		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: 0052126

Facility Name: Prairie Crossing Lvg Rehab

Address: 409 W Comanche Ave (Number) Shabbona (City) 60550 (Zip Code)

County: DeKalb

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

HFS ID Number:

Date of Initial License for Current Owners: 12/1/12

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847)517-7067

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 Crossing Lvg Rehab # 0052126 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	91	Skilled (SNF)	91	33,306	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	91	TOTALS	91	33,306	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	333	88	2,879	3,300	8
9	SNF/PED					9
10	ICF	13,524	3,597	1,007	18,128	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,857	3,685	3,886	21,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.34%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 12/01/12

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 91 and days of care provided 2,879

Medicare Intermediary Wisconsin Physician 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 Crossing Lvg Rehab # 0052126 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	208,558	28,155	5,449	242,162		242,162		242,162			1
2	Food Purchase		173,365		173,365		173,365	(19,916)	153,449			2
3	Housekeeping	136,073	40,136	-	176,209		176,209	9	176,218			3
4	Laundry	44,949	5,491	-	50,440		50,440		50,440			4
5	Heat and Other Utilities			52,488	52,488		52,488	698	53,186			5
6	Maintenance	67,867	52,536	13,294	133,697		133,697	1,254	134,951			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	457,447	299,683	71,231	828,361		828,361	(17,955)	810,406			8
	B. Health Care and Programs											
9	Medical Director	-	-	6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,596,860	81,537	22,039	1,700,436		1,700,436	21,387	1,721,823			10
10a	Therapy	-	-	-								10a
11	Activities	127,496	11,759	-	139,255		139,255		139,255			11
12	Social Services	34,137	-	-	34,137		34,137		34,137			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	1,758,493	93,296	28,039	1,879,828		1,879,828	21,387	1,901,215			16
	C. General Administration											
17	Administrative	85,563	-	207,600	293,163		293,163	(146,284)	146,879			17
18	Directors Fees			-								18
19	Professional Services			24,084	24,084		24,084	11,081	35,165			19
20	Dues, Fees, Subscriptions & Promotions			29,575	29,575		29,575	(5,141)	24,434			20
21	Clerical & General Office Expenses	323,417	-	72,170	395,587		395,587	35,065	430,652			21
22	Employee Benefits & Payroll Taxes			334,120	334,120		334,120	20,023	354,143			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			500	500		500	242	742			24
25	Other Admin. Staff Transportation		-	12,004	12,004		12,004	258	12,262			25
26	Insurance-Prop.Liab.Malpractice			2,755	2,755		2,755	102,407	105,162			26
27	Other (specify):* Management Allocation Benefits			-				12,057	12,057			27
28	**TOTAL General Administration**	408,980		682,808	1,091,788		1,091,788	29,708	1,121,496			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,624,920	392,979	782,078	3,799,977		3,799,977	33,140	3,833,117			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 Crossing Lvg Rehab #0052126 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			12,242	12,242		12,242	122,745	134,987			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			793	793		793	139,322	140,115			32
33	Real Estate Taxes			-				39,755	39,755			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			28	28		28	629	657			35
36	Other (specify):* MIP			-				24,564	24,564			36
37	TOTAL Ownership			421,063	421,063		421,063	(80,985)	340,078			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	75,886	394,098	469,984		469,984		469,984			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			176,811	176,811		176,811		176,811			42
43	Other (specify):* Non-Allowable Cos	-	-	29,357	29,357		29,357	(29,357)				43
44	TOTAL Special Cost Centers		75,886	600,266	676,152		676,152	(29,357)	646,795			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,624,920	468,865	1,803,407	4,897,192		4,897,192	(77,202)	4,819,990			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 Crossing Lvg Rehab # 0052126 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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(165,843)	30		9
10	Interest and Other Investment Income	(1,704)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(279)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(100)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,124)	43		24
25	Fund Raising, Advertising and Promotional	(64)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,514)	43		28
29	Other-Attach Schedule See PG5A	(97,056)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (272,684)		$	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)	195,482		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 195,482		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (77,202)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Prairie Crossing Lvg Rehab

