794	4,892	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	10,794	30	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	10,794	9	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	10,794	2,059	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	10,794	314	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	10,794	2,909	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	10,794	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	10,794	142	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	10,794	113	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	10,794	1,044	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 63,774	25

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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

Name of Related Organization: Midwest Health Operations, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: ((309)691-8113
Fax Number: ((309)691-8622

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

	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	Dietary	Resident Days	63,788	6	$	$	6,101	$	1
2	2	Food	Resident Days	63,788	6			6,101		2
3	3	Housekeeping	Resident Days	63,788	6			6,101		3
4	5	Utilities	Resident Days	63,788	6			6,101		4
5	6	Maintenance	Resident Days	63,788	6			6,101		5
6	7	Mgmt. Allocation of Benefits	Resident Days	63,788	6			6,101		6
7	9	Medical Director	Resident Days	63,788	6			6,101		7
8	10	Nursing and Medical Records	Resident Days	63,788	6			6,101		8
9	10A	Therapy	Resident Days	63,788	6			6,101		9
10	15	Mgmt. Allocation of Benefits	Resident Days	63,788	6			6,101		10
11	17	Administrative	Resident Days	63,788	6			6,101		11
12	19	Professional Services	Resident Days	63,788	6	5,155		6,101	493	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	63,788	6	1,050		6,101	100	13
14	21	Clerical and General Office	Resident Days	63,788	6			6,101		14
15	22	Employee Benefits and Payroll Ta	Resident Days	63,788	6			6,101		15
16	23	Inservice Training & Education	Resident Days	63,788	6			6,101		16
17	24	Travel and Seminar	Resident Days	63,788	6			6,101		17
18	25	Other Admin. Staff Transport.	Resident Days	63,788	6			6,101		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	63,788	6			6,101		19
20	30	Depreciation	Resident Days	63,788	6			6,101		20
21	31	Amortization	Resident Days	63,788	6			6,101		21
22	32	Interest	Resident Days	63,788	6	1,229		6,101	118	22
23	33	Real Estate Taxes	Resident Days	63,788	6			6,101		23
24	35	Rent-Equipment & Vehicles	Resident Days	63,788	6			6,101		24
25	TOTALS					$ 7,434	$		$ 711	25

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Sector		X	Mortgage	Varies	4/1/2020	$ 1,295,888	$ 1,295,888	3/31/23	Varies	$ 94,696	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,295,888	$ 1,295,888			$ 94,696	9
	B. Non-Facility Related*											
10								Interest Income Offset			(51)	10
11								Home Office Allocation-PHCM			142	11
12								Home Office Allocation-MHO			118	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 209	14
15	TOTALS (line 9+line14)						$ 1,295,888	$ 1,295,888			$ 94,905	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ______ 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 City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.		$ 4,762	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.)		$ 4,530	2
3. Under or (over) accrual (line 2 minus line 1).		$ (232)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,668	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.)**	Home Office Allocation	113 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 4,549	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	4,823	8
2016	4,735	9
2017	4,640	10
2018	4,556	11
2019	4,530	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0050823

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

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

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	15-000-022-05	Long-Term Care Facility	$ 4,530.02	$ 4,530.02
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,530.02	$ 4,530.02

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

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock 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. [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).

N/A

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

1. Total Amount Incurred: 64,889 2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 24,333 4. Dates Incurred: 2020

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	216,058	2008	$ 120,000	1
2					2
3	TOTALS	216,058		$ 120,000	3

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	47		2008	1970	$ 562,500	$	25	$ 22,500	$ 22,500	$ 281,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Alarm Control			2008	2,608		15	174	174	2,001	9
10	Patch Parking Lot			2009	3,200		7			3,200	10
11	Boiler Repair			2010	2,989		7			2,989	11
12	Roof Replacement on Low-Sloped Roof			2011	51,550		25	2,062	2,062	19,589	12
13	Sprinkler System Replacement			2012	103,900		25	4,156	4,156	39,482	13
14	Boiler Repair			2018	2,906		7	416	416	1,040	14
15	Parking Lot Resurfacing			2020	56,200		15	1,873	1,873	1,873	15
16	Generator			2020	54,205		15	1,807	1,807	1,807	16
17	Roof Repair			2020	5,500		7	393	393	393	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	Land Improvements Booked					3,870			(3,870)		30
31	Building Booked					26,899			(26,899)		31
32	Building Improvement Booked					1,125			(1,125)		32
33											33
34	2020-Home Office Allocation-Building Improvements				5,458			131	131		34
35	2020-Home Office Allocation-Land Improvements				547			35	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 City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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)		$ 851,563	$ 31,894		$ 33,547	$ 1,653	$ 353,624	70