ID# 0052126

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (2,662)	43	1
2	X Ray Expense Med A	(3,277)	43	2
3	Managed Care Costs	(15,437)	43	3
4	Miscellaneous Income	(272)	21	4
5	To disallow Chamber of Commerce	(175)	20	5
6	To reallocate management fees	(68,517)	17	6
7	To Disallow Lobbying expense	(6,716)	20	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**	(97,056)		49

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		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	19	Accounting Fees	$	Prairie Crossing Property LLC	100%	$ 8,515	$ 8,515	1
2	V	26	Insurance		Prairie Crossing Property LLC	100%	101,381	101,381	2
3	V	30	Depreciation		Prairie Crossing Property LLC	100%	285,979	285,979	3
4	V	32	Interest	213	Prairie Crossing Property LLC	100%	141,239	141,026	4
5	V	20	Licenses & Fees - PCL		Prairie Crossing Property LLC	100%	75	75	5
6	V	33	Real Estate Taxes		Prairie Crossing Property LLC	100%	37,575	37,575	6
7	V	35	Rent Income	408,000	Prairie Crossing Property LLC	100%		(408,000)	7
8	V	36	Other - MIP		Prairie Crossing Property LLC	100%	24,564	24,564	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 408,213			$ 599,328	$ * 191,115	14

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	2	Food	$	SW Financial Services Company	100%	$ 107	$ 107	15
16	V	3	Housekeeping		SW Financial Services Company	100%	9	9	16
17	V	5	Utilities		SW Financial Services Company	100%	698	698	17
18	V	6	Maintenance		SW Financial Services Company	100%	1,254	1,254	18
19	V	17	Administrative	87,600	SW Financial Services Company	100%	9,833	(77,767)	19
20	V	19	Professional Services		SW Financial Services Company	100%	2,666	2,666	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Financial Services Company	100%	1,675	1,675	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	56,724	56,724	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	242	242	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	258	258	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,026	1,026	25
26	V	27	Other		SW Financial Services Company	100%	12,057	12,057	26
27	V	30	Depreciation		SW Financial Services Company	100%	2,609	2,609	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	2,180	2,180	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	629	629	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			$ 87,600			$ 91,967	$ * 4,367	39

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	Moshe Herman	72.5	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	4.5	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	4.5			SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	4.5			Services Co.		Management Compa	4
5	Robin Krystal	4	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove				5
6	David Zuckerman	10	Oregon Living & Rehabilitation, LLC	Oregon				6
7					Groves Community	Independence, MO	Hospice	7
8					Hospice			8
9			Tower Hill Rehabilitation, LLC	South Elgin	Forest View Senior	Independence, MO	Independent	9
10					Residences		Living	10
11			Beauvais Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12			Hillside Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13			Rancho Manor Healthcare and Rehab	Florissant, MO				13
14			Rosewood Health & Rehab	Independence, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Seasons Care Center	Kansas City, MO	Program LLC			15
16			Carriage Square	St. Joseph, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LL	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20					Property LLC			20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23								23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Prairie Crossing	Shabbona	Real Estate	25
26					Property LLC			26
27								27
28					Tower Hill Property LI	South Elgin	Real Estate	28
29								29
30								30

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prope	St. Joseph, MO	Real Estate	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 Crossing Lvg Rehab # 0052126 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Moshe Herman	Owner	Administrative	72.5	See Sch 7C	15	33.0%	Salary & fees	$ 55,816	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	10	See Sch 7B	1.25	3.0%	Salary	5,139	17, 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 60,955		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 Crossing Lvg Rehab # 0052126 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 [ ]

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

Name of Related Organization: SW Financial Services Company
Street Address: 7434 North Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: ((847) 982-2300
Fax Number: ((847) 982-2304