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 14,786	$ 2,807	$ 1,810	$ (997)	5-10 yrs.	$ 8,519	71
72	Current Year Purchases	8,588	871	614	(257)	7 yrs.	614	72
73	Fully Depreciated Assets	116,629					116,629	73
74	Home Office Allocation			2,743	2,743			74
75	TOTALS	$ 140,003	$ 3,678	$ 5,167	$ 1,489		$ 125,762	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)	$ 1,111,566	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,572	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,714	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,142	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 479,386	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	N/A				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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 23,666 Description: See Attached Schedule 14A
(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.

Prairie City Rehab HC
0056440
Period Beginning 1/1/2020
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Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$ 19,110
Dishwasher	574
Copier	2,938
Home Office Allocation	1,044
	23,666

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,079	$ 31,185	$	2,079	$ 31,185	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		618	9,264		618	9,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,716	25,742		1,716	25,742	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				14,780		14,780	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			$	4,413	$ 66,191	$ 14,780	4,413	$ 80,971	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 Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ (68,214)	$ (68,214)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 57,241)	732,693	732,693	3
4	Supply Inventory (priced at Cost)	4,990	4,990	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,264	12,264	6
7	Other Prepaid Expenses	427,398	427,398	7
8	Accounts Receivable (owners or related parties)		531	8
9	Other(specify): Employee Education Loans	500	500	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,109,631	$ 1,110,162	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost		567,958	14
15	Leasehold Improvements, at Historical Cost	115,905	283,605	15
16	Equipment, at Historical Cost	6,098	140,003	16
17	Accumulated Depreciation (book methods)	(4,014)	(479,386)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		40,556	20
21	Restricted Funds	2,706	102,018	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 120,695	$ 774,754	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,230,326	$ 1,884,916	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,375	$ 310,375	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,629	40,629	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,668	4,668	32
33	Accrued Interest Payable		15,541	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	87,981	87,981	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 443,653	$ 459,194	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,295,888	40
41	Bonds Payable			41
42	Deferred Compensation	34,359	34,359	42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	14,487	72,465	43
44	Loan Payable-MCAD Adv. & SBA PPP	516,800	516,800	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 565,646	$ 1,919,512	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,009,299	$ 2,378,706	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 221,027	$ (493,790)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,230,326	$ 1,884,916	48

*(See instructions.)

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 614,310	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(463,304)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 151,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	70,021	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)**	$ 70,021	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)**	$ 221,027	24 *

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

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 1,881,625	1
2	Discounts and Allowances for all Levels	(271,174)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,610,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,598	6
7	Oxygen	136	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 95,734	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	2,067	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	22,362	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,557	20
21	Other Medical Services	358	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 29,344	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51	26
	E. Other Revenue (specify):******		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous & COVID Stimulus Revenue	31,729	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,729	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,767,309	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	423,980	31
32	Health Care	758,297	32
33	General Administration	327,372	33
	B. Capital Expense		
34	Ownership	50,121	34
	C. Ancillary Expense		
35	Special Cost Centers	49,819	35
36	Provider Participation Fee	87,699	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,697,288	40
41	**Income before Income Taxes (line 30 minus line 40)****	70,021	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 70,021	43
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,196,135	44
45	Private Pay - Net Inpatient Revenue	207,542	45
46	Medicare - Net Inpatient Revenue	201,559	46
47	Other-(specify) Insurance Net Inpatient Revenue	5,215	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,610,451	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 Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	1,791	$ 66,914	$ 37.36	1
2	Assistant Director of Nursing	450	500	12,345	24.69	2
3	Registered Nurses	4,249	4,285	122,386	28.56	3
4	Licensed Practical Nurses	4,207	4,223	98,071	23.22	4
5	CNAs & Orderlies	18,424	18,706	263,782	14.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	26,889	12.93	9
10	Activity Assistants	2,111	2,145	24,809	11.57	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,214	16.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,028	9,238	86,843	9.40	15
16	Dishwashers					16
17	Maintenance Workers	3,209	3,244	40,440	12.47	17
18	Housekeepers	6,642	6,700	77,335	11.54	18
19	Laundry					19
20	Administrator	2,006	2,167	69,996	32.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	301	301	5,492	18.25	23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	616	616	8,929	14.50	33
34	TOTAL (lines 1 - 33)	57,187	58,076	$ 939,445 *	$ 16.18	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,276	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	34	2,058	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	34	$ 14,334		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	116	$ 3,696	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	116	$ 3,696		53