	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	2	Food	Bed Days Available	678,198	12	$ 2,175	$	33,306	$ 107	1
2	3	Housekeeping	Bed Days Available	678,198	12	179		33,306	9	2
3	5	Utilities	Bed Days Available	678,198	12	14,206		33,306	698	3
4	6	Maintenance	Bed Days Available	678,198	12	25,536		33,306	1,254	4
5	17	Administrative - Salary	Average Hours Worked	45	12	13,000	13,000	1	361	5
6	17	Administrative - Salary	Average Hours Worked	45	12	185,000	185,000	1	5,139	6
7	17	Administrative - Salary	Average Hours Worked	45	3	13,000	13,000	15	4,333	7
8	19	Professional Services-Legal	Bed Days Available	678,198	12	29,559		33,306	1,452	8
9	19	Professional Services-Other	Bed Days Available	678,198	12	24,713		33,306	1,214	9
10	20	Dues, Fees, Subscriptions & Promo	Bed Days Available	678,198	12	34,103		33,306	1,675	10
11	21	Clerical & General Office Expense	Bed Days Available	678,198	12	962,284	962,284	33,306	47,257	11
12	21	Clerical & General Office Expense	Bed Days Available	678,198	12	192,782		33,306	9,467	12
13	24	Travel & Seminar	Bed Days Available	678,198	12	4,935		33,306	242	13
14	25	Other Admin. Staff Transportion	Bed Days Available	678,198	12	5,250		33,306	258	14
15	26	Insurance-Prop, Liab & Malpracti	Bed Days Available	678,198	12	20,882		33,306	1,026	15
16	27	Other - Mgmt Allocation of Benefi	Bed Days Available	678,198	12	245,503		33,306	12,057	16
17	30	Depreciation	Direct Cost	53,119					2,609	17
18	33	Real Estate Taxes	Bed Days Available	678,198	12	44,398		33,306	2,180	18
19	35	Rent - Equipment & Vehicles	Bed Days Available	678,198	12	12,804		33,306	629	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,830,309	$ 1,173,284		$ 91,967	25

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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** 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	CapitalOne		X	Mortgage	$ 29,692.33	1/1/2016	$ 4,059,180	$ 3,759,580	2/1/2051	0.0371	$ 141,239	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Prairie Crossing Assisted	X		Working Capital	Varies	1/1/2018	92,209	59,426	12/31/2020	0.0128	793	6
7	Wisconsin Physician Services		X	MCR Advance Payments	$10,035.83	4/30/2020	240,860	240,860	4/30/2022	0.0000	-	7
8	SBA-PPP Loan		X	Payroll & Oper Exp	None	4/27/2020	557,123	557,123	4/27/2022	0.0100	-	8
9	TOTAL Facility Related				$39,728.16		$ 4,949,372	$ 4,616,989			$ 142,032	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(1,917)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,917)	14
15	TOTALS (line 9+line14)						$ 4,949,372	$ 4,616,989			$ 140,115	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,564 Line # 36

* 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 Crossing Lvg Rehab # 0052126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 37,300	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.)	2019	$ 36,875	2
3. Under or (over) accrual (line 2 minus line 1).		$ (425)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,000	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
	Alloc. Fr. Mgmt. Co.	2,180	
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.		$ 39,755	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	32,628	8
	2016	33,332	9
	2017	34,360	10
	2018	35,869	11
	2019	36,875	12

2020 Tax Accrual= 36,875.24 * 1.03 = 37,981.50.
Will use $38,000

	FOR BHF USE ONLY		
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 Crossing Living & Rehabilitation Center, LLC COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0052126

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long-Term Care Property	$ 36,875.24	$ 36,875.24
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 44,397.67	$ 2,180.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,272.91	$ 39,055.24

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach 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 Crossing Lvg Rehab # 0052126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,645 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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).

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Resident Care	122,902	1994	$ 50,000	1
2					2
3	TOTALS	122,902		$ 50,000	3

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	91		1994		$ 2,643,587	$	39	$ 67,784	$ 67,784	$ 1,793,535	4
5											5
6	Mgmt. Alloc		1995		21,256		39	607	607	15,579	6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650		20			2,650	9
10	Various			1990	65,810		20			65,810	10
11	Various			1991	20,536		20			20,536	11
12	Various			1992	5,466		10			5,466	12
13	Various			1993	13,848		20			13,848	13
14	Various			1994	39,334		20			39,334	14
15	Various			1995	13,479		20			13,479	15
16	Various			1996	11,533		20			11,533	16
17	Various			1997	18,996		20			18,996	17
18	Various			1998	141,664		20			141,664	18
19	Various			1999	2,415		20			2,415	19
20	Air Handler			2000	1,150		10			1,150	20
21	Air Handler			2000	1,870		10			1,870	21
22	Air Handler			2000	1,900		10			1,900	22
23	Driveway			2001	3,040		20	152	152	2,926	23
24	Nurses Call System			2001	2,745		10			2,745	24
25	Air Handler			2001	1,350		10			1,350	25
26	Security System			2001	1,507		10			1,507	26
27	Telephone System			2001	1,928		10			1,928	27
28	Heating and Cooling System			2002	1,078		20	54	54	1,002	28
29	Drapes			2003	1,528		10			1,528	29
30	Sidewalk Repair			2003	1,250		20	63	63	1,099	30
31	Wallpaper - North Dining Hall			2004	3,007		20	150	150	2,477	31
32	Air Handlers			2005	6,391		20	320	320	4,958	32
33	Windows, fascia and gutters & oversize downspouts			2005	60,785		20	3,039	3,039	47,106	33
34	Security control panel			2005	688		20	34	34	528	34
35	Patio & Fountain			2006	18,666		20	933	933	11,664	35
36	Fence			2006	2,008		20	100		1,451	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 Crossing Lvg Rehab # 0052126 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	3 Glass Doors	2006	$ 1,826	$	10	$	$	$ 1,826	37
38	Fire Alarm System	2006	5,392		20	270	270	3,914	38
39	Asphalt	2006	4,200		20	210	210	3,045	39
40	Landscaping	2006	99,698		20	4,985	4,985	72,282	40
41	Kitchen Air Conditioners	2007	5,193		20	260	260	3,509	41
42	Roof	2008	21,179		20	1,059	1,059	13,237	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036		20	802	802	10,025	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800		20	390	390	4,485	45
46									46
47	Repave Parking Lots	2010	6,798		20	340	340	3,570	47
48	Sealcoat Parking Lots	2010	2,610		20	131	131	1,375	48
49	Retaining Walls & Walkways	2010	16,190		20	810	810	8,355	49
50	Replanting Trees	2010	10,119		20	506	506	5,311	50
51	Remove and replace sidewalks	2011	17,386		20	869	869	7,389	51
52	Install cabinets for nurse's station	2011	19,000		20	950	950	9,025	52
53	Install Attic Heat Detector	2011	4,427		20	221	221	2,108	53
54	Plank Flooring	2011	46,744		20	2,337	2,337	22,210	54
55	Install fire dampers	2011	6,668		20	333	333	3,172	55
56	Install 4 ton Air Handler and 4 ton condensor	2011	15,694		20	785	785	7,449	56
57	Install 16 bathroom radiant exhaust fans	2011	7,000		20	350	350	3,325	57
58									58
59	Repair Plumbing	2013	4,115	150	40	103	(47)	772	59
60	New Water Line	2013	34,000	1,236	40	850	(386)	6,375	60
61	Sprinkler System	2013	136,367	4,959	40	3,409	(1,550)	25,568	61
62									62
63	75 Gallon Hot Water Heater	2014	4,502	164	40		(164)		63
64	Drain Tile Work	2014	5,000	156	40	125	(31)	375	64
65									65
66	Installed Steel Sleeve and New Concete Floor	2015	3,911	142	20	196	54	1,076	66
67	Removed and replace sidewalk	2015	19,230	946	20	962	16	5,289	67
68	Repair block wall, tuckpointing and stucco	2015	7,050		20	353	353	1,939	68
69	Laundry Chute Improvements - Sprinklers and vent for dryer	2015	2,930	107	20	147	40	806	69
70	TOTAL (lines 4 thru 69)		$ 3,642,530	$ 7,860		$ 94,988	$ 87,028	$ 2,459,845	70