Prairie City Rehab HC
0056440
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	166	166	4,404	26.53
Transportation	450	450	4,525	10.06
TOTAL	616	616	8,929	

Facility Name & ID Number Prairie City Rehab HC # 0056440 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kendel Brooks	Administrator	0	$ 40,833
Amanda Abel	Administrator	0	29,163
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,996

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 87,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 87,000

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 6,675
Mediacom	Computer Services	1,687
Sector	Title Lien Search-July 2020	168
First Citizens Bank	Financial Records Fee-June	88
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 8,618

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,381
Unemployment Compensation Insurance	13,188
FICA Taxes	65,149
Employee Health Insurance	4,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	54
Home Office Allocation	4,892
Administrator Benefits	14,004
TOTAL (agree to Schedule V, line 22, col.8)	$ 113,081

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	340
Health Care Worker Background Check	
(Indicate # of checks performed 11)	
Patient Background Checks 34	1,030
Miscellaneous Licenses & Permits	948
Home Office Allocation	1,571
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,879

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	9
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9

**See instructions.

Prairie City Rehab HC
0056440
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,618
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	166
Duane Morris	Legal	232
Lexis Nexis	Legal	5
Livingston, Barger, Brant, Schroeder	Legal	9
Miller, Hall, Triggs	Legal	29
Miscellaneous	Legal	11
SB2	Legal	86
SmithAmundsen LLC	Legal	531
Sorling Northrup	Legal	151
Illinois Secretary of State	Legal	63
CliftonLarsonAllen	Accounting	660
Ginoli & Co.	Accounting	901
Ability Network	Computer Services	1,694
Allscripts	Computer Services	267
AOD Matrix Care	Computer Services	2,976
AT&T	Computer Services	3
ATS	Computer Services	162
CCH	Computer Services	9
Charter Communications	Computer Services	15
Citrix Systems	Computer Services	51
Comcast	Computer Services	17
ITSavvy	Computer Services	78
Kemper Technology	Computer Services	387
Miscellaneous	Computer Services	75
Pearl Technology	Computer Services	70
Stratus Networks	Computer Services	307
TR Professional	Computer Services	7
David Budde	Other Prof Fees	7
DJ Howard and Associates	Other Prof Fees	13
Getzler Henrich & Associates	Other Prof Fees	52
LRI Consulting Services	Other Prof Fees	51
McQuellon Consulting	Other Prof Fees	32
Miscellaneous	Other Prof Fees	62
Optimizer	Other Prof Fees	28
Registered Agent Solutions	Other Prof Fees	15
RSM McGladrey	Other Prof Fees	168
SB2	Other Prof Fees	215
Sedgwick CMS	Other Prof Fees	289
Tarver Program Consultants	Other Prof Fees	40
Total (agree to Schedule V, line 19, column 8)		18,552

Prairie City Rehab HC
0056440
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	2,331
Auto Repairs		4,632
Mileage-Travel		594
Home Office Allocation		2,059
		9,616

Facility Name & ID Number **Prairie City Rehab HC** **# 0056440** **Report Period Beginning: 1/1/2020 Ending: 12/31/2020**

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 political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,902** Line **10**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **87,699**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,067**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.