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	
1	Totals from Page 12A, Carried Forward		$ 3,642,530	$ 7,860		$ 94,988	$ 87,128	$ 2,459,845	1
2									2
3	Install dryer vents and gas pipes for dryer	2015	3,223	117	20	162	45	887	3
4	Replace electric hot water heater with gas water heater	2015	13,430	488	20	672	184	3,694	4
5	Install 24" catch basin, grate, and drain pipe	2015	2,975	107	20	149	42	820	5
6									6
7	Surveillance camera's - Entire Building	2016	14,590		5	2,918	2,918	13,131	7
8	Sidewalk from courtyard to parking lot	2016	3,685		15	246	246	1,106	8
9	Door Replacement - South Entrance	2016	21,000		15	1,400	1,400	6,300	9
10	Door Replacement - West Entrance	2016	21,000		15	1,400	1,400	6,300	10
11	Door Replacement - North Entrance	2016	21,000		15	1,400	1,400	6,300	11
12	Door Replacement in excess of amounts reported on lines 9-11	2016	4,229		15	283	283	1,269	12
13									13
14	Mitsubishi Split System - HVAC System	2018	6,263		20	314	314	810	14
15									15
16	Roofing Updates	2019	2,840		15	190	190	284	16
17									17
18	Kitchen Remodel-drywall, lights, ceiling, replace glass, flooring	2020	10,256		15	342	342	342	18
19	Make up air unit	2020	27,900		15	930	930	930	19
20	Parking lot	2020	58,829		15	1,961	1,961	1,961	20
21	Cement pad for outdoor walk in cooler	2020	2,845		15	95	95	95	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,856,595	$ 8,572		$ 107,450	$ 98,878	$ 2,504,073	34

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	
1	Totals from Page 12B, Carried Forward		$ 3,856,595	$ 8,572		$ 107,450	$ 98,878	$ 2,504,073	1
2									2
3	Allocated from SW Financial Services Co. - Leasehold Improvemen	1995	2,379					2,379	3
4	Allocated from SW Financial Services Co. - Leasehold Improvemen	1996	396					396	4
5	Allocated from SW Financial Services Co. - Leasehold Improvemen	1997	459					459	5
6	Allocated from SW Financial Services Co. - Leasehold Improvemen	1998	393					393	6
7	Allocated from SW Financial Services Co. - Leasehold Improvemen	1999	1,090					1,090	7
8	Allocated from SW Financial Services Co. - Leasehold Improvemen	2005	2,255			113	113	1,748	8
9	Allocated from SW Financial Services Co. - Leasehold Improvemen	2007	1,277			64	64	862	9
10	Allocated from SW Financial Services Co. - Leasehold Improvemen	2009	2,666			133	133	1,533	10
11	Allocated from SW Financial Services Co. - Leasehold Improvemen	2013	1,423			71	71	534	11
12	Allocated from SW Financial Services Co. - Leasehold Improvemen	2014	1,435			72	72	467	12
13	Allocated from SW Financial Services Co. - Leasehold Improvemen	2015	295			20	20	108	13
14									14
15									15
16									16
17	To tie to financial statements			2,987			(2,987)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,870,663	$ 11,559		$ 107,923	$ 96,364	$ 2,514,042	34

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	$ 216,903	$ 683	$ 22,443	$ 21,760	5-7	$ 210,647	71
72	Current Year Purchases	15,791		1,579	1,579	5	1,579	72
73	Fully Depreciated Assets	396,903					396,903	73
74	Allocated from Management Co.	9,452		488	488		7,368	74
75	TOTALS	$ 639,049	$ 683	$ 24,510	$ 23,827		$ 616,497	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 Care	2009 Ford E450	2009	$ 15,138	$ -	$ 1,514	$ 1,514	5	$ 1,514	76
77					-	-				77
78					-	-				78
79	Allocated from Management C	2017 Land Rover Evoque	2017	5,206	-	1,041	1,041	10	3,644	79
80	TOTALS			$ 20,344	$	$ 2,555	$ 2,555		$ 5,158	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)	$ 4,580,056	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,242	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,987	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 122,745	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,135,697	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Prairie Crossing Lvg Rehab # 0052126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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:				$ N/A			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? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 28 Description: Medical Supplies
(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	Allocated from Management Co. & RE			629	18
19					19
20					20
21	TOTAL		$	$ 629	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 Prairie Crossing Lvg Rehab # 0052126 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

It is the policy of this facility to only hire certified nurses aides.

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.)

		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	39(3)	hrs	$	2,569	$ 184,990	$	2,569	$ 184,990	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		819	39,329		819	39,329	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,653	169,779		2,653	169,779	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				75,886		75,886	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			$	6,041	$ 394,098	$ 75,886	6,041	$ 469,984	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 Crossing Lvg Rehab # 0052126 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	$ 1,624,717	$ 1,674,432	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 46,526)	1,253,961	1,253,961	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	25,383	52,281	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Schedule 17A	191,378	576,623	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,095,439	$ 3,557,297	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	50,000	13
14	Buildings, at Historical Cost	-	2,664,843	14
15	Leasehold Improvements, at Historical Cost	241,496	1,205,820	15
16	Equipment, at Historical Cost	31,225	659,393	16
17	Accumulated Depreciation (book methods)	(104,540)	(3,135,697)	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 (spe **Goodwill**	-	910,000	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 168,181	$ 2,354,359	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,263,620	$ 5,911,656	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 39,465	$ 39,465	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	40,477	40,477	28
29	Short-Term Notes Payable	857,409	59,426	29
30	Accrued Salaries Payable	34,648	34,648	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,753	5,753	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	38,000	32
33	Accrued Interest Payable	-	11,623	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	367,647	755,438	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,345,399	$ 984,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	4,557,563	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	60,311	60,311	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 60,311	$ 4,617,874	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,405,710	$ 5,602,704	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,857,910	$ 308,952	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,263,620	$ 5,911,656	48

***(See instructions.)**

Facility Name: **Prairie Crossing Lvg Rehab**
IDPH License ID Number: **0052126**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
1140	#NAME?	#NAME?	#NAME?
1500	#NAME?	#NAME?	#NAME?
1501	#NAME?	#NAME?	#NAME?
1502	#NAME?	#NAME?	#NAME?
1503	#NAME?	#NAME?	#NAME?
2073	#NAME?	#NAME?	#NAME?
4060	#NAME?	#NAME?	#NAME?
6050	#NAME?	#NAME?	#NAME?
6055	#NAME?	#NAME?	#NAME?
3015	#NAME?	#NAME?	#NAME?
	Total - Line 9	**#NAME?**	**#NAME?**
		#NAME?	#NAME?

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
7055	#NAME?	#NAME?	#NAME?
7310	#NAME?	#NAME?	#NAME?
7145	#NAME?	#NAME?	#NAME?
8811	#NAME?	#NAME?	#NAME?
8813	#NAME?	#NAME?	#NAME?
	Total - Line 36	**#NAME?**	**#NAME?**
		#NAME?	#NAME?

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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**	$ 668,409	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	2,687	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 671,096	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,186,814	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)**	$ 1,186,814	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)**	$ 1,857,910	24	*

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

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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	$ 5,188,733	1
2	Discounts and Allowances for all Levels	(-)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,188,733	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	232,690	6
7	Oxygen	828	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 233,518	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	654,166	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	-	13
14	Non-Patient Meals	-	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	-	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	-	19
20	Radiology and X-Ray	-	20
21	Other Medical Services	-	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 654,166	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	1,704	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,704	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	5,885	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,885	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,084,006	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	828,361	31
32	Health Care	1,879,828	32
33	General Administration	1,091,788	33
	B. Capital Expense		
34	Ownership	421,063	34
	C. Ancillary Expense		
35	Special Cost Centers	499,341	35
36	Provider Participation Fee	176,811	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,897,192	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,186,814	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,186,814	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,618,579	44
45	Private Pay - Net Inpatient Revenue	776,784	45
46	Medicare - Net Inpatient Revenue	1,783,132	46
47	Other-(specify) Hospice	10,238	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,188,733	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^Entity is a cash basis taxpayer.

Facility Name: **Prairie Crossing Lvg Rehab**
IDPH License ID Number: **0052126**
Fiscal Year End: **12/31/2020**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Medicaid Income Adjustments	5,583
Wage Assingment Fees	30
Misc Income	272
Total - Line 28	**5,885**
	-

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,096	2,160	$ 79,463	$ 36.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,532	9,854	315,699	32.04	3
4	Licensed Practical Nurses	11,828	12,470	363,520	29.15	4
5	CNAs & Orderlies	48,606	50,195	838,178	16.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,192	11,652	127,496	10.94	10
11	Social Service Workers	1,871	1,966	34,137	17.36	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,070	38,778	18.74	13
14	Head Cook	5,807	6,010	66,135	11.00	14
15	Cook Helpers/Assistants	9,573	9,967	103,645	10.40	15
16	Dishwashers					16
17	Maintenance Workers	3,901	4,093	67,867	16.58	17
18	Housekeepers	12,805	13,367	136,073	10.18	18
19	Laundry	4,230	4,416	44,949	10.18	19
20	Administrator	2,088	2,160	85,563	39.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,758	8,949	323,417	36.14	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,302	139,328	$ 2,624,920 *	$ 18.84	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	Monthly	$ 5,449	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				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)		$ 11,449		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	18	$ 932	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	718	21,107	10(3)	52
53	TOTAL (lines 50 - 52)	736	$ 22,039		53

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristen Etchinson	Administrator	0	$ 85,563
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,563

B. Administrative - Other

Description	Amount
SW Financial Services Fees (Eliminated on Sch. V, Col. 7)	$ 87,600
Moshe Herman/Momentum Healthcare	120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 207,600

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	Unemployment Consultant	$ 510
Ehrmann Gehlbach Badger & Cons	Legal	419
Rubinbrown Llp	Accounting	22,760
RSM US LLP	Accounting	395
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 24,084

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,846
Unemployment Compensation Insurance	25,288
FICA Taxes	196,149
Employee Health Insurance	62,791
Employee Meals	20,023
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	3,836
Holiday Expense	210
TOTAL (agree to Schedule V, line 22, col.8)	$ 354,143

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 259)	3,109
Patient Background Checks 150	1,500
Health Care Council of Illinois	13,432
Miscellaneous Dues & Permits	3,633
Miscellaneous Inspections & Licenses	3,996
Allocated from Management Co. & RE	1,675
Less: Chamber Dues	(175)
Less: Public Relations Expense	(6,716)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,434

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	500
Allocated from Home Office	242
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 742

**See instructions.

Facility Name: **Prairie Crossing Lvg Rehab**
IDPH License ID Number: **0052126**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Balance B/F from page 21		24,084
	Total (agree to Schedule V, line 19, column 3)	24,084
	Allocated from Home office - Legal	1,452
	Allocated from Home office - Accounting	1,214
	Allocated from Real Estate - Accounting	8,515
	Non Allowable legal	(100)
	Total (agree to Schedule V, line 19, column 8)	35,165

Facility Name & ID Number Prairie Crossing Lvg Rehab # 0052126 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? **Y**
If YES, give association name and amount. **Health Care Council of Illinois - 13,432**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,720** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **176,811**
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. $ **20,023** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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